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

WEDNESDAY, MARCH 13, 2024
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
Maura Byron
José Mayorga, M.D.

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 Health website at www.caloptima.org.

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at: https://us06web.zoom.us/webinar/register/WN_mkQ3dzz-SWiPeYqLAsJ38w and Join the Meeting.
Webinar ID: **857 6683 9721**
Passcode: **631970** -- 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 December 13, 2023 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

REPORT/DISCUSSION ITEMS
3. Recommend that the Board of Directors Receive and File 2023 CalOptima Health Quality Improvement Evaluation and Recommend Board of Directors Approval of the 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan

4. Recommend that the Board of Directors Approve the 2023 CalOptima Health Utilization Management Program Evaluation and the 2024 CalOptima Health Integrated Utilization Management/Case Management Program Description

5. Recommend that the Board of Directors Receive and File 2023 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan

6. Recommend that the Board of Directors Approve Recommendation for Vice Chair Appointment to the Whole-Child Model Family Advisory Committee

ADVISORY COMMITTEE UPDATES
7. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

8. Whole-Child Model Family Advisory Committee Report

INFORMATION ITEMS
9. Applied Behavior Analysis and Behavioral Health Pay-for-Value Programs

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee on March 13, 2024 at 3:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_mkQ3dzz-SWiPeYqLAsJ38w

To **Join** from a PC, Mac, iPad, iPhone or Android device:
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Passcode: **631970**

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MEMORANDUM

DATE: March 13, 2024

TO: CalOptima Health Quality Assurance Committee

FROM: Richard Pitts, D.O., Ph.D., Chief Medical Officer

SUBJECT: Chief Medical Officer Report — March 13, 2024, Quality Assurance Committee

COPY: Sharon Dwiers, Clerk of the Board

A. New Medical Management Platform (Jiva) Update

Jiva, CalOptima Health's new Medical Management Platform, successfully went live on February 1, 2024, replacing the previous medical management program, Guiding Care. During the first two weeks of go-live, a command center was set up to support users. The center was staffed with subject matter experts (SMEs) available both by phone and in person, CalOptima Health's team members, as well as team members of our vendor, ZeOmega.

Approximately 310 million records were transferred from Guiding Care to Jiva.

To minimize service disruption and ensure a seamless transition, CalOptima Health has taken actions to test the performance of the new medical management platform beyond the limits of normal operations, also known as "stress-testing."

Jiva will support our Case Management, Utilization Management (UM), Grievance and Appeals Resolution Services (GARS), Pharmacy, Behavioral Health, Population Health Management, and other member-facing functions. Jiva will increase efficiency and expedite the work process through its features of automated workflows and visibility of deadlines. For instance, letters will be automatically generated, attached to the workflows, and sent to members and providers as applicable. Upcoming due dates and overdue tasks are now visible to ensure compliance.

B. Skilled Nursing Facilities (SNF) Access Program: July 1, 2023 - June 30, 2026

The purpose of CalOptima Health's SNF Access Program is to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who require SNF post-hospitalization care.

As of December 2023, CalOptima Health has 68 active contracted SNFs in Orange County (out of 72 SNFs), 32 SNFs out-of-county, and 16 contracts in progress for both in and out-of-county.

Since July 2023, CalOptima Health has created an internal workgroup to discuss common discharge barriers. Contracts at four SNFs were amended to cover additional charges for bedside dialysis. A focused workgroup was also created to facilitate SNF collaboration and to discuss shared challenges.

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C. Comprehensive Community Cancer Screening and Support Program

CalOptima Health's Comprehensive Community Cancer Screening and Support Program was launched to create a culture of cancer prevention, early detection, and collaboration with partners to work toward a shared goal of dramatically decreasing late-stage cancer incidence for breast, cervical, colorectal, and lung cancer and ensuring that all Medi-Cal members have equitable access to high-quality care.

On February 8, CalOptima Health announced up to $15 million over two years in first-round grant funding to increase early detection and reduce late-stage diagnoses of these cancers among its Medi-Cal members. This funding is part of the Board-approved five-year, $50.1 million program. Grants supporting the following three areas for funding will be considered in the first round:

- Capacity Building: Activities may include hiring staff, patient navigators, or consultants with lived experience, providing training and skills development, or implementing other strategies to improve services and support.
- Infrastructure and Capital Improvements: Proposed projects may include investments in technology and/or equipment that support improved systems, workflows, outreach, and access.
- Care Coordination Collaboratives: Eligible projects may include the creation and/or expansion of partnerships or collaboration with other organizations and systems of care.

This funding will support activities that improve services and supports for CalOptima Health Medi-Cal members and at minimum result in the following expected outcomes:

- Increase community and member awareness and engagement,
- Increase access to cancer screening,
- Decrease late-stage cancer discovery, and
- Improve member experience throughout cancer treatment.

CalOptima Health will consider applications from nonprofit and for-profit organizations, joint ventures, or partnerships that serve the identified purpose of this funding opportunity. CalOptima Health's Board approved the Notice of Funding Opportunity (NOFO) on February 1, 2024. The application deadline is **March 29, 2024**. The grant start date will be June 1, 2024. A second round of competitive grants will be available in the future to build upon best practices and/or priorities emerging from the first round.

Link to the active webpage for the NOFO:
https://www.caloptima.org/en/About/CurrentInitiatives/CancerInitiatives

"A culture is what it is and that's not the barrier. The barrier is that if we don't understand the culture then we can't be very effective in communicating what we think may be beneficial for health - like getting cancer screening tests."

-Helen Meissner, Ph.D., Chief of the National Cancer Institute's Applied Cancer Screening Research Branch

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

December 13, 2023

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee (Committee) was held on December 13, 2023, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Trieu Tran called the meeting to order at 3:07 p.m. and led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; José Mayorga, M.D.
(All Committee members participated in person)

Members Absent: None

Others Present: Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Ryan Dunlevy, Outside General Counsel, Kennaday Leavitt; Linda Lee, Executive Director, Quality Improvement; Monica Macias, Director, PACE; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

1. Chief Medical Officer Report

Richard Pitts, D.O., Ph.D., Chief Medical Officer, reviewed the Chief Medical Officer Report with the Committee and started off by providing an update on the Jiva project. Dr. Pitts noted that Jiva will replace CalOptima Health's care management program, Guiding Care, which tracks everything to do with a member's health care. Dr. Pitts also noted that the transition is a heavy lift for the organization and touches most departments. The target date for Jiva to go live is February 1, 2024. Dr. Pitts noted that the collaboration between Jiva staff and CalOptima Health has been outstanding. He has been the executive presence on the CalOptima Health side, and he meets with the key leaders every Monday, Wednesday, and Friday at 7:30 a.m. Dr. Pitts added that CalOptima Health is on track for the February 1, 2024, go-live for the Jiva platform.

Dr. Pitts also provided an update on skilled nursing facilities and the progress being made with vancomycin to treat infections.

PUBLIC COMMENTS

There were no requests for public comment.

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CONSENT CALENDAR

2. Approve the Minutes of the October 17, 2023, Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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

INFORMATION ITEMS

3. Department of Health Care Services Equity and Practice Transformation Program

Yunkyung Kim, Chief Operating Officer, reported that CalOptima Health is participating with the Department of Health Care Services (DHCS) in their efforts to promote equity and practice transformation at the practice level. Ms. Kim noted that this is a five-year state-wide program that allows small practices to draw down state assistance through participation in the state's equity and practice transformation activities in Orange County. CalOptima Health has met with its providers, including community clinics and health networks, to promote the state program to enable their access to the program and to encourage applications to the state. Ms. Kim added that staff recommended to DHCS that all 62 eligible applicants in Orange County be considered for continued assessment and participation in the program. She also added that unfortunately the state has postponed the announcement of which providers in Orange County will continue to participate. Ms. Kim noted that CalOptima Health is also waiting to hear back from the state on what the performance criteria will be to draw down the incentive dollars. CalOptima Health will be ready to support its providers in meeting those performance targets so they can access the additional resources. Ms. Kim noted that CalOptima Health will keep the Committee, as well as the broader provider community, informed of the state's final determination on the selected providers.

Ms. Kim responded to Committee members' questions and comments.

4. 2024 Medicare Stars Update

Linda Lee, Executive Director, Quality Improvement, presented an update on CalOptima Health's 2024 Centers for Medicare & Medicaid Services (CMS) stars program. Ms. Lee provided background on the CMS stars program, noting that CMS established a quality performance system that looks at Part C and Part D measures. Part C measures are an aggregate of inpatient and outpatient services, and Part D measures are the prescription drug services. Ms. Lee provided the details of the benefits of being a high performing plan and the downside of being a low performing plan. She reminded the Committee that in 2023 CalOptima Health had a decrease in its Part C rating, from 3.5 stars in 2022 to 2.5 stars in 2023. Ms. Lee reported that for 2024 CalOptima Health increased its Part C rating to 3.0 stars and added that its Part D rating remained at 3.5 stars. She noted that the ratings puts CalOptima Health's overall performance at 3.0 stars and cures the potential risk of becoming a low performing plan. Ms. Lee added that CalOptima Health continues to focus on improving its Medicare performance year over year and highlighted some of the measures where its ratings improved in 2024 as well as areas where additional focus is needed.

Ms. Lee and Ladan Khamseh, Executive Director, Operations, and Michael Hunn, Chief Executive Officer, responded to Committee members' questions and comments.

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5. Hospital Quality Program Update

Ms. Lee presented an update on CalOptima Health's Hospital Quality Program. She shared that although hospitals play a significant and important role in providing care to CalOptima Health's members, historically many of CalOptima Health's quality programs were aimed at health network performance. Ms. Lee added that under CalOptima Health's current leadership, a decision was made to highlight the importance of hospital partners and promote hospital quality and extend incentive programs to its hospital partners. In December 2022, the Board of Directors approved a five-year Hospital Quality Program. Ms. Lee shared the baseline data collection for the Hospital Quality Program and explained that CalOptima Health then reviewed the hospital quality metrics that are currently used in the industry, including the areas of quality outcomes, patient experience, and patient safety. Ms. Lee noted that to minimize the burden on the hospitals, CalOptima Health elected to use hospital measures that the hospitals were already reporting to external entities. She also noted that this technique has been used by some of CalOptima Health's sister plans in the Inland Empire and others to leverage existing measures. Ms. Lee reported that quality and patient experience measures come from CMS inpatient quality measures that are reported on CMS's Hospital Care Compare website. She added that the website has star ratings for quality and patient experience for hospitals across the country. In the area of patient/hospital safety, CalOptima Health is using the LeapFrog safety grade. Ms. Lee reviewed the measurement values and weighting, as well as incentive dollars that hospitals can potentially earn. She also briefly reviewed hospital performance for 2021 and 2022, noting that there are some areas where hospitals performed well and other areas where there were opportunities for improvement. None of the hospitals are earning 100 percent of their potential incentives. Ms. Lee noted that staff will continue to update the Committee and Board of Directors throughout the five-year Hospital Quality Program.

Ms. Lee responded to the Committee members' questions and comments.

6. Measurement Year 2022 Healthcare Effectiveness Data and Information Set (HEDIS) Health Network Trends

Ms. Lee reviewed the Measurement Year 2022 HEDIS measures that DHCS requires CalOptima Health to report for the Medi-Cal program through the Managed Care Accountability Set (MCAS). She reviewed the various measures noting that CalOptima Health did not receive a sanction for this measurement year, but she did call out one measure where CalOptima Health was below the minimum performance level, which was lead screening. Ms. Lee reviewed the measures and performance trends in detail and intervention efforts at all levels to improve performance. She noted that CalOptima Health continues to meet with health networks and providers to stay on target and share best practices.

Ms. Lee, Mr. Hunn, and Ms. Kim responded to Committee members' questions and comments.

7. Update on the National Committee for Quality Assurance (NCQA) Accreditation, Health Equity, and Credentialing

Ms. Lee provided an update on the status of CalOptima Health's upcoming re-survey for the NCQA health plan accreditation, as well as an update on where CalOptima Health stands with the upcoming DHCS requirement to achieve health equity accreditation. Ms. Lee reviewed key dates and the timeline for the health plan re-survey. CalOptima Health's materials are due to NCQA on April 30, 2024, and include program documents, policies and procedures, member materials, provider materials, and reports. She provided additional details of next steps with regard to accreditation and

shared areas that CalOptima Health is on track and potential areas of risk. Ms. Lee shared that the accreditation is a two year look back from April 2022 to April 2024 – CalOptima Health is currently in the middle of year two. She also noted that CalOptima Health's NCQA consultants have been conducting mock audits to prepare for the upcoming re-survey and they have been taking a stricter approach of how an NCQA auditor will conduct their review of files. Through each step, CalOptima Health has been communicating and retraining health networks and internal staff, on a go forward basis.

Ms. Lee also provided a brief update on health equity accreditation, which is a program that NCQA has had for several years. In the past, health equity accreditation was not a complete accreditation status, but was something called multicultural distinction. This was for plans and entities that have a health equity focus. DHCS requires Medi-Cal plans to achieve and secure health equity accreditation by 2026. Ms. Lee reviewed what falls under health equity accreditation. She shared that the goal of the program is to identify disparities, address social risk factors, and work towards dismantling the systemic and structural barriers that generate bias or discrimination in health care. She noted that equity is tied very closely with quality and the need to identify disparities to ensure that all members have access to quality health care. CalOptima Health is tentatively scheduling accreditation for June of 2025. Ms. Lee noted that there is much work to be done to prepare for this accreditation and that she and Dr. Michaell Rose, CalOptima Health's Chief Health Equity Officer, will work together to close inequities in health care.

The following items were accepted as presented.

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

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

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

ADJOURNMENT
Hearing no further business, Chair Tran adjourned the meeting at 4:18 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 13, 2024

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 13, 2024
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

3. Receive and File 2023 CalOptima Health Quality Improvement Evaluation and Recommend Board of Directors Approval of the 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Linda Lee, MPH, Executive Director, Quality Improvement, (714) 867-9655

Recommended Actions

- Receive and file the 2023 CalOptima Health Quality Improvement Evaluation, and
- Recommend the Board of Directors approve the 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan.

Background

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and customer service provided to its members, which aligns with CalOptima Health's vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members. The QIHETP is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks.

CalOptima Health's QIHETP is reviewed, evaluated, and approved annually by the Board of Directors. The QIHETP defines the structure within which quality improvement (QI) activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima Health members.

The 2023 Quality Improvement Program Evaluation (QI Evaluation) analyzes the core clinical and service indicators to determine if the 2023 QI Program has achieved its key performance goals during the year.

CalOptima Health had the following achievements in 2023:

- September 2023: Received a 4 out of 5 in NCQA's Medicaid Health Plan ratings for the ninth year in a row.
- October 2023: Community Action Partnership of Orange County presented CalOptima Health with its Community Hero Award for its work on housing and food security.
- October 2023: The Eli Home presented its Humanitarian Award for CalOptima Health's contribution to serving abused and unhoused children and families.

In 2023, CalOptima Health remained committed to innovative approaches to improving quality of care and quality of service. CalOptima Health expanded strategies to improve member health outcomes,

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member experience, and provider engagement by (i) continuing to promote the COVID-19 vaccinations through the COVID-19 Vaccination Incentive Program, (ii) launching the Student Behavioral Health Incentive Program to increase behavioral health screening and referrals, (iii) launching the Enhanced Cre Management (ECM) Academy to bring on new ECM providers, and (iv) launching a Street Medicine Program as part of CalAIM.

Discussion

CalOptima Health staff has updated the 2024 QIHETP and Workplan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across all lines of business.

The 2024 QIHETP is based on the Board of Directors-approved 2023 QI Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all lines of business to ensure they are consistent with regulatory requirements, NCQA standards, and CalOptima Health's strategic initiatives.

The revisions are summarized as follows:

1. Updated existing program initiatives to align with health equity and current operational practices.
2. Updated 2024 priority areas and goals:
    - Priority Area 1: Maternal Health:
        - Goal 1 – Close maternity care disparity for Black and Native American persons by 50%.
    - Priority Area 2: Children's Preventive Care:
        - Goal 1 - Exceed the 50th percentile for all children's preventive care measures.
        - Goal2 – Close racial/ethnic disparities in well-child visits and immunizations by 50%.
    - Priority Area 3: Behavioral Health Care:
        - Goal 1 – Improve maternal and adolescent depression screening by 50%.
        - Goal 2 - Improve follow-up for mental health substance disorder by 50%.
    - Priority Area 4: Program Goals:
        - Goal 1 – Medi-Cal: Exceed the minimum performance levels for the Medi-Cal Accountability Set.
        - Goal 2 - OneCare: Attain a four-star rating for Medicare.
3. Updated new program initiatives:
    - Health Equity Framework.
    - Comprehensive Community Cancer Screening and Support Program.
    - Five-Year Hospital Quality Program.
4. Updated the QI Program staffing and resources to reflect current organizational structure:
    - Added a Chief Health Equity Officer.
    - Added Medical Directors to support a Medical Model.

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5. Updated the QI Committee structure by adding a new Population Health Management Committee.
6. Removed programs that sunset in 2023.
7. Updated sections in the QI Program to reflect current operational processes and workflows.

The 2024 QIHETP and Work Plan will be flexible and able to align with strategic goals and objectives as defined by the Board of Directors. Staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

2024 QIHETP annual work plan focus areas include:

1. Preventive measures and screenings identified in the Department of Health Care Services (DHCS) Quality Strategy (Bold Goals).
2. Social determinants of health factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
3. Quality initiatives to improve member experience, focused on increasing member access to care.

The recommended changes to CalOptima Health's QIHETP reflect current clinical operations and are necessary to meet the requirements specified by the Centers of Medicare and Medicaid Services, DHCS, and NCQA accreditation standards.

Fiscal Impact

The recommended action to approve the 2024 QIHETP has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2023-24 Operating Budget. Staff will include updated expenditures for the period of July 1, 2024, through December 31, 2024, in the FY 2024-25 Operating Budget.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2023 Quality Improvement Program Evaluation
2. 2024 Quality Improvement and Health Equity Transformation Program and Work Plan DRAFT FINAL (Redline version)
3. Proposed 2024 Quality Improvement and Health Equity Transformation Program and Work Plan DRAFT FINAL (Clean version)
4. PowerPoint Presentation: 2023 QI Evaluation, 2024 Quality Improvement and Health Equity Transformation Program and Work Plan

/s/ Michael Hunn *03/08/24*
Authorized Signature **Date**

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2023 QUALITY IMPROVEMENT (QI) PROGRAM EVALUATION



FEBRUARY 2024

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2023 QUALITY IMPROVEMENT (QI) PROGRAM ANNUAL EVALUATION SIGNATURE PAGE

Quality Improvement and Health Equity Committee Chairperson:

Richard Pitts, D.O., Ph.D. CalOptima Health Chief Medical Officer	Date

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Tran, M.D.	Date

Board of Directors Chairperson:

Clayton M. Corwin	Date

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2023 CalOptima Health

Quality Improvement (QI) Program Annual Evaluation

Section 1: CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

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.

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public health plan and with our members and providers.



Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2022–2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in June 2022. Our core strategy is the "inter-agency" co-creation of services and programs, together with our delegated networks, providers and community partners, to support the mission and vision.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

CalOptima Health also aligns our strategic plan with the priorities of our federal and state regulators.

Section 2: Executive Summary

The 2023 Quality Improvement (QI) Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved key performance goals throughout the 2023 year. This evaluation focuses on quality activities implemented during measurement year 2023, which impacted performance, to improve health care and services available to CalOptima Health members. The look back period for the 2023 QI Evaluation is Q4'2022 through the end of Q3'2023, and Q4'2023 is added where available.

The QI Program for 2023 outlined major program initiatives. Threaded into the initiatives continued to be interventions that support both the Department of Health Care Services (DHCS) Comprehensive Quality Strategy and the Centers for Medicare & Medicaid Services (CMS) National Quality Strategy. These strategies aim for care that is equitable, high-quality and value-based and considers the needs of the whole person.

In 2023, the QI Program Initiatives aligned with CalOptima Health's strategic priorities with a focus on health equity, social determinants of health, member engagement, improved access to care and improved quality outcomes. CalOptima Health remained focused on advancing Quality Improvement and Health Equity (QIHE) initiatives to achieve 2023 QIHE goals and objectives to provide members with access to quality health care services. CalOptima Health continued to utilize the Plan-Do-Study-Act (PDSA) and continuous quality improvement (CQI) approach to developing initiatives in 2022 that continued into 2023. These initiatives are focused on long-term improvements in selected high-priority measures.

In 2024, based on the 2023 QI Program Evaluation, CalOptima Health will continue to support a strategy, as identified in the 2024 Quality Improvement and Health Equity Transformation Program (QIHETP), formerly known as the Quality Improvement (QI) Program, that aligns with CalOptima Health's strategic priorities and regulatory requirements and focuses on activities and incentives that will improve member engagement, access to care and quality outcomes. The 2024

QIHETP Annual Work Plan will profile key areas that offer opportunities for improvement to be implemented or continued as outlined in the 2024 QIHETP.

2.1 2023 Achievements

September 2023: CalOptima Health's Medi-Cal plan was recognized by the National Committee for Quality Assurance (NCQA). For the ninth year in a row, our Medi-Cal plan was among the top plans in California, according to the NCQA's Medicaid Health Plan Ratings 2023. CalOptima Health earned 4 stars out of 5 stars.

November 2023: Two community-based organizations honored CalOptima Health's work serving vulnerable populations. Community Action Partnership of Orange County presented CalOptima Health with its Community Hero Award for our work on housing and food security. The Eli Home presented its Humanitarian Award for our contribution to serving abused and unhoused children and families.

December 2023: CalOptima Health was honored twice by the Orange County Business Council's Turning Red Tape Into Red Carpet Awards. We received a nomination for Public-Private Partnership with Chrysalis on a workforce development program. CEO Michael Hunn was nominated for Leadership in Public Service.

Throughout the year, our executives were honored for their successful leadership at CalOptima Health. This recognition includes:

- Nancy Huang, Chief Financial Officer, was a finalist in the Orange County Business Journal's CFO of the Year Awards.
- Richard Pitts, D.O., Ph.D., Chief Medical Officer, was named a Health Care Hero by the Community Health Initiative of Orange County.
- Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, was honored by the Los Angeles Times as an OC Visionary and for the OC Inspirational Women Awards.
- Carmen Katsarov, Executive Director, Behavioral Health Integration, was appointed to Gov. Gavin Newsom's Behavioral Health Task Force.
- Deanne Thompson, Executive Director, Marketing and Communications, won a gold award from Health Care Communicators of Southern California.
- Michael Hunn, CEO, was appointed to the California Association of Health Plans Board of Directors.

2.2 Review of 2023 Quality Improvement (QI) Goals

Goal 1: Develop and implement a comprehensive Health Equity Framework that transforms practices, policies and systems at the member, organizational and community levels.

In response to CalOptima Health's strategic plan, staff began the process to identify and address health equity and social determinants of health (SDOH) for vulnerable populations throughout Orange County. A Health Equity Framework was developed and includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive readiness assessment to determine organizational capacity to undertake a health equity redesign. The framework allows for opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.

CalOptima Health's Health Equity and Social Determinants of Health Framework

Create a culture of health equity throughout CalOptima by using data to measure inequities and developing strategies to address them. Throughout the process, create opportunities for feedback from internal and external stakeholders and include their voices in the design and implementation process.



Goal 2: Improve quality of care and member experience by attaining an NCQA health plan rating of 5.0, and at least a 4.0-star rating for Medicare.

In 2023, CalOptima Health's Medi-Cal plan was recognized by NCQA. For the ninth year in a row, our Medi-Cal plan was among the top plans in California, according to the NCQA's Medicaid Health Plan Ratings 2023. While CalOptima Health did not attain a 5.0 rating, CalOptima Health did maintain a 4.0 rating. For Medicare, CalOptima Health received a 3.0-star rating and not the goal of 4.0-star rating.

Goal 3: Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare and Hospital Quality.

Value-Based Payment Program or Pay for Value (P4V) Program
CalOptima Health's Value-Based Payment Performance Program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health Networks (HNs), including CalOptima Health Community Network (CCN), and HNs' primary care physicians (PCPs) are eligible to participate in the Value-Based Payment Programs. CalOptima Health has adopted the Integrated Healthcare Association (IHA) pay for performance methodology to assess performance. Performance measures are aligned with the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) for Medi-Cal and a subset of CMS Star measures for OneCare. In 2023, staff generated and shared monthly Prospective Rate reports with all health networks and CCN clinics and providers to show their performance

on all clinical Healthcare Effectiveness Data and Information Set (HEDIS®) value-base payment measures. A Health Network Report Card was also shared with the HNs that summarizes their performance and Health Network Quality Rating (HNQR) on all clinical HEDIS P4V measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience survey measures. Value-based payment checks were issued to the HNs in Q4 2023.

Five-Year Hospital Quality Program 2023–2027
CalOptima Health developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience and patient safety. Hospitals may earn annual incentives based on achievement of benchmarks. In 2023, CalOptima Health developed and distributed to each contracted hospital baseline score cards indicating hospital performance for measurement year 2022. The first year for incentive payments will be in measurement year 2023 paid out in Q4 2024.

2.3 Overall Effectiveness of the 2023 Quality Improvement Program

Overall, the 2023 QI Program was effective in identifying opportunities for improvement and enhancing processes and outcomes. Sufficient resources were committed to support committee activities and to complete projects detailed in the work plan.

Review of the scope, composition and business of the individual committees led management to review the existing committee structure, which resulted in the development of a new subcommittee, the Population Health Management Committee (PHMC). The PHMC will provide overall direction for continuous process improvement and oversight of population health activities, monitor compliance with regulatory requirements and ensure that population health initiatives meet the needs of CalOptima Health members. The committee will also ensure that all population health initiatives are performed, monitored and communicated according to the PHM Strategy and Work Plan. The PHMC is responsible for reviewing, assessing and approving Population Needs Assessment (PNA), Population Health Management (PHM) Strategy activities, and PHM Work Plan progress and outcomes and recommend evidence-based and/or best practice activities to improve population health outcomes and advance health equity.

Leadership played an active role by participating in and chairing the Quality Improvement Health Equity Committee (QIHEC) and subcommittee meetings, providing input on quality-related opportunities, helping to identify barriers and develop and implement effective approaches to achieve improvements. The current level of leadership involvement in the QI Program was more than adequate this past year, as we ended the year with 15 Medical Directors. No additional leadership involvement is needed for the upcoming year, with the addition of the new Medical Directors and our new Chief Health Equity Officer (CHEO). The Chief Medical Officer (CMO), the Deputy Chief Medical Officer (DCMO), the Quality Medical Director, and the Executive Director, Quality Improvementwere active participants in QIHEC and subcommittees; integral in providing oversight and direction of the Quality Improvement and Health Equity Transformation Program (QIHETP). The CMO, as the senior physician, designates the Quality Medical Director and the CHEO to serve as co-Chairs of QIHEC. Network providers and CalOptima Health medical

directors are assigned to each committee and subcommittee to provide subject matter expertise dependent on the scope and role of the committee. CalOptima Health's QI annual work plan effectively monitored and reported on the numerous quality-related efforts underway throughout the organization. The work plan was updated and reviewed by the QIHEC on a quarterly basis.

CalOptima Health was successfully evaluated by regulators and accrediting bodies, with particular emphasis on quality and safety of care, coordination and integration of services, and provision of effectiveness and efficacy of processes.

Practicing network physicians provided input through QIHEC and the following subcommittees: Credentialing and Peer Review Committee (CPRC) and Whole Child Model Clinical Advisory Committee (WCM CAC). Practitioner participation in the QI Program was deemed satisfactory for the past year. To enhance provider participation in the QI Program, QI staff will consider adding community partners to be committee participants. CalOptima Health members and consumers advocates provided input through the Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC) contributed input from the provider community.

In addition to demonstrating improvements in equitable clinical care, staff promoted clinical practice guideline adherence. Potential quality of care process was revised to include a clinical review of quality-of-care grievances and potential quality issues were better identified, tracked and monitored through the CPRC. Patient safety was addressed through the monitoring of potential quality issues, facility site reviews and regular review of provider credentials. Coordination and collaboration among departments, such as between Fraud, Waste and Abuse and potential quality issues (PQI) supported more effective clinical and service improvements.

Improvements were made in several HEDIS areas. Better provider record abstraction and encounter data capture led to improved scores. Quality staff conducted office staff trainings on medical record best practices around the HEDIS process and shared HEDIS gap reports to assist providers in identifying members needing preventive screenings or other care. Providers were invited to CCN Virtual Meetings, also known as CCN Lunch and Learns, and webinars directing providers to online materials. These activities are expected to continue and be enhanced in 2024.

Member experience remains CalOptima Health's biggest opportunity. Across all product lines there were several member satisfaction measures that did not meet goals: getting needed care, getting care quickly, and overall rating of health plan. Workgroups were developed to focus on areas to improve Member Experience for OneCare. CalOptima Health implemented a predictive analytics tool to identify members for outreach. The Customer Service department deployed several changes that contributed to positive member experience.

Improvements were made in several HEDIS areas and MCAS measures met the minimum performance levels (MPLs) with the exception of one measure, Lead Screening in Children (LSC), which was newly added to the minimum performance level measurement set. OneCare attained a 3.0-star rating for Measurement Year (MY) 2022. This year, CalOptima Health conducted multi-modal member and provider outreach that included mailings, interactive voice response (IVR), text messaging, newsletters and telephonic outreach. Advertisements on the radio, television, social media and print along with member health rewards were used to promote well visits, preventive screenings and immunizations.

The QI Program will continue to focus on opportunities to improve equitable clinical care, safety and service in the areas outlined in this report. Member satisfaction continues to be an area of

focus and enterprise efforts are underway to improve this. Timely access to care continues to be an area of focus and CalOptima Health will focus on the need to improve provider data to improve care. There are multiple clinical (and/or clinical data) areas that still need improvement, such as blood lead screening. These and other QI activities are detailed in the 2024 QIHETP Work Plan and will be tracked through the QI committees and the governance structure.

2.4 Recommendations for 2024

For 2024, CalOptima Health will develop and implement the Quality Improvement and Health Equity Transformation Program (QIHTP) and QIHETP Work Plan, formerly known as the QI Program and Work Plan. The QIHETP will align with CalOptima's strategic goals and objectives as defined by the Board of Directors as well as with the priorities of our federal and state regulators, as identified in the Centers for Medicare & Medicaid Services (CMS) National Quality Strategy and the DHCS Comprehensive Quality Strategy. The QIHETP Work Plan will remain flexible, and staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a dignified and equitable manner.

Based on the 2023 QI Program Evaluation, CalOptima Health will continue to focus on the following initiatives and projects to drive improvements that impact members.

A. Incorporate SDOH factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
B. Collaborate with external stakeholders and partners in comprehensive assessments of members.
C. Develop robust community-based interventions using analytical tools, such as geo-mapping, in collaboration with community partners and entities that have a good understanding of the target population barriers and behaviors.
D. Strategize and streamline member outreach by using multiple modes of communication via contracted external vendors, including through website, direct mailings, email, interactive voice response (IVR) calls, mobile texting, targeted social media campaigns and robocall technology.
E. Expand collaboration on quality initiatives in partnership with health networks to broaden and expand the reach of coordinated data sharing to close gaps in care.
F. Expand quality initiatives to improve member experience, focused on increasing member access to care.

CalOptima Health also recommends the following new initiatives and projects to drive improvements that impact members.

A. Monitor, evaluate and take timely action to address necessary improvements in the quality of care delivered by all providers in any setting, and take appropriate action to improve upon health equity.
B. Incorporate feedback provided by members and network providers in the design, planning and implementation of CQI activities, particularly on interpreter services and access to care.
C. Enhance member and provider data collection to ensure the provider network can meet cultural and linguistic needs of our members.

2.5 Recommended Priority Areas and Goals for 2024

Based on the evaluation of the 2023 QI Program, CalOptima Health has identified the following Priority Areas and Goals for 2024. These recommended priority areas and goals are aligned with CalOptima Health's 2022–25 Strategic Goals and DHCS Bold Goals.

A. Maternal Health
    1. Close racial/ethnic disparities in well-child visits and immunizations by 50%
    2. Close maternity care disparity for Black and Native American persons by 50%
B. Children's Preventive Care
    1. Exceed the 50th percentile for all children's preventive care measures
C. Behavioral Health Care
    1. Improve maternal and adolescent depression screening by 50%
    2. Improve follow-up care for mental health and substance disorder by 50%
D. Program Goals
    1. Medi-Cal: Exceed the minimum performance levels (MPLs) for MCAS
    2. OneCare: Attain a Four-Star Rating for Medicare

Section 3: Quality Improvement (QI) Program Structure

Activities in the 2023 Quality Improvement (QI) Program and associated QI Work Plan focused on refining the structure and process of care delivery, with the emphasis on member-centric activity and consistency with regulatory and accreditation standards. All activities were undertaken in direct support of the Mission, Vision, Values and Strategic Initiatives of CalOptima Health.

3.1 Quality Improvement (QI) Program Documents

The components of the QI Program are closely aligned to meet the goal of continuously improving the quality of care for members.

A. 2023 Quality Improvement and Health Equity Transformation Program (QIHETP) Description — Developed and implemented a robust written QIHETP description that focused on improving standards of care and addressing gaps in care identified in the prior year's evaluation. The organization enhanced the QIHETP by including "new initiatives" in the program description that will outline measurable goals and objectives that CalOptima Health will focus on in subsequent years.
B. 2023 Quality Improvement and Health Equity Transformation Program (QIHETP) Work Plan — Created to monitor and evaluate performance of QI measures and interventions on an ongoing basis. This is a dynamic document that may change throughout the year based on priorities and opportunities.
C. 2022 QI Program Evaluation — Completed a comprehensive evaluation of the 2023 QI Program and QI Work Plan at the end of the year that assesses the performance on measures and indicators and the assessment laid the groundwork for the 2024 QIEHTP.
D. 2023 Utilization Management (UM) Program – Developed and implemented a written UM Program that defines the oversight and delivery of CalOptima Health's structure, clinical processes and programmatic approach to review health care services, treatment and supplies, and provide quality, coordinated health care services to CalOptima Health members.

E. 2022 UM Evaluation — Completed a comprehensive evaluation of the 2023 UM Program at the end of the year that evaluates the impact of the UM Program.

The following quality improvement documents were also reviewed and approved by the QIHEC and used to drive the quality improvement activities:

- The Population Health Strategy
- The Cultural and Linguistic Program
- The Pay for Value Program

3.2 Reviews of QI Documents

CalOptima Health successfully completed reviews of all of the above documents with the Quality Improvement Health Equity Committee (QIHEC) and/or Subcommittees during 2023. The documents were reviewed and approved by both the Quality Assurance Committee of CalOptima Health's Board of Directors and CalOptima Health's Board of Directors.

Feedback from the providers who participated in the QIHEC and/or Subcommittees meetings was included in program documents (i.e., Program Description, Work Plan and Evaluation).

3.3 Quality Improvement Health Equity Committee (QIHEC) and Subcommittees

Quality Improvement Health Equity Committee (QIHEC)

Committee Background:

A. The QIHEC is the primary committee that is responsible for the Quality Improvement and Health Equity Transformation Program (QIHETP), the QIHETP Work Plan and QIHETP Evaluation, and reports to the Quality Assurance Committee (QAC) of the CalOptima Health Board of Directors.
B. The committee is comprised of the Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO), CalOptima Health Chief Health Equity Officer (CHEO), CalOptima Medical Directors, CalOptima external physicians and community partners.
C. The committee is responsible for providing overall direction for continuous quality improvement processes, overseeing activities that are consistent with CalOptima Health's strategic goals and priorities, and monitoring compliance with regulatory and licensing requirements related to QI projects and activities.
D. The committee provides critical feedback and guidance to the QI department on key initiatives. The QIHEC also reviews and approves all the key QI documents in a timely manner.

Committee Changes in 2023:

A. QIHEC Charter updates were approved
    a. Committee name was updated to QIHEC
    b. Added Co-Chairperson – CalOptima Health Chief Health Equity Officer (CHEO)
    c. Updated the charter term from "physician" to "practitioners"
    d. Added department support from Customer Service and Cultural and Linguistic Services to reflect departments staff who are currently participating in the committee.

e. Added responsibilities:
    i. Provide the written QIHEC progress report to DHCS upon request
    ii. Make the written summary of the QIHEC activities publicly available on the CalOptima Health website on a quarterly basis.
    iii. Analyze, evaluate and react as needed to the results of the QIHETP and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other CalOptima Health committees.
    iv. Institute actions to address performance deficiencies and ensure appropriate follow-up of identified performance deficiencies

B. Latino Health Access representative joined in October 2023.
C. Orange County Health Care Agency representative joined in November 2023.
D. Orange County Global Medical Center representative joined in May 2023.
E. Established QIHEC annual reporting calendar for ensuring that all required quality elements are regularly reported to QIHEC.
F. Established a QIHEC Committee recruiting process.
G. Health Equity components were incorporated in the design and planning for quality elements.
H. Added a process to monitor areas of noncompliance to required quality elements and reported them to QIHEC; this includes problems and/or issues effecting member care.

Committee Action in 2023:

A. In 2023, the QIHEC was chaired by the Quality Medical Director, a designee of the Chief Medical Officer.
B. The QIHEC met monthly in 2023 to review and provide feedback on key clinical and other coordination of care initiatives, including member outreach, provider education and outreach, incentives, educational materials and more.
C. The committee reviewed and approved the 2023 QI Program Description, the 2023 QI Work Plan, the 2022 QI Evaluation, the 2023 UM Program and the 2022 UM Evaluation. The QIHEC also reviewed and approved the Population Health Management Strategy and the Cultural and Linguistics Program.
D. The committee reviewed and approved the policies and procedures and made recommendations regarding policy decisions.
E. The committee reviewed and provided feedback on key reports: annual analysis of HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) access to care; and complaints and appeals. Part of the feedback included specific actions that CalOptima Health could take to improve performance.
F. The committee received quarterly reports from the Credentialing and Peer Review Committee (CPRC), Utilization Management Committee (UMC), Member Experience Committee (MEMX), Grievance and Appeals Resolution Services (GARS) and Whole Child Model Clinical Advisory Committee (WCM CAC). These reports were summarized and presented quarterly to the QAC.
G. A new subcommittee will be developed in 2024 to provide overall guidance to the implementation and oversight of the Population Health Management Strategy.

3.3.1 Credentialing Peer Review Committee (CPRC)

Committee Background:

A. The purpose of the CPRC is to maintain a peer review and credentialing program that aligns with the regulatory and accreditation standards, promotes continuous improvement

of the quality of health care provided by the CalOptima Health network, conducts peer-level review and evaluation of provider performance and credentialing information against CalOptima Health requirements and appropriate clinical standards, and investigates patient care outcomes that raise quality and safety concerns for corrective actions.

B. CPRC meets monthly and is comprised of the CMO, DCMO, CalOptima Health Medical Directors and physicians from the community who are contracted with CalOptima Health and are currently in practice. CPRC is supported by the Executive Director of Quality Improvement, Director of Quality Improvement, Quality Improvement department staff, and Legal representatives.

Committee Changes in 2023:

A. This year, the CPRC had one CalOptima Health Behavioral Health (BH) medical director resign due to retirement, but a new BH Medical Director was added and participated in CPRC. Two new medical directors were added to the committee, overseeing both Delegation Oversight and Street Medicine.
B. To date, the Committee consists of 13 CalOptima Health medical directors and four community physicians representing various medical specialties. CalOptima staff and General Counsel provide support to the CPRC. CalOptima Health also hired a new Manager of Credentialing who participates in CPRC by presenting credentialing files.

Committee Actions in 2023:

A. In 2023, the CPRC was chaired by the Credentialing Medical Director, a designee of the Chief Medical Officer.
B. In 2023, the committee met monthly to review credentialing and PQI cases and concerns and review and approve the Credentialing Clean List and Credentialing Closure List.
C. PQI trends were evaluated every 6 months.
D. Three new boards/certifications were recommended to CPRC and approved for credentialing:
    1. American College of Academic Addiction Medicine
    2. National Board of Physicians & Surgeons
    3. American Board of Venous and Lymphatic Medicine Certificate
E. CalOptima Health policies related to quality, credentialing and PQIs were reviewed and approved.
F. CPRC approved the independent contracting and credentialing of Nurse Practitioners, under Assembly Bill 890, which was approved by the State of California in 2021 and implemented in 2023. Under the provision, Nurse Practitioners may practice independently and are not required to have a supervising physician.
G. Five physicians were recommended for de-credentialing due to one or more of the following: sanction findings or 805-reports identified, a PQI investigation and/or failing three consecutive Medical Record Reviews.
H. One infectious disease physician was identified with an accusation by the state board through ongoing monitoring.

3.3.2 Grievance and Appeals Resolution Services (GARS) Committee

Background: The Grievance and Appeals Resolution Services (GARS) Committee serves to protect the rights of our members, and to promote the provision of quality health care services and

enforces that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring.

The GARS Committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima Health providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS Committee is chaired by the Director of GARS, meets at least quarterly, and reports to the QIHEC.

Committee Actions in 2023: The GARS Committee met quarterly in 2023 as an ongoing effort to identify trends for the purposes of identifying barriers and initiatives to improve access to care and services and to improve the overall member experience.

3.3.4 Member Experience (MEMX) Committee

Committee Background: The purpose of the MEMX is to improve the member experience and drive initiatives to achieve member experience goals established by the corporate strategic plan or QI Work Plan. The MEMX also ensures members have access to quality health care services for all product lines and programs. The committee is comprised of the Chief Medical Officer, the Deputy Chief Medical Officer, Medical Directors, a variety of business units that impact member experience, and support staff from the Quality Analytics department.

Committee Changes in 2023:

A. In 2023, the committee added a co-chair, the Executive Director, Quality Improvement to co-chair the committee with the Executive Director, Operations.
B. MEMX meeting frequency changed from bi-monthly to quarterly.
C. The committee reviewed the charter and made the following changes:
    1. Changed title of Chair to Co-Chair
    2. Added Medical Director Designee; Deputy Chief Medical Officer, Medical Management; Medical Director, Medical Management; Executive Director, Medicare Programs; Executive Director, Quality; Director Operations Management; and Executive Director, Quality Improvement
    3. Modified titles for Executive Director, Population Health Management; Executive Director, Behavioral Health Integration; and Director, Behavioral Health Integration
    4. Removed Chief Operating Officer as Chair and member, and Director, Program Implementation as member.

Committee Actions in 2023:

A. In 2023, the committee met quarterly, with one additional ad-hoc meeting focused on the Member Experience Improvement Plan.
B. In 2023, the Member Experience Improvement Plan was developed to improve the OneCare Star rating to a 3 or above. The plan includes five workgroups aimed at improving member satisfaction and focus on the three tactical priorities:
    1. Improving access to care
    2. Improving customer service
    3. Improving provider office efficiency

C. The MEMX Committee reviewed and provided guidance on the following items:
    1. Customer Service OneCare Member Satisfaction Outreach Campaign (CAHPS-like Survey)
    2. Request for proposal for CAHPS improvement
    3. Issuing Corrective Action Plans (CAPs) for HNs with a Member Experience HN Quality Rating score below <2.5
    4. Customer Service OneCare Member Satisfaction Survey (Annual Wellness focus)
    5. Provider noncompliance notification and CAPs for Timely Access
    6. Annual Timely Access Survey
    7. Access related regulatory submissions, including Annual Network Certification (ANC) and Subcontracted Network Certification (SNC) Submission

3.3.5 Utilization Management Committee (UMC)

Committee Background: The UMC is led by a CalOptima Health Medical Director. This senior level physician is involved in UM activities, including but not limited to implementation, supervision, oversight and evaluation of the UM Program.

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Health Direct, CalOptima Health Community Care Network (CCN) and through the delegated HNs to identify areas of under or over utilization that may adversely impact member care. The UMC is responsible for the annual review and approval of medical necessity criteria and protocols, and the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation. Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIHEC and QAC. With the assistance of the UM Program specialist, the Director of UM or designee maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIHEC. Oversight and operating authority of UM activities is delegated to the UMC, which reports up to QIHEC and ultimately to QAC and the Board of Directors.

UMC Scope and Responsibilities

A. Provides oversight and overall direction for the continuous improvement of the UM Program, consistent with CalOptima Health's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima Health and delegated HNs.

B. Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
C. Reviews and approves the UM Program Description, medical necessity criteria, UMC Charter, UM policies and the UM Program Evaluation on an annual basis.
D. Reviews and analyzes UM operational and outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
E. Reviews and approves annual UM metric targets and goals.
F. Reviews progress toward UM Program goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
G. Promotes a high level of satisfaction with the UM Program across members, practitioners, stakeholders and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
H. Reviews, assesses and recommends UM best practices used for selected diagnoses or disease classes.
I. Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
J. Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:
    1. Benefit Management Subcommittee (BMSC)
    2. Pharmacy and Therapeutics (P&T) Committee
K. Reports to the QIHEC on a quarterly basis, communicates significant findings and makes recommendations related to UM issues.

Committee Changes in 2023:

A. Added UMC voting members
    1. Medical Director, Behavioral Health Integration
    2. Medical Director, Medicare Programs
    3. Medical Director, Population Health and Equity
    4. Medical Director, Network Relations
    5. Medical Director, Appeals and Grievances and Case Management
    6. Medical Director, Street Medicine
    7. Medical Director, CalAIM & Medical Director, Appeals and Grievance
B. UMC Charter Updates
    1. Added section for 2023 Meeting frequency: Quarterly, a minimum of four times per year. Ad-hoc committee meetings to address specific issues.
    2. Under Direct Reporting Subcommittees:
        a. Added UM Workgroup Subcommittee
    3. Updated UMC Goals section

Committee Actions in 2023:

A. April 2023 Ad Hoc (e-vote)
    1. 2022 UM Program Evaluation

2. 2023 UM CM Integrated Program Description

B. May 2023 UMC Meeting
    1. 2023 UMC Charter
C. November 2023 Meeting
    1. Approval of UM Criteria/Hierarchy of Clinical Decision-Making

3.3.5.1 Pharmacy and Therapeutics (P&T) Committee

Committee Background: The CalOptima Health Pharmacy and Therapeutics (P&T) Committee is responsible for development of the drug formularies, which are based on sound clinical evidence, and are reviewed at least annually by practicing practitioners and pharmacists. The committee includes 13 voting members who are practicing physicians or pharmacists. At least one physician and one pharmacist are required to be experts in the treatment of elderly or disabled people. The committee is chaired by a CalOptima Health Medical Director.

P&T Committee Goals:

A. Promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima members.
B. Meet CMS formulary regulatory requirements.
C. Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's strategic goals and priorities.
D. Promote an interdisciplinary approach to driving continuous improvement in pharmacy utilization.
E. Support compliance with regulatory and licensing requirements and accreditation standards related to pharmacy-related initiatives.
F. Monitor, evaluate and act on pharmacy-related care and services members are provided to promote quality of care outcomes.

P&T Committee Responsibilities:

A. Review new medications and prior authorization criteria as outlined in CalOptima Health Policy GG.1409: Physician-Administered Drug Prior Authorization Required List Development and Management and Policy MA.6103: Pharmacy and Therapeutics Committee.
B. Review individual requests for changes to the formularies from practitioners in the community.
C. Review and update the OneCare formulary and Medi-Cal prior authorization list on an ongoing basis to ensure access to quality pharmaceutical care that is consistent with the program's scope of benefits.
D. Review anticipated and actual utilization trends overall as well as for specific drug classes.
E. Review and evaluate pharmacy-related issues related to delivery of health care to CalOptima Health members.
F. Assess outcomes of pharmacy-related HEDIS and Medicare Star measures to drive improvements.
G. Review and evaluate patterns of pharmaceutical care and key utilization performance indicators.
H. Evaluate and make recommendations on pharmacy issues that pertain to CalOptima Health-wide initiatives, such as treatment guidelines, disease management programs, QI studies, etc.
I. Review and make recommendations on selected pharmaceutical provider educational activities.

J. Recommend pharmacy-related policy decisions.

The P&T Committee meets a minimum of four times per year and reports to the UMC.

Committee Changes in 2023: None

Committee Actions in 2023:

A. In 2023, the committee met on February 16, May 18, August 17 and November 16.
B. Approved changes to the OneCare formulary and Medi-Cal prior authorization list.
C. Performed annual reviews of the OneCare formulary and Medi-Cal prior authorization list.
D. Reviewed medication withdrawal and recall notifications.
E. Approved applicable policy and procedure revisions.
F. Analyzed drug utilization review information, including over- and underutilization reports.

3.3.5.2 Benefit Management Subcommittee (BMSC)

Committee Background: The BMSC is a subcommittee of the Utilization Management Committee (UMC). The BMSC is chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, The BMSC establishes a single source for the revisions and updates to CalOptima Health's authorization rules based on benefit updates. Benefit sources include but are not limited to Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

The BMSC is responsible for the following:

A. Maintaining a consistent benefit set for all lines of business.
B. Revising and updating CalOptima Health's authorization rules.
C. Making recommendations regarding the need for prior authorization for specific services.
D. Clarifying financial responsibility of the benefit, when needed.
E. Recommending benefit decisions to the UMC.
F. Communicating benefit changes to staff responsible for implementation.

Committee Changes in 2023:

A. Additions to the 2023 BMSC Committee Charter include:
    1. Added new section: Term of Membership: Terms are a function of employment and job responsibility related to utilization and benefit management daily operations and functions.
    2. Added Medical Director who oversees Population Health and Equity
    3. Removed Director, Program Implementation, Manager, Utilization Management (Prior Authorizations) and Manager, Utilization Management (Concurrent Review)
    4. Added Alternate voting members:
        a. Director, Utilization Management (Alternate: Manager, Prior Authorizations)
        b. Director, Behavioral Health Integration (Alternate: Medical Director who oversees Behavioral Health)
        c. Director, Claims (Alternate: Manager, Claims/Coding Initiatives)
        d. Director, Pharmacy (Alternate: Manager, Clinical Pharmacist)
    5. Added new section: Term of Membership: Terms are a function of employment and job responsibility related to utilization and benefit management daily operations and functions.

6. Added new section: Direct Committee Reporting: Utilization Management Committee (UMC) – Quarterly
7. Added Goals section:
    a. Ensure new benefits are implemented in accordance with regulatory requirements.
    b. Ensure new and/or revised benefit codes requiring prior authorization comply with regulatory, contractual and statutory requirements.
    c. Ensure changes, additions or modifications to benefits are reported to the UMC committee.

B. Changes to the 2023 BMSC Committee Charter include:
    1. Combined Purpose and Committee Scope sections into BMSC Scope and Responsibilities section.
        a. Removed Committee Principles Section
        b. Use a member-focused approach
        c. Maintain subcommittee member involvement
        d. The source for benefit codes reviewed by the BMSC may come from multiple areas, such as MMCD All Plan Letters, new and/or updated codes from the Medi-Cal monthly bulletin or HCPCS quarterly policy updates. Pharmacy has Pharmacy and Therapeutics (P&T) Committee which will determine pharmacy codes that need to be added (or deleted) to the prior authorization required list. Pharmacy will email UM the list of codes that have been approved and the effective date (UM Prior Authorization Drug List for (Month) for UM Dept).

Committee Actions in 2023:

A. Reviewed 195 codes
    A. 144 codes were reviewed and added for prior authorization
    1. 41 codes reviewed and determined no prior authorization was needed
    2. 10 codes were removed from the Prior Authorization List

3.3.6 Whole Child Model Clinical Advisory Committee (WCM CAC)

Committee Background: WCM Clinical Advisory Committee (WCM CAC) was formed in 2018 pursuant to DHCS All Plan Letter (reference 18-023 updated to 21-005 on December 10, 2021) to ensure clinical and behavioral health services for children with California Children's Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS providers.

The WCM CAC is chaired by CalOptima Health Chief Medical Officer (CMO) or Medical Director Designee. WCM CAC met quarterly in 2023 and will continue to meet quarterly in 2024.

Committee Changes in 2023:

A. The WCM CAC approved to update their charter and moved to include County of Orange Social Services Agency Medical Director and Regional Center of Orange County Medical Director to the WCM CAC.

Committee Actions in 2023:

A. Informed committee on DHCS audit preparation, redetermination effort, pediatric CalAIM, transition efforts of aging out WCM members, care coordination, and Kaiser Permanente transition.
B. Reviewed and analyzed data relating to UM, Grievance and Appeals, BH, Customer Service, Pharmacy, quality metrics, network adequacy and DHCS notice updates.
C. Updated on Performance and Monitoring of Pediatric Risk Stratification Process (PRSP).
D. In 2024, the committee plans to meet at least quarterly and maintain the current committee member composition.

3.4 Assessment of QI Staff and Resources

CalOptima Health continues to dedicate significant resources and staffing to meet the needs of the QI Program. At the beginning of 2023, there were many vacant positions supporting Quality and the QIHEC. However, throughout the year CalOptima Health's Human Resources department worked with the business areas to fill needed positions to the support the QI Program.

In 2023, CalOptima Health added the following positions:

A. A new Chief Health Equity Officer (CHEO) to design and implement policies that ensure health equity is prioritized and addressed.
B. Eight Medical Directors to oversee and provide guidance on PACE, UM, OneCare, Behavioral Health, Delegation Oversight, Street Medicine CalAIM, and have experience and background in transplants ,transgender, and gender affirming care.
C. Staff/positions to focus on OneCare:
    1. Executive Director, Medicare Programs
    2. Director, Medicare Programs
    3. Director, Medicare Stars and Quality Initiatives

In 2023, staff also filled the following key positions to support Quality Improvement:

A. Medical Director, Behavioral Health
B. Director, Utilization Management
C. Manager, Credentialing

The QI Program also received support from the following key departments within the organization, including but not limited to the following:

A. Quality Improvement
B. Quality Analytics
C. Population Health Management
D. Behavioral Health Integration
E. Case Management
F. Customer Service (including outreach and engagement)
G. Provider Relations and Contracting

3.5 Review of System Resources

CalOptima Health dedicated significant resources to ensuring there are adequate systems in place to monitor and evaluate performance of QI programs on an ongoing basis. The resources include

HEDIS analysts for reporting, plus extensive analytic staff support. Additional support and collaboration were provided by the Provider Relations, Network Management, GARS, and Customer Service departments.

CalOptima Health utilizes three enterprise data systems for utilization and care management (GuidingCare by Altruista), claims payment (Facets), and credentialing data management (Cactus by Symplr). Data from these systems are stored in a data warehouse and integrated through data work flows to identify improvement opportunities. Business and IT resources are allocated to create robust tools utilizing Tableau to analyze and generate quality reports, gaps in care reports and other relevant reports to support the QI Program.

In 2023, CalOptima Health executed a contract and began the transition to a new care management platform, Jiva Healthcare Enterprise Platform (JIVA), which will go live on February 1, 2024. The Jiva represents a comprehensive set of AI-power solutions that integrate data, apply advanced analytics, automate workflows, and optimize team efficiency and effectiveness with clinical content-driven care pathways.

CalOptima Health also issued Request for Proposals (RFPs) for an NCQA-Certified Credential Vendor Organization (CVO) and a single integrated provider lifecycle management system for credentialing, contracting and provider data management. CalOptima Health is seeking a CVO to establish the qualifications of licensed medical professionals by verifying their credentials and a system that will integrate the process and data for the identified business units as part of the provider lifecycle management. CalOptima Health completed demonstration phases and selected primary vendors for both RFPs and is working toward securing contracts in 2024.

3.6 Overall Assessment of Program Structure

CalOptima Health had adequate staffing and resources required to meet the needs of the QI Program and organizational program requirements. CalOptima Health will continue to evaluate the needs of the program through the Work Plan, on a quarterly basis, and add staffing and resources, as needed, to supplement the departments supporting the QI Program. The organization receives adequate feedback from its community practitioners about the development and implementation of the QI initiatives and programs. CalOptima Health continues to have significant participation from the medical directors in the development and implementation of clinical initiatives and programs throughout the year. The medical directors and QI directors report the information to senior leadership.

The Charter was reviewed, and the following modifications were made:

For 2024, the QIHEC is seeking to develop a new committee to focus specifically on Population Health Management. This new committee, called the Population Health Management Committee (PHMC), is being formed to address CalOptima Health's need to focus on PHM needs, barriers, initiatives and to meet DHCS requirements for PHM. The PHMC will provide overall direction for continuous process improvement and oversight of population health activities, monitor compliance with regulatory requirements and ensure that population health initiatives meet the needs of CalOptima Health members. The committee will also ensure that all population health initiatives are performed, monitored and communicated according to the PHM Strategy and Workplan. The PHMC is responsible for reviewing, assessing and approving Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes and recommend evidence-based and/or best practice activities to improve population health outcomes and advance

health equity. The committee will be chaired by the PHM Medical Director, a designee of the CMO, will meet quarterly and report quarterly to QIHEC.

Section 4: Program Oversight

4.1 National Committee for Quality Assurance Accreditation and Health Equity

Background: In 2012, the National Committee for Quality Assurance (NCQA) awarded initial Health Plan Accreditation (HPA) to CalOptima Health for the organization's Medicaid (Medi-Cal) line of business. CalOptima Health received "Accredited" status, scoring 100% on HPA Standards. The status recognizes CalOptima Health for service and clinical quality that meets or exceeds rigorous requirements for consumer protection and quality improvement. Since 2012, CalOptima Health has maintained its "Accredited" status by participating in a certification renewal survey every three years: 2015, 2018 and 2021. In 2021, CalOptima Health was awarded "Accredited" status on our Medicaid-HMO, scoring 100% on 2022 HP Standards. CalOptima Health is currently seeking certification renewal and will be completing the renewal survey on April 30, 2024, for our Medicaid-HMO.

CalOptima Health is also seeking NCQA Health Equity (HE) Accreditation, as required by DHCS, and aims to be awarded HE accreditation by January 2026.

Program Goals:

Health Plan Accreditation Goal:

A. To complete HPA Accreditation Renewal Survey by July 1, 2024.
B. To be awarded HPA Certification Renewal with an "Accredited" status in 2024.

Health Equity Accreditation Goal:

A. To complete a comprehensive gap analysis for HE Accreditation.
B. To develop and implement a comprehensive workplan to attain HE Accreditation by January 2026.

Program Deliverables/Progress:

Survey	Deliverables / Domain	Documents Completed	Date Completed
HPA	QI Standards and Elements (QI1–Q5)	2023 QI Program, 2023 QI Work Plan (Q1-Q3), 2022 QI Evaluation, QIHEC meetings 2022–2023, policies, PCP contracts, Continuity and Coordination Reports (Year-one), transition to other care examples, Delegation Oversight documents for Kaiser.	April 2022–Current

Survey	Deliverables / Domain	Documents Completed	Date Completed
HPA	PHM Standards and Elements (PHM1–PHM7)	2023 PHM Strategy, evidence sent to members that involve interactive, Data Integration Evidence, Population Needs Assessment Report(s), Segmentation Report (s), Policies, CM Data and Referral Sources Report, Member and Provider Communications, Web screen-print(s), PHM Measuring Effectiveness Reports Annual Delegation Oversight documents for all Delegates. Mock File Reviews: CCM HN and CCN Mock Audit	April 2022-Current March 2023–Ongoing
HPA	UM Standards and Elements (UM1–UM13)	2023 UM and CM Programs, 2022 UM Evaluation, 2023 UMC meeting minutes, Interrater Reliability (IRR) Analysis Reports (Concurrent Review, Medical Director, Pharmacy, Prior Auth, BH), policies, member and provider communications, job descriptions, use of board-certified consultants examples, web screen-prints, pharmaceutical patient safety issues examples, Pharmacy & Therapeutics Committee minutes, UM System Controls Desktop Procedures (DTPs), annual Delegation Oversight documents for all delegates. Mock File Reviews: Appeals CCN and UM Medical Denials HN and CCN	April 2022–Current April 2023–Nov 2023 April 2023–Nov 2023
HPA	Network Management Standards and Elements (NET1–NET6)	Availability and Accessibility Annual Reports, Assessment of Network Adequacy reports, PCP term letter examples, policies, Continued Access to Practitioner examples, web screen-prints, Physician Directory update examples, Assessment of Physician Directory Accuracy, Hospital Directory update examples, Usability Testing Report, annual Delegation Oversight documents for all delegates.	April 2022–Current
HPA	Credentialing and Recredentialing Standards and Elements (CR1–CR8)	Policies, DTP, Credentialing Peer Review Committee (CPRC) meeting minutes, ongoing monitoring log, PQI Trend Report and examples of interventions, Assessing Medical Providers Report, annual Delegation Oversight documents for all delegates. Mock File Reviews: CR HN and CCN Mock Audit(s)	April 2023–Dec 2023 May 2023–Dec 2023
HPA	ME Standards and Elements (ME1–ME8)	Web-screen prints, member and provider communication, Availability Cultural Needs and Preferences report, interpreter services contracts, DHCS contract, policies, DTPs, Quality and Accuracy of Information Report, Timeliness Report, Member Experience Evaluation Report, BH Complaints and Appeal Report, annual Delegation Oversight documents for all delegates.	April 2022–Dec 2023
HE	HE Standards	Reviewed HE standards with stakeholders	Jan 2023–Dec 2023
HE	HE Standards	CalOptima Health has engaged our NCQA consultant to conduct a readiness assessment, gap analysis, and recommendations in 2023. Executive leadership will also conduct a strategy and planning meeting in December 2023	

Quantitative Analysis:

A. Health Plan Accreditation
    1. 95% of Year-One documents (4/30/2022–4/30/2023) have been collected.
    2. CalOptima Health NCQA Program manager is currently working on the collection of Year-Two documents (4/30/2023–4/30/2024) needed for Health Plan Accreditation submission. 80% of Year-two documents have been collected. Staff to complete final reviews and revisions to documents before submitting for final review by consultant.
B. Health Equity Accreditation
    1. Consultant completed a review of all the applicable standards.
    2. Developed a work plan.
    3. Several working sessions have taken place to meet with owners and identify gaps in meeting specific elements.
    4. Consultant does not anticipate any difficulty in meeting the January 2026 target date for completing Health Equity accreditation.

Qualitative Analysis/Barriers:

A. New staff being assigned to write the reports has caused several document revisions to ensure compliance.
B. Multiple audits occurring simultaneously (caused delays meeting internal due dates for year-one NCQA accreditation deliverables).
C. NCQA clarifications to standards have caused mid-cycle updates to documents to align with clarifications. Complex Case Management Mock File reviews and UM Medical Denials mock audits have resulted with findings that require remediation plans to be implemented to ensure compliance and reduce potential point loss and/or risk to accreditation.
    a. **Complex Case Management:** Remediation plan includes internal and HN training on 4/20/2023. Starting with May charts. weekly file audits of all files will be reviewed by the RN/Manager at completion of initial assessment. Results will be documented in an audit tool. Follow-up mock file review were conducted in July 2023. Ongoing monitoring of files continued.
    b. **UM Medical Denials:** During mock audits conducted in Nov 2023, risk areas were identified and a remediation plan was implemented to monitor denial files:
        i. CCN: All letters will undergo review using a checklist to ensure adherence to NCQA requirements.
        ii. Delegates will be required to implement the same checklist process.
        iii. Monthly file review (random sample of10 files starting in January 2024)
            1. Any findings from the internal and delegate monthly file reviews will be addressed with CalOptima Health's CMO and HN CMOs
            2. Corrective action plans will be issued if noncompliance is found.

Conclusion and Next Steps: The collection and completion of deliverables for both Health Plan and Health Equity accreditation will continue until the submission date. CalOptima Health's NCQA consultant has developed a detailed work plan that outlines all gaps, recommended actions, and due dates. Weekly meetings with CalOptima Health staff and the consultant will be working sessions to review the work plan and monitor task completion. Executive leadership will conduct a

strategy and planning meeting for HE in December 2023, followed by implementation meetings beginning in January 2024.

Planned Activities	Date of Completion
Health Plan Accreditation	
Document Collection: April 30, 2022–April 30, 2024 (24 months) • Year-one (4/30/22–4/30/23) • Year-two (4/30/23–4/30/24)	April 30, 2024
Preliminary document submission: Delegation worksheet, draft virtual file review Agenda, PHM Program with Interactive Contract (PHM1B Workbook) to NCQA.	March 15, 2024
Collect and submit file universes for: UM Denial/CM/UM and CR Files	April 30, 2024
Receive initial issues list from NCQA surveyors	May 25, 2024
Receives file review selection lists	June 3, 2024
Two-day virtual file review session w/surveyor(s)	June 17–18, 2024
Health Equity Accreditation	
Conduct a comprehensive Population Needs Assessment (PNA).	February 2024
Making changes to the member data repository or warehouse to collect, store and retrieve sexual orientation and gender identity (SOGI) data.	TBD
HE Program Description and Annual Evaluation	TBD
Ensure diverse member advisory committee	TBD
Development of surveys to collect feedback on interpreter and translation services	May 2024

4.2 Student Behavioral Health Incentive Program (SBHIIP)

Background: As a component under the Child and Youth Behavioral Health Initiative (CYBHI) and in accordance with State law AB 133, Welfare & Institutions Code Section 5961.3, the DHCS designed the Student Behavioral Health Incentive Program (SBHIP).

The program has a funding allocation of $389 million designated over a three-year period of January 1, 2022–December 31, 2024. The program will provide incentive payments to CalOptima Health when SBHIP goals and metrics are completed and DHCS approved. The SBHIP goals and metrics are associated with targeted interventions approved by DHCS to increase access for preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for TK–12 children in public schools. The program has three main objectives:

- Breaks down silos and improve coordination of student BH services through communication with schools, school-affiliated programs, managed care plans (MCPs), county behavioral health, and behavioral health providers.

- Increase the number of TK–12 students enrolled in Medi-Cal receiving behavioral health services provided by schools, school-affiliated providers, county behavioral health departments, and county offices of education.
- Increase non-specialty services on or near school campuses.

CalOptima Health is partnering with the following organizations to achieve the expected goals: Orange County Department of Education (OCDE) and their 29 public school districts, Orange County Health Care Agency (OCHCA), Children's Hospital of Orange County (CHOC), Hazel Health (a national leader in school-based telehealth), and Western Youth Services (a local non-profit organization providing mental health services and trainings for students, school staff and parents). CalOptima Health and our partners will continue to work together throughout the remaining timeline for SBHIP to identify additional behavioral health resources for our school-aged youth.

Program Goal(s): The performance outcome metric assigned to each of the targeted interventions listed below must reflect and/or support the goal to increase access to behavioral health services (capacity, infrastructure, sustainability, behavioral health service) for Medi-Cal members on or near campus.

Intervention/Actions: As required by DHCS for Orange County, CalOptima Health collaborated with the OCDE leadership team and their representatives from the 29 public school districts to select four targeted interventions from a list of 14 to increase behavioral health access for public school-aged youth in the county:

A. Behavior Health Screenings and Referrals

Required Action: Enhance the performance of Adverse Childhood Experiences and other age and developmentally appropriate behavioral health screenings on or near school campuses, and build out referral processes in schools (completed by behavioral health provider), including when positive screenings occur, providers taking immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) on or near school campuses and ensuring access or referral to further evaluation and evidence-based treatment, when necessary.

B. Building Stronger Partnerships to Increase Access to Medi-Cal Services

Required Action: Build stronger partnerships between schools, MCPs and county behavioral health plans so students have greater access to Medi-Cal covered services. This may include providing for technical assistance, training, toolkits, and/or learning networks for schools to build new or expanded capacity of Medi-Cal services for students, integrate local resources, implement proven practices, ensure equitable care, and drive continuous improvement.

C. Technical Assistance Support for Contracts

Required Action: Medi-Cal MCPs execute contracts with county behavioral health departments and/or schools to provide preventive, early intervention and behavioral health services. It is expected that this targeted intervention will go above and beyond the Memorandum of Understanding (MOU) requirement.

D. IT Enhancements for Behavioral Health Services

Required Action: Implement information technology and systems for cross-system management, policy evaluation, referral, coordination, data exchange, and/or billing of health services between the school and the MCP and county behavioral health department.

Program Deliverables Progress

Deliverables	Completion Date
DHCS Targeted Intervention Project Plans Approved	3/8/23
DHCS Payment for Approved Project Plans	5/1/23
Bi-Quarterly Report Due to DHCS	6/29/23
DHCS Payment for Approved Bi-Quarterly Report	10/30/23
Bi-Quarterly Report Due to DHCS	12/29/23

Conclusion and Next Steps: The program continues throughout 2024. Infrastructure enhancements, new programs, contracting, school-based staff hiring, and training must be completed and ready for full operation January 1, 2025. The following required next steps will enable SBHIP to successfully achieve its objectives and performance outcome metric.

A. Behavioral Health Screenings and Referrals

Required Next Steps: Co-facilitate meetings with OCDE to lead all the SBHIP partners to: 1) perform a more in-depth look at the screeners and assessments from a clinical perspective; 2) review the clinical documentation systems that are being used throughout all 29 school districts to decide for enhancements or system purchases; and 3) align the areas in the referral and screening process between all the SBHIP partners.

B. Building Stronger Partnerships to Increase Access to Medi-Cal Services

Required Next Steps: Proceed with the development of 10 additional WellSpaces. CHOC and OCDE are evaluating the readiness of selected school districts. After the readiness evaluation, CHOC and OCDE will finalize the exact school sites within these districts whose WellSpaces will be funded under SBHIP.

C. Technical Assistance Support for Contracts

Required Next Steps: Outline necessary requirements to execute 29 school districts/LEAs contracts to become CalOptima Health school-based providers.

D. IT Enhancements for Behavioral Health Services

Required Next Steps: CalOptima Health, OCDE and the superintendents assess the school districts' needs for IT enhancements to support upcoming state-required billing operations, electronic health record functionality and closed-loop referral process.

4.3 COVID-19 Vaccination and Communication Strategy

Background: On December 11, 2020, the Food and Drug Administration (FDA) used an Emergency Use Authorization (EUA) to allow the administration of the COVID-19 vaccine in the United States.

On January 7, 2021, the CalOptima Health Board of Directors approved the COVID-19 Member Vaccine Incentive Program (VIP). The goal of this program was to motivate members to obtain the required doses of the COVID-19 vaccination by providing nonmonetary gift cards. The proposed efforts were funded through Intergovernmental Transfer (IGT) funds and awarded a $25 nonmonetary gift card per dose of the COVID-19 vaccine.

The COVID-19 VIP eligibility expanded to include multiple brands, doses and younger age groups to align with the most current vaccination recommendations. Members who are 6 months of age and older may qualify for a gift card. CalOptima Health also expanded the COVID-19 VIP eligibility criteria to align with the Centers for Disease Control and Prevention (CDC) recommendations – members can receive health rewards per vaccine dose recommended and completed, up to four total. In addition to offering nonmonetary incentives, CalOptima Health also offered member education as an essential strategy to promote vaccination. The member education materials focused on the importance of vaccination and aimed to correct misconceptions.

Program Goal(s): CalOptima Health has been committed to implement interventions that promote COVID-19 vaccinations to meet a minimum of 70% vaccination rate among members 18 years of age and older. These interventions include member health rewards as a part of the COVID-19 VIP; member and provider publications; and text message campaign. CalOptima Health met the goal and reached a 70.28% vaccination rate for members 18 years of age and older.

Action/Interventions:

Planned Activities	Description	Date of Completion
Digital ad and paid social media post	Ad and social media post about the COVID-19 Member Health Reward	5/31/2023
Text Messaging Campaign	Text campaign reminding members of eligibility for COVID-19 VIP and end of program	9/29/2023
CalOptima Health's Member Health Rewards Website	Updated language about eligibility for COVID-19 VIP and end of program	7/21/2023

Results:

A. As of November 22, 2023, out of all CalOptima Health eligible members ages 6 months and up (942,061), the total vaccinated membership was 550,511; yielding a total vaccination percentage is 58.4%.
B. Upon review of the vaccination rates by race/ethnicity, most categories have remained close to or at least achieved a 50% vaccination rate with Asian being the highest at 79.7% and Black being the lowest at 46.2%. See table below: COVID-19 Vaccination Rates by Race/Ethnicity.

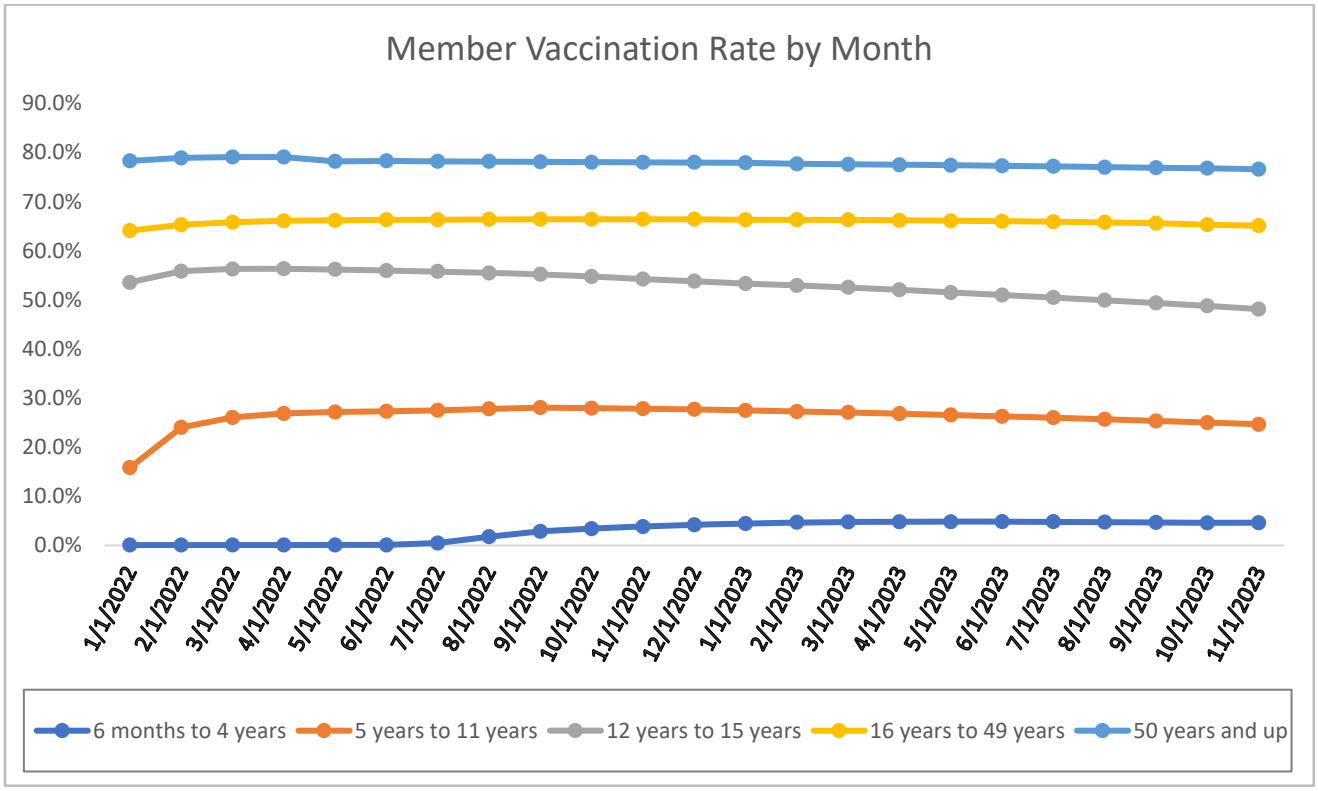
COVID-19 Vaccination Rates by Race/Ethnicity

Vaccination Rates	Race/Ethnicity					
Data as of 11/22/2022	*Alaskan Nat / American Indian*	*Asian*	*Black*	*Hispanic*	*Others*	*White*
Numerator	647	147,079	7,509	229,110	87,604	78,562
Denominator	1,341	184,632	16,250	436,795	156,257	146,786
Rate	48.2%	79.7%	46.2%	52.7%	56.1%	53.5%

Vaccination rate includes members who have been vaccinated with at least 1 dose of the COVID-19 vaccine.

C. Upon review of vaccination rates by age bands per month, there is a plateauing trend for all age groups. See chart below: COVID-19 Member Vaccination Rates by Month.

COVID-19 Member Vaccination Rates by Month



Vaccination rate includes members who have been vaccinated with at least 1 dose of the COVID-19 vaccine.

Quantitative Analysis:

A. CalOptima Health has met the goal of 70% vaccination rate among members that are 18 years of age and older.
B. Plateauing trends in vaccination show that members who have not started their COVID-19 vaccination are unlikely to start currently.

Qualitative Analysis/Barriers:

A. CDC's continuous efforts to build on recommendations for the COVID-19 vaccine may have led to confusion surrounding vaccination guidelines for different age bands.

B. Some members experienced COVID-19 vaccination hesitancy, especially for younger ages groups (6 months to 4 years).
C. COVID-19 VIP relies on passive identification for gift card assignment in which members do not need to submit any documentation to CalOptima Health to receive a health reward. However, since CalOptima Health relies on multiple sources to receive member vaccination data (i.e., California Immunization Registry, claims and encounter data), lag in identification created member dissatisfaction and the multiple data sources also increased data inaccuracies that required reconciliation. Many members experienced a waiting period of several months after completing their COVID-19 vaccinations to receive incentives.
D. COVID-19 VIP's data structures and stipulations needed to be modified to ensure that program requirements aligned with CDC's current recommendations.

Conclusion and Next Steps:

A. In November of 2022, staff proposed three modifications to the COVID-19 VIP to the Board of Directors and was approved to:
    1. Provide ample time for younger age groups to receive vaccination status by extending the deadline to get their COVID-19 vaccine(s).
    2. Reward up to four health rewards to all qualifying members to encourage updated dose completions.
    3. Update all communication to provide clear health reward guidelines and encourage member vaccination before the end of the COVID-19 VIP on December 31, 2023.
B. Results from Chart A: COVID-19 Member Vaccination Rates by Month show that younger age groups increased their vaccination rates at the end of 2022 until mid-year of 2023 – validating the Board of Directors decision to extend the VIP beyond the state-mandated requirement.
C. CalOptima Health reached 70.28% COVID-19 vaccinations among members 18 years of age and older and therefore met the goal of 70%. With data showing the unlikelihood of members starting their vaccination series currently, the decision to end the COVID-19 VIP on December 31, 2023, is a reasonable one.

4.4 California Advancing and Innovating Medi-Cal (CalAIM) and Initiatives for the Unhoused

Background: California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reforms.

Program Goal(s):

A. Identify and manage member risk and need through whole-person care approaches and addressing SDOH.
B. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
C. Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Actions/Interventions:

Planned Activities	Description	Date of Completion
Launch Enhanced Care Management (ECM) Academy as a pilot program to bring on new ECM providers.	The first cohort was completed 7/1/2023 and 20 new ECM providers went live. The second cohort will go live on 1/1/2024.	12/31/2023
Increase CalOptima Health's capacity to provide Community Supports through continued expansion of provider network.	The provider network has grown to 77 organizations over the past two years, offering all 13 community supports along with ECM.	12/31/2023
Continue to increase utilization of benefits.	The number of members receiving benefits has jumped to 43,991.	12/31/2023
Establish oversight strategy for the CalAIM program.	A CalAIM Medical Director was hired in December 2023 and will assist in the development of the oversight strategy.	TBD
Implement Street Medicine Program	Services went live in Garden Grove on April 1, 2023.	4/1/2023
Select and fund Homeless Health Initiative Program (HHIP) projects through Notice of Funding Opportunity (NOFO)	HHIP NOFO Round 1 granted $29.8 million in capacity building, capital and equity grants in April 2023 and HHIP NOFO Round 2 granted $52.3 million in capital projects in October 2023.	Ongoing
Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	Clinic and shelter providers have been selected to launch this program, and it will commence on 1/1/2024.	1/1/2024

Results:

The number of CalOptima Health members who have received Community Supports in 2023 is depicted below. A total of nearly 44,000 members have been connected to CalAIM benefits.

Number of CalOptima Health Members with Community Supports

Community Support	# of Members with Service in 2023
ECM	2,152
Asthma Remediation	21
Day Habilitation Programs	635
Environmental Accessibility Adaptations	78
Housing Deposits	736
Housing Navigation	4,120
Housing Tenancy and Sustaining Services	1,367
Medically Supportive Food/Meals/Medically Tailored Meals	38,295
Nursing Facility Transition/Diversion to Assisted Living Facilities	17

Personal Care/Homemaker Services	677
Recuperative Care	627
Respite Services	198
Short-Term Post-Hospitalization Housing	152
Sobering Centers	553

Table caption: Data demonstrating the take-up of ECM and Community Supports benefits.

The number of members enrolled in CalAIM benefits in 2023 compared with the previous year is depicted below.

The Number of Members Enrolled in CalAIM benefits in 2022 and 2023

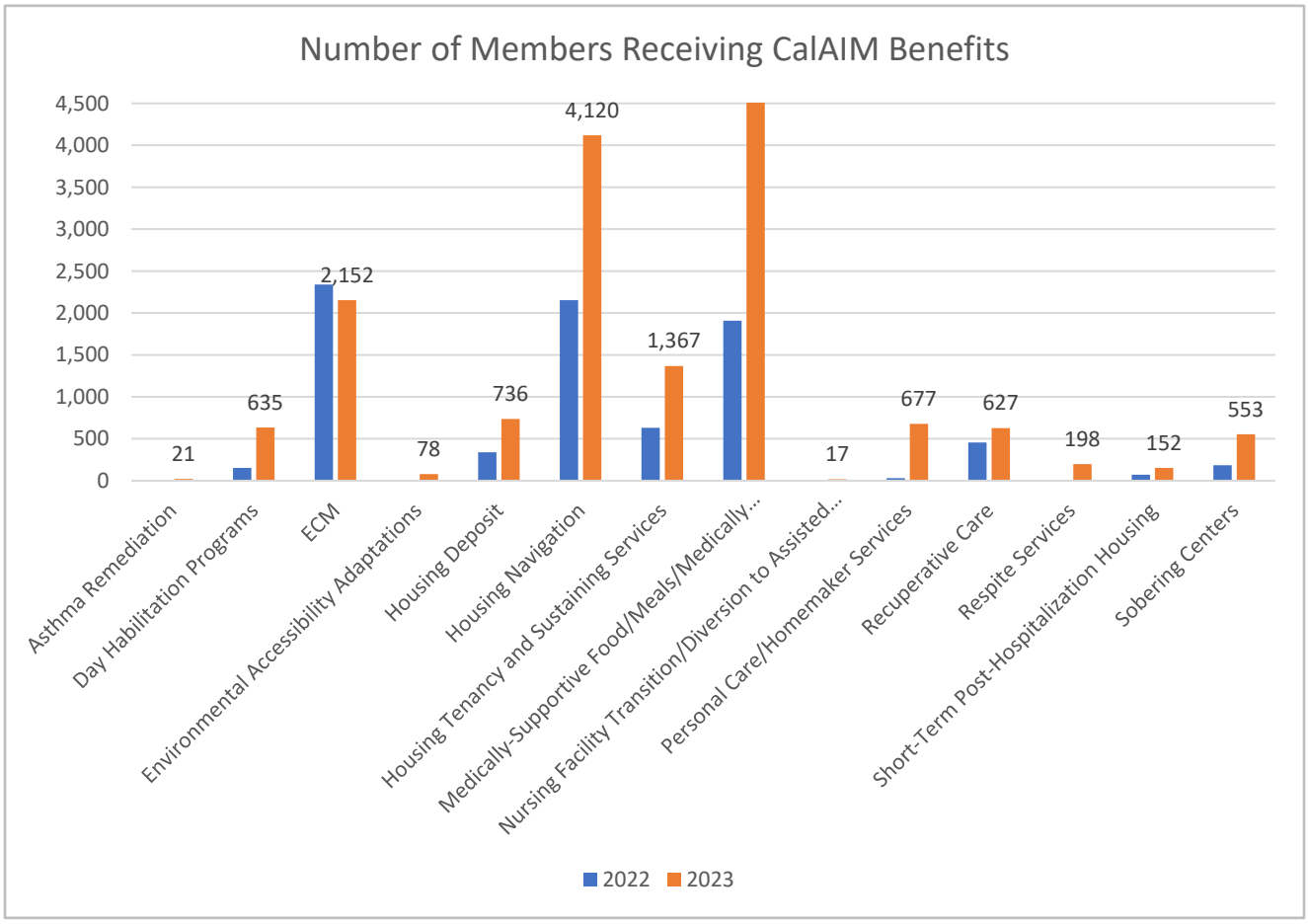


Chart caption: Number of CalOptima Health members receiving each Community Support or ECM,2022 to 2023.

The number of CalOptima Health members outreached to, enrolled in and served by the Garden Grove Street Medicine Program is depicted below.

CalOptima Health Members Outreached to, Enrolled in and Served by the Garden Grove Street Medicine Program

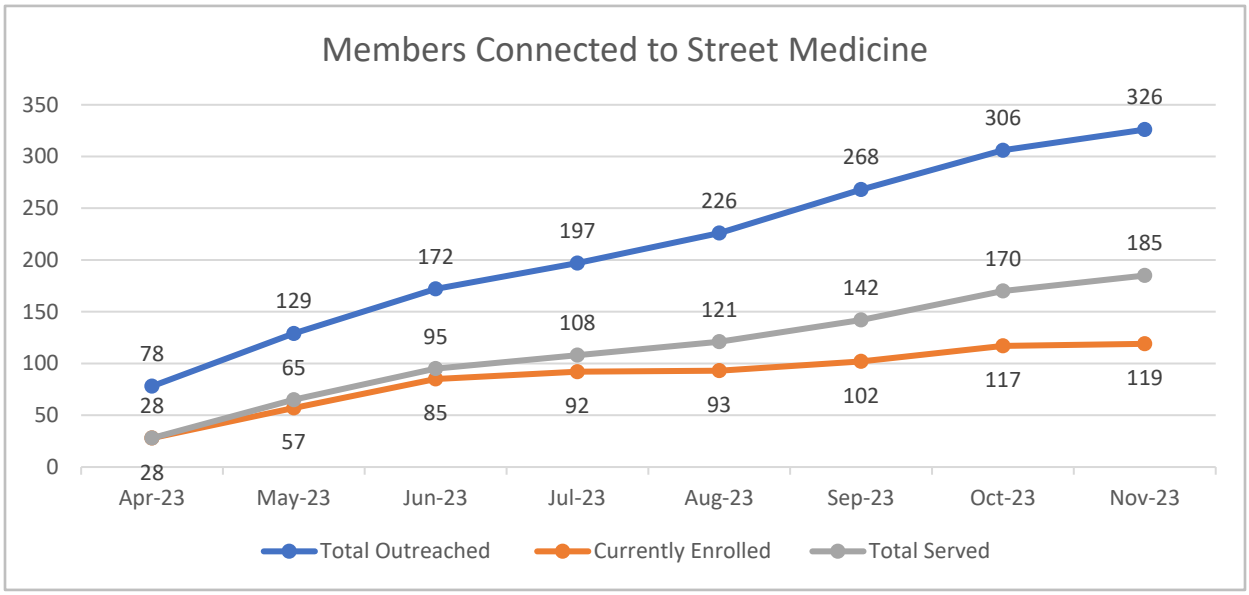


Chart caption: Number of CalOptima Health members outreached to, enrolled in and served by the Street Medicine Program in Garden Grove.

Quantitative Analysis: Uptake of all Community Supports increased in 2023, compared to 2022. ECM uptake has not grown as quickly as some of the other benefits, but with many new providers being onboarded in 2023, we expect this number to grow substantially in 2024. Enrollment in the Street Medicine Program is also increasing.

Barriers/Qualitative Analysis: The majority of objectives have been accomplished for this program. With so much effort concentrated on launching the program, designing the benefits, engaging providers, and ensuring services are accessible and utilized, the team has not fully designed the oversight strategy for CalAIM programs. This will be the focus as the new CalAIM Medical Director is onboarded.

Conclusion and Next Steps: CalOptima Health continues to build the foundation of our CalAIM efforts, most recently with the onboarding of a CalAIM Medical Director. Community partnerships are at the heart of this work, and as a result, the team's efforts are focused on the following:

A. Building the capacity of these partners.
B. Codifying modes of collaboration and increasing training protocol.
C. Efficiently and effectively conveying expectations.

This work will continue in 2024 and beyond.

4.5 Value-Based Payment

4.5.1 Health Network Quality Rating — Pay for Value

Background: CalOptima Health's Pay for Value Performance Program (P4V Program) recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's

mission of serving members with excellence and providing quality health care. HNs and CCN PCPs are eligible to participate in the P4V Program.

Program Goal(s): The purpose of CalOptima Health's P4V Program is to:

A. Recognize and reward HNs and CCN PCPs for demonstrating quality performance.
B. Provide comparative performance information for members, providers and the public on CalOptima Health's HN and CCN PCP performance; and
C. Provide industry benchmarks and data-driven feedback to HNs and CCN PCPs on their quality improvement efforts.

Based on feedback received from HNs on recommendations to refine the P4V program by aligning with industry-based programs and to provide rewards for year-over-year improvement, the P4V program has adopted the Integrated Healthcare Association pay for performance methodology for MY2024. The methodology will use attainment and improvement to assess performance and is based on the CMS hospital value-based purchasing model.

Actions/Interventions:

Description	Date of Completion
Generate and share monthly Prospective Rate reports with all HNs and CCN clinics and providers to show their performance on all clinical HEDIS P4V measures.	Ongoing each month
Generate and share a Health Network Report Card at each year that summarizes their performance and Health Network Quality Rating (HNQR) on all clinical HEDIS P4V measures and CAHPS member experience survey questions.	Ongoing each year
Participate in Quality meetings with all HNs to discuss their performance on the measures and look at trending reports for the last few months.	Ongoing quarterly meeting meetings with HNs

Results:

Health Network Quality Rating Member Experience	Survey	# Measures	Total Weight	Total Points	Rating
CalOptima Health	Adult	8	12.0	21.0	2.0
AltaMed	Child	6	9.0	21.0	2.5
AMVI Care	Adult	8	12.0	13.5	1.0
CCN	Adult	8	12.0	25.5	2.0
CHOC	Adult	6	9.0	28.5	3.0
Family Choice	Adult	8	12.0	16.5	1.5
Heritage-Regal	Adult	8	12.0	27.0	2.5
Kaiser	Adult	8	12.0	37.5	3.0
Noble	Adult	7	10.5	31.5	3.0
Optum-Arta	Adult	8	12.0	30.0	2.5
Optum-Monarch	Adult	8	12.0	43.5	3.5
Optum-Talbert	Adult	8	12.0	18.0	1.5

Health Network Quality Rating Member Experience	Survey	# Measures	Total Weight	Total Points	Rating
Prospect	Child	7	10.5	19.5	2.0
UCMG	Adult	8	12.0	16.5	1.5

Health Network Quality Rating HEDIS	# Measures	Total Weight	Total Points	Rating
CalOptima Health	14	14	53	4.0
AltaMed	14	14	44	3.0
AMVI Care	14	14	55	4.0
CCN	14	14	49	3.5
CHOC	12	12	45	4.0
Family Choice	14	14	49	3.5
Heritage-Regal	13	13	34	2.5
Kaiser	14	14	60	4.5
Noble	14	14	49	3.5
Optum-Arta	14	14	41	3.0
Optum-Monarch	14	14	48	3.5
Optum-Talbert	14	14	41	3.0
Prospect	14	14	46	3.5
UCMG	14	14	53	4.0

Health Network Quality Rating Overall Rating	# Measures	Total Weight	Total Points	Rating
CalOptima Health	22	26.0	74.0	3.5
AltaMed	20	23.0	65.0	3.5
AMVI Care	22	26.0	68.5	3.0
CCN	22	26.0	74.5	3.5
CHOC	18	21.0	73.5	4.0
Family Choice	22	26.0	65.5	3.0
Heritage-Regal	21	25.0	61.0	3.0
Kaiser	22	26.0	97.5	4.5
Noble	21	24.5	80.5	4.0
Optum-Arta	22	26.0	71.0	3.0
Optum-Monarch	22	26.0	91.5	4.0
Optum-Talbert	22	26.0	59.0	3.0
Prospect	21	24.5	65.5	3.0
UCMG	22	26.0	69.5	3.0

Quantitative Analysis:

A. Nine of 13 HNs showed an improvement in Member Experience survey questions overall rating when compared to the previous year. Two HNs showed a decline in their overall rating for member experience and two HNs had the same rating as the previous year. CalOptima Health also showed an improvement in Member Experience survey questions overall rating when compared to the previous year.
B. Eight of 13 HNs showed a decline in HEDIS measures performance overall rating when compared to the previous year. One HN showed an improvement in their overall rating for HEDIS performance, and three HNs had the same rating as the previous year. CalOptima Health also showed a decline in HEDIS performance rating when compared to the previous year.
C. Two of 13 HNs showed an improvement in overall Health Network Quality Rating (HNQR) when compared to the previous year. Seven HNs showed a decline in their overall HNQR, and four HNs had the same HNQR as the previous year. CalOptima Health had the same HNQR overall when compared to the previous year.

Qualitative Analysis/Barriers:

A. It is difficult to demonstrate improvements when the incentivized measures are the same set of measures that have been used for several years. Many of these measures have less room for improvement.
B. There is a data lag of two to three months from the time the member received a particular service at the provider's office and the time it takes CalOptima Health to receive the claims and encounters data. Hence, the Prospective Rate reports we generate for HNs are not as updated as real-time data that some HNs receive through robust electronic software systems. This leads to a disconnect in the data we report and the atad HNs see at their end.
C. Receiving timely supplemental data from HNs and providers continues to be a challenge because of limited storage capacity in the data warehouse.
D. There are no metrics to measure improvement in lifestyle behaviors, such as diet, exercise, and smoking cessation that contribute hugely to determining health outcomes.
E. Only a small fraction of all care that is delivered by providers is addressed by performance measures.

Conclusion and Next Steps:

A. Adopt the Integrated Healthcare Association pay for performance methodology to assess performance. The methodology uses both attainment and improvement to assess performance and the greater of either the attainment or the improvement score is used to calculate incentive payments.
B. HNs that score below the 50th percentile for a measure will be required to submit an improvement plan for that measure to CalOptima Health.

4.5.2 Five-Year Hospital Quality Program

Background: CalOptima Health's hospitals and their affiliated physicians are integral components of delivering health services to members and play a critical role in providing care to our members. For many years, CalOptima Health has been providing quality incentive payments to its HNs to drive quality improvement outcomes and member satisfaction. CalOptima Health is seeking to establish a Hospital Quality Program for CalOptima Health's contracted hospitals to improve

quality of care for members through increased patient safety efforts and performance-driven processes.

Program Goals: Hospital performance measures would serve to:

A. Support hospital quality standards for Orange County in support of CalOptima Health's mission.
B. Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts.
C. Recognize hospitals demonstrating quality performance.
D. Provide comparative information on the performance of CalOptima Health's contracted hospitals.
E. Identify areas for improvement and for working collaboratively with these hospitals to ensure quality care for CalOptima Health members.

Actions/Interventions:

Description	Date of Completion
Develop five-year Hospital Quality Program.	December 2022
Create and distribute baseline hospital quality score cards to each contracted hospital.	December 2023
Issue notice of grant opportunity to contracted hospitals that currently do not report to CMS or Leapfrog.	December 2023

Results

Quantitative Analysis: Using calendar year 2022 baseline data from the measurement period prior to the adoption of CalOptima Health's Hospital Quality Program, hospitals would have earned between 0% to 90% of the allowable incentive amount. Eleven hospitals do not report the full measurement set.

Qualitative Analysis/Barriers: Hospitals vary in the completeness of reporting to CMS and Leapfrog and therefore data availability varies to fully participate in the Hospital Quality Program. A barrier is that reporting to Leapfrog and Leapfrog participation is voluntary and not mandatory.

Conclusion and Next Steps: CalOptima will continue to educate contracted hospitals on the availability of grant opportunities and the Hospital Quality Program to support reporting. The first year of incentive payments for the Hospital Quality Program will be in 2024.

4.6 Redetermination

Background: During the COVID-19 Public Health Emergency (PHE), Medi-Cal members were not required to renew annually to maintain their coverage. So for approximately three years, all redeterminations were paused, and members did not have to take action to maintain their eligibility. When the PHE ended and redeterminations restarted on April 1, 2023, the California DHCS urged Medi-Cal managed care plans to launch efforts to raise awareness among their members so that members responded to requests for renewal information and did not lose coverage

if they were still eligible. In April 2023, CalOptima Health launched a comprehensive, multipronged campaign to highlight the importance of Medi-Cal renewal that continues to the present. Ongoing outreach and communications efforts are essential because longstanding Medi-Cal members have gotten out of the habit of annual renewals and new members who gained coverage during the pandemic have never completed the process.

Program Goals:

A. Educate members about the Medi-Cal renewal process.
B. Prepare member advocates and community-based organizations to support the renewal process.
C. Ensure members take the necessary steps to renew coverage.
D. Support members who transition to other coverage if they are no longer eligible for Medi-Cal.

Actions/Interventions:

Planned Activities	Description	Date of Completion
Communications Toolkit	A multilingual toolkit for community partners to use at www.caloptima.org/en/Renew/Toolkit. These materials are co-branded with County of Orange Social Services Agency (SSA), which also intends to use these same resources to ensure message alignment.	Launched March 2023; use is ongoing
InfoSeries	A virtual meeting on Medi-Cal renewal that attracted more than 400 health care professionals and community stakeholders. The meeting included speakers from SSA, Covered California and CalOptima Health.	March 2023
Community Navigators	Contracted community navigator services to support Medi-Cal renewal by attending events, conducting outreach calls, serving in community health centers as resource staff and completing other functions to support members' renewals.	Started June 2023 and ongoing
Member Engagement Tool	New member engagement tool to support Medi-Cal renewal communications, including texting, emails and robocalls, and support collaboration with SSA to coordinate our outreach to members.	Started April 2023 and ongoing
Media Coverage	Comprehensive outreach to media to raise awareness about Medi-Cal renewal in print, online and TV outlets.	Started April 2023 and ongoing
Community Events	Large-scale community events in partnership with SSA that attract members to attend to renew their Medi-Cal.	Six events in 2023
City Engagement	Joint city council presentations with SSA to share information about Medi-Cal renewal, encourage cities to promote renewal using our toolkit materials and to host events as appropriate.	Ongoing
Advertising Campaign	Major, multimodal advertising campaign to raise awareness regarding Medi-Cal, including digital, print, radio and outdoor advertising.	October 2023 and ongoing

Results:

Medi-Cal Renewal Summary

Redetermination Date	Total Members	Members Who Returned Packets Late	Members Disenrolled as of January 22, 2024
June 2023	70,710	19.7%	22.4%
July 2023	65,539	31.4%	19.8%
August 2023	65,461	28.5%	16.7%
September 2023	63,470	27.1%	14.4%
October 2023	56,557	30.3%	14.5%
November 2023	64,379	30.1%	14.2%
December 2023	71,461	21.1%	6.6%
January 2024	54,758	22.7%	Not available yet
TOTAL MEMBERS PROCESSED	**512,335**	N/A	**15.5%**

Source: CalOptima Health Redetermination Dashboard, January 22, 2024

Quantitative Analysis: CalOptima Health has met our objectives in terms of raising awareness regarding Medi-Cal renewal. The comprehensive program has been well received and will continue through June 2024. At the time of this writing, the full year of renewals has not been completed. However, data suggest that member disenrollment is lower than anticipated prior to the start of the process. Engagement levels across the many planned activities were high. For example, community events drew thousands of attendees each time. Thousands of text messages have been sent, and the member engagement platform vendor stated that our response rates are consistently higher than similar health plans.

Qualitative Analysis/Barriers:

A. Ongoing challenges include not being able to reach members due to lack of current contact information and the scope of trying to connect with CalOptima Health's largest member population in history.
B. Further, there has been a steep learning curve as we developed new processes, such as for the texting campaigns, and engaged with new partners, such as the contracted community navigators.
C. Lastly, there are some disconnects between what CalOptima Health needs in terms of reporting and what SSA has available, and this has created concerns about the timeliness and quality of the information about member renewal rates.

Conclusion and Next Steps: CalOptima Health intends to continue efforts to raise awareness about the importance of Medi-Cal renewal now that the process has resumed its annual recurrence. The outreach will be coordinated with SSA to ensure a countywide approach that results in retaining eligible members. This may include plans for ongoing personalized outreach, such as texting, email and robocalls, when it is time for a member to renew their coverage. A member population that has continuous access to health coverage promotes delivery of preventive care and quality outcomes.

4.7 Utilization Management Program

The 2023 Utilization Management (UM) Program description defines and outlines CalOptima Health's clinical activities to provide optimal utilization and quality health care services that are delivered compassionately at the right time and in the appropriate setting.

CalOptima Health evaluates the UM program structure, scope, processes and information sources used to determine utilization trends, medical necessity and benefit coverage determinations. This evaluation of UM activity is reviewed and approved annually by the UMC, the QIHEC and the QAC. The look back period for the 2023 UM program evaluation is Q4 2022 through the end of Q3 2023.

For details, please see the 2023 UM Program Evaluation.

4.8 Quality Performance Measures

4.8.1 Medi-Cal: Managed Care Accountability Set (MCAS)

Background: CalOptima Health annually collects, tracks and reports quality performance measures, including the MCAS HEDIS measures, to DHCS. Measures are calculated and reported at the required reporting unit level and are stratified according to requirements. The results are compared against NCQA national percentiles and DHCS Minimum Performance Level (MPL).

Program Goal(s): Our goal is to meet higher percentiles than previous year, MPL or higher percentiles for measures.

Actions/Interventions:

Description	Date of Completion
HEDIS results with benchmarks and four years of trending and the top opportunities for improving low performance measures were presented to the following stakeholders: • Executive team • QIHEC • CalOptima Quality Forum with Health Networks • Behavioral Health Quality Improvement workgroup • Quality Initiative team	Q3–Q4 2023
We also generate monthly prospective reports by Health Networks to monitor measure-level progress. The reports with member-level detail data (gap report) are sent to providers for gap closure.	Ongoing

For action and interventions for each performance measure, see the Quality of Clinical Care Section.

Results: MCAS selected measures with MPL requirements achieved or exceeded the MPL with the exception of one measure, Lead Screening in Children (LSC), which was newly added this measurement year. Detailed rates are presented in the charts below.

Medicaid HEDIS Measures	HEDIS MY2019	HEDIS MY2020	HEDIS MY2021	HEDIS MY2022	MPL*	Met MPL
Childhood Immunization Status (Combo 10)	40.59%	45.50%	47.69%	39.42%	34.79%	Yes
Chlamydia Screening in Women	73.64%	71.86%	72.48%	72.11%	55.32%	Yes
Immunization for Adolescents (Combo 2)	55.61%	53.32%	50.73%	51.82%	35.04%	Yes
Well-Child Visits in the First 30 Months of Life 0-15 months	NA	43.18%	49.31%	55.78%	55.72%	Yes
Well-Child Visits in the First 30 Months of Life 15-30 months	NA	71.76%	67.29%	71.20%	65.83%	Yes
Child and Adolescent Well-Care Visits	NA	50.58%	53.99%	51.49%	48.93%	Yes
Lead Screening in Children	67.72%	53.32%	63.99%	63.02%	63.99%	No
Breast Cancer Screening	63.43%	59.52%	57.64%	57.81%	50.95%	Yes
Cervical Cancer Screening	66.67%	57.60%	62.28%	57.73%	57.64%	Yes
Prenatal and Postpartum Care (Timeliness of Prenatal Care)	95.13%	89.78%	90.97%	88.08%	85.40%	Yes
Prenatal and Postpartum Care (Postpartum Care)	83.21%	78.35%	81.60%	81.15%	77.37%	Yes
Controlling High-Blood Pressure	72.81%	64.48%	67.37%	65.85%	59.85%	Yes
HbA1c Poor Control (>9.0%)	29.74%	35.26%	28.75%	30.41%	39.90%	Yes
Follow-up After ED visit for Alcohol and Other Drug Dependence 30-day	NA	NA	4.6%	24.05%	21.24%	Yes
Follow-up After ED visit for Mental Illness (30-day)	49.74	46.74%	45.44%	58.83%	54.51%	Yes

**Medicaid 50th percentile*

Quantitative Analysis:

A. Out of 15 measures, 14 met the MPL. One newly selected in MY2022 measure, (Lead Screening in Children), did not meet the MPL. It is less than 1% lower than MPL (63.02% vs 63.99%).

Measures	Analysis	Status
Childhood Immunization Status	Rate decreased in MY2022 from 47.69% to 39.42% but still at the national 75th percentile.	Met MPL
Chlamydia Screening in Women	Rate decreased in MY2022 from 72.48% to 72.11% but still at the national 90th percentile.	Met MPL
Immunization for Adolescents	Rate increased in MY2022 from 50.73% to 51.82%.	Higher than MPL at the national 90th percentile
Well-Child Visits in the First 30 Months of Life (0-15 Months)	Measure did not meet the MPL in the previous year (MY2021). With all the initiatives, the rate of MY2022 increased 6.5% from 49.31% to 55.78%.	Met MPL
Well-Child Visits in the First 30 Months of Life (15-30 Months)	Rate increased in MY2022 from 67.29% to 71.2%	Higher than MPL

Measures	Analysis	Status
Child and Adolescent Well-Care Visits	Rate decreased in MY2022 from 53.99% to 51.49%.	Met MPL
Lead Screening in Children	Rate decreased in MY2022 from 63.99% to 63.02%. Less than 1% lower than MPL.	Did not meet MPL
Breast Cancer Screening	Rate decreased in MY2022 from 57.67% to 57.81%.	Met MPL
Cervical Cancer Screening	Rate decreased in MY2022 from 62.28% to 57.73%.	Met MPL
Prenatal Care	Rate decreased in MY2022 from 90.97% to 88.08% but still at the national 66th percentile.	Met MPL
Postpartum Care	Rate decreased in MY2022 from 81.6% to 81.15% but still at the national 66th percentile.	Met MPL
Controlling High Blood Pressure	Rate decreased in MY2022 from 67.37% to 65.85% but still at the national 75th percentile.	Met MPL
HbA1c Poor Control for Patients with Diabetes (>9%)	Rate increased in MY2022 from 28.75% to 30.41% but still at the national 90th percentile.	Met MPL
Follow-up After ED visit for Alcohol and Other Drug Dependence 30-day	Rate increased in MY2022 from 4.6% to 24.05%.	Met MPL
Follow-up After ED visit for Mental Illness 30-day	Rate increased in MY2022 from 45.44% to 58.83%.	Met MPL

Qualitative Analysis/Barriers:

A. The main barrier for encounter data is to determine the rendering provider's specialty. Some encounters are submitted using a provider group identification number (ID) and not the rendering provider's ID. Some HEDIS measures require that services be conducted by a specific provider type, such as well-care visits must be rendered by a PCP. Services submitted by a provider group ID without a specific specialty type cannot be captured.
B. Through medical records review, the other barriers to non-compliance are:
    1. The services are out of the required timeframe. For example, these are immunizations given after the second birthday.
    2. The lack of data exchanges. For example, PCPs are not notified about ED/inpatient visits and are unable to provide follow-up care.
C. For actions and interventions for each performance measure, see the Quality of Clinical Care Section.

Conclusion and Next Steps:

A. All HEDIS measures are audited by NCQA certified auditors and were designated as "reportable" to NCQA and DHCS for NCQA accreditation, Health Plan Rating and MCAS reporting.
B. Member-level detail or patient level detail (PLD) files are submitted to DHCS.
C. MCAS selected measures having MPL requirements achieved MPL or higher except one newly selected measure, Lead Screening in Children.
D. Lead Screening in Children is a high- priority measure for improvement due to performance below the MPL.

4.8.2 OneCare: STAR Performance Measures

Background: CalOptima Health annually collects, tracks and reports quality performance measures, including the CMS Star measures, to CMS. Measures are calculated and reported at the required reporting unit level and are stratified according to requirements. The results are compared against NCQA national percentiles, and the Star cut points as benchmarks.

Program Goal(s): Our goal is to meet higher percentiles than previous year and 3-Star cut-points or higher.

Actions/Interventions:

Description	Date of Completion
HEDIS results with benchmarks and four years of trending and the top opportunities for improvement for low performance measures were presented to the following stakeholders: • Executive team • QIHEC • CalOptima Quality Forum with Health Networks • Behavioral Health Quality Improvement workgroup • Quality Initiative team	Q3–Q4 2023
We also generate monthly prospective reports by HNs to monitor measure-level progress. The reports with member-level detail data (gap report) are sent to providers for gap closure.	Ongoing

For action and interventions for each performance measure, see the Quality of Clinical Care Section.

Results:

A. All HEDIS MY2022 measures are audited by NCQA certified auditors and were designed as "reportable" to NCQA and CMS for Star Rating. Member-level detail or patient level detail (PLD) files are submitted to CMS.
B. The MY2022 Overall Star Rating is 3.0.
C. HEDIS Star Measures — detailed rates are presented in the charts below.

Medicare HEDIS Measures	HEDIS MY2019	HEDIS MY2020	HEDIS MY2021	HEDIS MY2022	Star Rating (MY2022)
Breast Cancer Screening (C01)	69%	67%	66%	66%	3
Controlling High-Blood Pressure (C11)	79%	71%	71%	68%	3
Colorectal Cancer Screening (C02)	62%	59%	62%	65%	3
Care for Older Adults (SNP) - Medication Review (C06)	88%	82%	84%	84%	3
Care for Older Adults (SNP) - Pain assessment (C07)	86%	83%	84%	85%	3
Diabetes Care - Blood Sugar Controlled (A1c>9) (C10)	16%	25%	19%	22%	3
Diabetes Care - Eye Exam (C09)	66%	69%	79%	73%	4
Osteoporosis Management in Women Who Had a Fracture (C08)	NA	NA	NA	NA	NA
Plan All-Cause readmissions - 18+ (C15)	8%	8%	8%	9%	4
Statin Therapy for Patients with Cardiovascular Disease - treatment (C16)	79%	71%	85%	82%	2
Annual Flu Vaccine (C03)	71%	69%	69%	68%	2
Transitions of Care - Notification Admission	8%	10%	17%	18%	NA
Receipt Discharge Info	0%	10%	5%	7%	NA
Engagement after Discharge	79%	79%	83%	78%	NA
Transitions of Care - Med Reconciliation (C14)	56%	59%	69%	62%	3
Transitions of Care - (average) (C17)	36%	39%	44%	41%	2
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (C18)	52%	41%	46%	47%	2

Quantitative Analysis:

Measures	Analysis	Status
Diabetes Care Eye Exam	Rate decreased in MY2022 from 78.96% to 73.33%.	Reached 4 Star cut-off
Plan All-Cause Readmissions	Rate increased in MY2022 from 8% to 8.57%.	Reached 4 Star cut-off
Breast Cancer Screening	Rate decreased in MY2022 from 66.17% to 65.69%.	Reached 3 Star cut-off
Colorectal Cancer Screening	Rate increased in MY2022 from 62.34% to 65.24%.	Reached 3 Star cut-off
Controlling High Blood Pressure	Rate decreased in MY2022 from 70.76% to 67.82%.	Reached 3 Star cut-off

Measures	Analysis	Status
Care for Older Adults Medication Review	Rate decreased in MY2022 from 84.24% to 83.7%.	Reached 3 Star cut-off
Care for Older Adults Pain Assessment	Rate increased in MY2022 from 84.24% to 85.4%.	Reached 3 Star cut-off
Diabetes Care Blood Sugar Controlled	Rate increased in MY2022 from 19.13% to 21.67%.	Reached 3 Star cut-off
Medication Reconciliation	Rate decreased in MY2022 from 69.23% to 62.45%.	Reached 3 Star cut-off.
Statin Therapy for Patients with Cardiovascular Disease	Rate decreased in MY2022 from 85.48% to 82%.	At 2 Star cut-off.
Follow-up After Emergency Visit for People with Multiple High Risk Chronic Conditions	A new Star measure for MY2022. The rate increased in MY2022 from 46.21% to 47.4%.	At 2 Star cut-off.
Transitions of Care	A new Star measure in MY2022. The rate decreased in MY2022 from 43.51% to 41.33%.	was at 2 Star cut-off.

Qualitative Analysis/Barriers:

For actions and interventions for each performance measure, see the Quality of Clinical Care Section.

Conclusion and Next Steps:

A. While CalOptima Health received a 3.0 Stars in Overall Rating for our Medicare product for MY 2022, CalOptima Health's OneCare Stars Improvement Workgroups will continue to focus on initiatives to improve performance for our quality measures.
B. Due to performance at 2.0 Stars, the opportunities for improvement are:
    1. Transitions of Care
    2. Follow-up After Emergency Visit for People with Multiple High Risk Chronic Conditions
    3. Statin Therapy for Patients with Cardiovascular Disease

4.9 Care Coordination and Care Management

4.9.1 OneCare Model of Care: Health Risk Assessment (HRAs)

Background: The comprehensive health risk assessment (HRA) facilitates care planning and offers actionable items for the Interdisciplinary Care Team (ICT). HRAs are completed in person, by phone, or by mail and accommodate the member's language preference. The voice of our members is reflected within the HRA, which is specific to the assigned model of care. HRAs are completed within 90 days of initial eligibility and then annually .

Program Goal(s):

A. OneCare members will have the initial HRA outreach and completion within 90 days of eligibility.
B. OneCare members will have the HRA outreach and completion annually within 365 days from the previous HRA or by outreach target month if no previous HRA was completed.
C. The goal for outreach and completion is 95% and is adjusted according to DHCS guidance for members who we are unable to contact or decline participation. CMS Star Measures goal for 2023 is to increase from 1.0 to 3.0 stars.

Action/Interventions: Multiple interventions were implemented in 2023 to support the increase of HRA completion rate.

Planned Activities	Date of Completion
Restructuring of HRA Outreach Team	January 2023
Increase outreach calls	May 2023
Creation of HRA dashboard to monitor HRA completion rates and projections for CMS Star Measure	April 2023
Addition of member incentive for HRA completion	July 2023
Addition of Facets User Warning Message for customer service to support coordinated outreach efforts	June 2023
Conduct in-person HRA during New Member Orientation	September 2023
Ad hoc mailing of OneCare HRA to members for second HRA	October 2023

Results:

The CMS Star historical and projected rates are depicted below.

Star Ratings Measure	Completed	Stars
2021 Measurement Year	36%	*
2022 Measurement Year	35%	*
2023 Measurement Year	54%	Minimum 2

** 2023 Rate in Process, as of 12/07/23; 2023 Cut Points for 2 Stars = 46%, 3 Stars = 62%*

DHCS 2.1 Initial HRA outreach and completed in 90 days from Eligibility Quarter 1-3 and depicted below.

DHCS Reporting 2.1 HRA	Members enrolled for 90 days	Members who decline HRA	Members who are unable to contact for HRA	Members who complete HRA	% Members reached, willing and completed assessment
Q1 Revision	952	93	252	605	100%
Q2 Revision	879	45	159	675	100%
Q3 Revision	814	28	149	637	100%

DHCS 2.3 Annual HRA annual outreach and completion will be reported for 2023 in February 2024 is depicted below.

Annual OC HRA	Members due for annual HRA	Members who decline HRA	Members who are unable to contact for HRA	Members who complete HRA	% members reached, willing and completed assessment
Q1	7,486	734	3,655	2,786	90%
Q2	2,570	169	817	1,576	99%
Q3	2,452	65	441	1,944	100%

There is no prior year comparison for DHCS reporting for Core 2.1 or Core 2.3, since 2023 is the first year for reporting.

Quantitative Analysis:

A. CMS Star Rating for 2023 projected to be at least 2 Stars and is at 54% as of 12/7/2023. This is a significant increase from the 2022 Rating of 35%. The potential remains for achieving 3.0 Stars for 2023. This data validates the effectiveness of efforts to prioritize HRA collection.
B. Initial HRA outreach and completion met the goal for DHCS 2.1 reporting in Quarters 1-3.
C. Annual HRA outreach and completion met the goal for Quarter 1-3 and will be reported to DHCS in February 2024 as annual measure.

Barriers/Qualitative Analysis:

A. Low rates for OneCare HRA completion as baseline coming into 2023.
B. Members continue to decline participation in the HRA despite increased outreach and incentive.
C. Members remain unable to contact despite multiple phone calls, due to invalid phone numbers, no response to phone calls and letters, no existing phone numbers, and unreliable addresses.

Conclusion and Next Steps:

A. HRA outreach and completion meet DHCS expectations for both initial and annual HRA. We expect this to continue into 2024.
B. CMS Star Ratings for HRA completion showed significant increase from 2022 to 2023. We expect this success to continue into 2024 and believe that the interventions of 2023 lay foundation for an increase to 3.0 or 4.0 Stars.
C. Case Management prioritized the 2023 HRA completion and will continue to explore and implement strategies to engage members for HRA completions, including consideration of different modalities.

4.9.2 Interdisciplinary Care Team (ICT) and Individual Care Plan (ICP)

Background: The Individual Care Plan (ICP) is developed through the Interdisciplinary Care Team (ICT) process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the HRA and by the ICT. Barriers to meeting

treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per care management level. The ICP is updated annually and with change in condition.

Program Goals:

A. Core 3.2 Initial ICP completion within 90 days of eligibility.
B. Benchmark 90% adjusted.

Actions/Interventions:

Planned Activities	Date of Completion
Utilized newly developed reporting to validate and oversee outreach and completion of ICP per regulatory guidance.	January 2023
Developed and implemented communication process with HNs for tracking outreach and completion to meet benchmarks.	January 2023
Automation of data ICP process for members who are unable to contact or decline to improve the timeliness of initiation of the care plan.	June 2023

Results:

DHCS reporting 3.2 ICP completion within 90 days of eligibility is depicted below**.**

DHCS Reporting Quarter	Members Enrolled for 90 Days	Members Unwilling to Complete an ICP	Members Who Are Unable to Contact for ICP	Members Who Complete a Care Plan	% Members Reached, Willing and Completed a Care Plan
Q1 Revised	952	99	133	406	56%
Q2 Revised	879	82	178	471	76%
Q3	814	124	185	371	73%

Quantitative Analysis:

A. 2022 comparison for OneCare is not available as Core 3.2 is new reporting for the OneCare line of business with requirements for collaboration not previously measured in OneCare.
B. The benchmark set was based on OneCare Connect (OCC) Core 3.2 reporting and was not met due to the high volume of transitioning members between lines of business. DHCS announced correction to reporting requirements and allowed for resubmission of Quarter 1 and 2 reporting.

Barriers/Qualitative Analysis:

A. ICP timeliness not met due to sunset of OCC with mass transition of members to the OneCare line of business. Transition members without HRA in 2022 required outreach within 90 days of their January 1, 2023, effective date. This amplified the volume of members that required ICP development and ICP updates. The volume burden caused ICP development to extend beyond 90 days of eligibility.

B. Initial guidance from DHCS directed the inclusion of OCC to OneCare transition members for Core 3.2 reporting: ICP completion within 90 days of eligibility. DHCS acknowledged and modified the guidance in October 2023 to revise Quarter 1 and Quarter 2 reporting.
C. Inability to reach members for collaboration on ICP development due to inability to contact through phone calls, invalid phone numbers, no response to phone calls and letters, no existing phone numbers, and unreliable addresses.

Conclusion and Next Steps:

A. The data demonstrates an opportunity for improvement in the timeliness of ICP development.
B. Case Management will continue to monitor and communicate to the HNs on ICP development for newly effective members to improve timeliness.

4.10 Managed Long-Term Services and Supports (MLTSS)

Background: The purpose of MLTSS is to prevent or delay member institutionalization by providing support to CalOptima Health members who require consistent and ongoing caregiving assistance through the coordination of three primary programs. Medi-Cal MLTSS includes two categories: Home- and Community-Based Services (HCBS) and Institutional/Nursing Facility- with three programs Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and Long-Term Care. The purpose of LTSS is to prevent or delay member institutionalization by providing support to CalOptima Health members who require consistent and ongoing caregiving assistance through the coordination of three primary programs:

A. Home- and Community-Based Services (HCBS)
    1. Community-Based Adult Services (CBAS)
    2. Multipurpose Senior Services Program (MSSP)
B. Institutional/Nursing Facility
    1. Long-Term Care (includes subacute care, hospice and the ICF/DD homes)

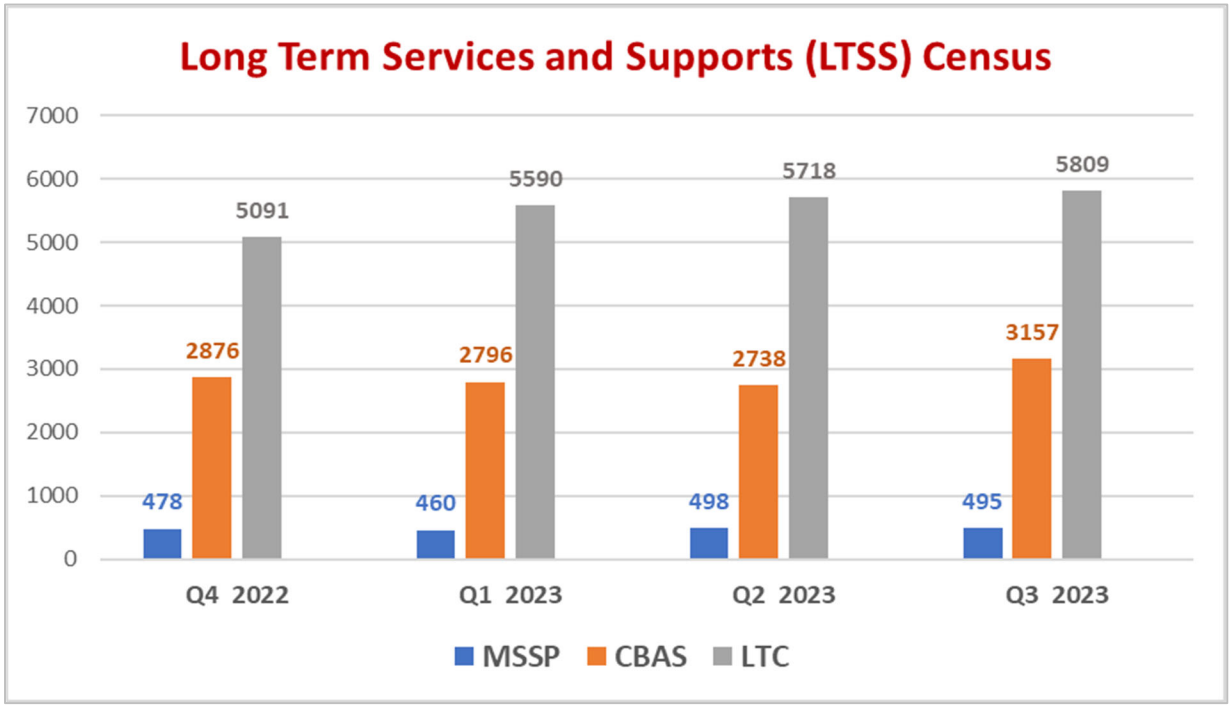
Program Goals:

A. Increase access to Home- and Community-Based Services (HCBS).
B. Safely decrease LTC Nursing Facility utilization while supporting our members to remain living in the community.
C. Improve clinical and quality of living outcomes.
D. Build on member choice.

Actions/Interventions:

A. Engaged with all providers to train in transitions of care requirements, authorization documentation and DHCS regulations.
B. Presented CalOptima Health LTSS services at provider conferences.
C. Cross trained LTSS staff in all LTSS services to provide consistent provider and member care during staffing shortages.

Results:



Quantitative Analysis:

A. The LTC program had an overall growth of 12.4% in member census. This is attributable to the end of the pandemic and members being readmitted to LTC facilities.
B. The CBAS program experienced an overall growth rate of 9% in member census. This is attributed to the end of the pandemic, increased use of congregate day care and new CBAS centers opening.
C. The MSSP program experienced an overall growth rate of 3.5% in member census. This was attributed to the end of the pandemic and the California Department of Aging (CDA) expanding available slots from 455 to 568, which allowed for increased admissions.

Qualitative Analysis/Barriers:

A. The primary barriers for growth are related to the staffing challenges in all three programs, which makes it difficult to expand capacity.

Conclusion and Next Steps:

A. The data reflects the ongoing need for LTSS programs and services for the population that CalOptima Health serves. There will be ongoing efforts in LTSS to work with our partners to expand services in these programs.

4.11 Transitions of Care

Background: DHCS has outlined a phased approach in the Population Health Management (PHM) Policy Guide to provide Transitions of Care Services (TCS) starting January 1, 2023. TCS are provided to members transitioning from levels of care, including hospitalizations and skilled nursing facilities. Beginning in 2023, members identified as TCS High Risk, per the DHCS definition, have been receiving outreach from TCS Case Management staff. The goal of outreach is to ensure all the member's needs are met post-hospitalization, including a follow-up visit with

the member's PCP in order to conduct a medication review and resolution of discharge summary follow-up items.

TCS Case Management staff are also responsible for ensuring collaboration, communication and coordination with the following to facilitate safe and successful transitions:

- Members and their families/support persons/guardians
- Hospitals
- Emergency Departments
- LTSS
- Physicians (including the member's PCP)
- Nurses
- Social workers
- Discharge planners
- Service providers

For members enrolled with Case Management or ECM, the assigned Case Manager will administer TCS protocols. The Case Manager will connect recently discharged members with tools and resources that encourage and empower self-management skills to reduce the potential of a readmission and optimize the member's quality of life.

TCS is provided to ensure members are supported from discharge planning until they have been successfully connected to all needed services and supports. Members may also be referred to ongoing Case Management, ECM or Community Supports if appropriate.

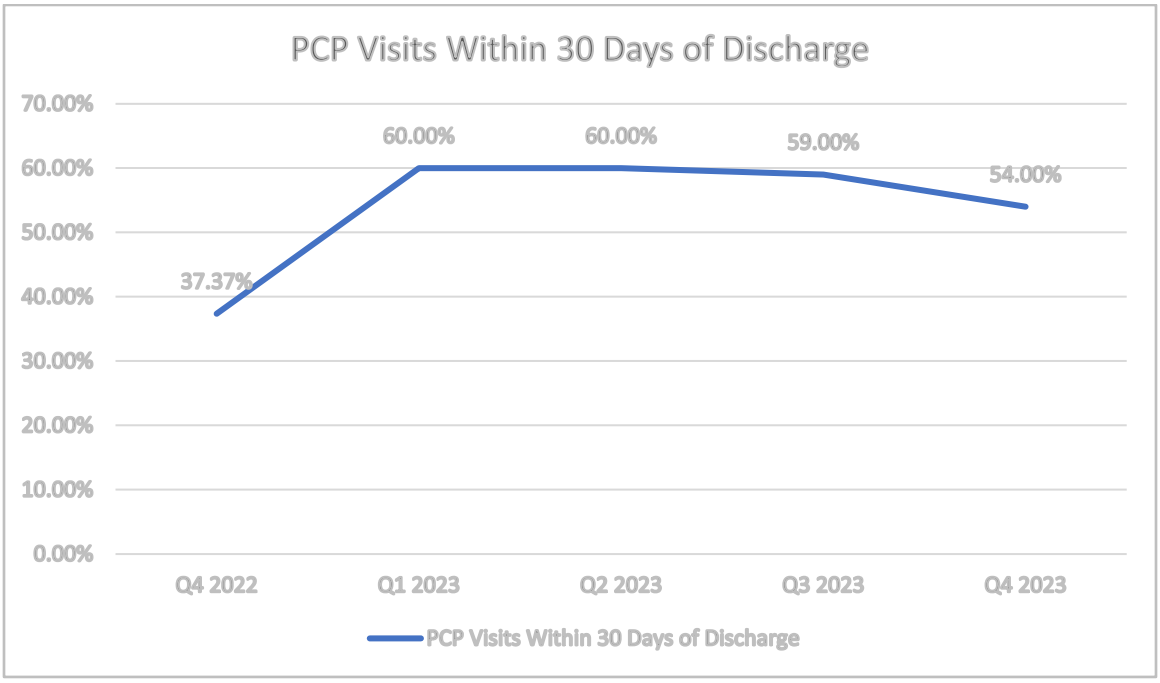
Program Goal(s): Improve the member's follow up with their PCP within 30 days post discharge from the hospital.

Actions/Interventions:

Description	Date of Implementation
Enhanced the Post Discharge Call Assessment.	October 2023
Enhanced post discharge call reporting to include the percentage of compliant calls.	October 2023
Expanded eligibility criteria to Case Management follow-up and coordination	January 2023, ongoing
Developed a resource letter for the hospital discharge staff to give to TCS High Risk members when they discharge. The letter provides the name of their assigned TCS Case Manager and their phone number.	Implemented in July 2023, ongoing
Created a TCS High Risk Flag to align with the DHCS policy guide.	Implemented in April 2023, ongoing
Enhanced the PCP Discharge Notice to remind the PCP to file the Discharge Summary and Medication Reconciliation list in the member's medical chart and to schedule a follow up with the member	In process

Description	Date of Implementation
Created an Inpatient Utilization Strategy Workgroup to identify members at risk for readmission and the development and implementation for focused and targeted transition support.	Implemented in October 2023, ongoing
Educated hospital discharge staff (in individual facility clinical rounds held weekly and biweekly and planned facility trainings) on ECM, community supports and integrated case management available to serve members with social driver of health needs.	Implemented in June 2023, ongoing
Review ADT data file transfers and identify a mechanism for real time PCP admit discharge, and transfer notification.	Implemented in October 2023, ongoing
Identify members with chronic readmissions and attempt to enroll in ongoing case management for health education and ongoing chronic care coaching.	In process
Created a TCS Workgroup to plan, develop and implement TCS DHCS requirements with cross functional involvement of the following departments: UM, CM, BH, PHM, Analytics, CalAIM, Provider Services	March 2023, ongoing

Results:



Quantitative Analysis: Quarter over quarter data analysis for Q4 2022–Q3 2023 shows a 23% increase in PCP visits within 30 days of discharge from Q4 2022 to Q1 2023. Q2 2023 was unchanged from Q1 2023, and data analysis shows a 1% decrease from Q2 2023 to Q3 2023.

Qualitative Analysis/Barriers: Post-discharge follow-up visit data are presented and discussed at the quarterly UMC meeting and/or the bi-weekly UM Workgroup Meeting. Both meetings consist

of but are not limited to the following staff: CalOptima Health Medical Directors, Executive Directors of Medical Management and Behavioral Health Integration, Directors of UM, Pharmacy, Quality Improvement, Case Management, Grievances and Appeals, and Behavioral Health. Managers of Quality Improvement, Utilization Management and Long-Term Support Services. Data is reviewed at these meetings to assess barriers and identify opportunities for improvement interventions.

Through these committee meetings, CalOptima Health identified the following barriers and impacts to readmission rates. Barriers and/or impacts include but are not limited to the following:

A. Although CalOptima Health can measure member success of completing a PCP follow-up appointment within 30 days of discharge, the lag in claims data can impact timely interventions to improve member PCP access in the first 30-days post discharge.
B. Coordination of Care barriers between hospitals and outpatient providers continues to negatively impact readmission rates.
    1. Technology limitations exist between hospitals and PCP including the ability to communicate directly with a PCP or automate a referral or post discharge support and/or services (i.e., Case Management/Community Supports).
    2. CalOptima Health also recognized the importance of the notification rate on patient engagement. Predischarge coordinated engagement in care transition planning may also be low due to the administrative burden for the hospital team, as well as the member's willingness to coordinate care and services while the member is still in the hospital.
C. Hospitals often operate with limited administrative and case management support due to shortage of health care practitioners and staffing protocols. These capacity limitations lead to a potential delay of notification to the PCP in a timely manner, resulting in missing the opportunity for the PCP to see the patient. In addition, because of staff capacity limitations, hospital staff are frequently unable to schedule member follow up visits with their PCP prior to discharge from the hospital.

Additional challenges include but are not limited to:

A. Inability to coordinate care prior to a member leaving the hospital against medical advice.
B. Difficulty reaching the member after discharge from the hospital. If a member is not responsive to outreach for support to navigate the health care system, the member may not understand all the actions needed to prevent a readmission (health literacy).
C. PCP availability, including after hours, does not fit all member needs for a follow up appointment after discharge.
D. Member symptoms and reason for hospitalization improve so there is not a perceived need to see the PCP.
E. Member and/or provider lack of adoption to telehealth options.
F. With the uptick of COVID cases, there may be fear again of the member accessing care.

Conclusion and Next Steps:

A. CalOptima Health committees continue to meet and review data, identify opportunities for improvement, develop and implement interventions and monitor the effectiveness of these interventions.

B. Work with hospital partners to gain additional electronic medical record (EMR) access for CalOptima Health staff to send timely discharge summaries and medication reconciliation to the PCP to incorporate in the member outpatient chart.
C. Enhance engagement of members through focused training and staff core competency building. The training includes the importance of motivational interviewing style to promote appropriate adherence to treatment post discharge for sustainable outcomes. Motivational interviewing will assist with member empowerment and addressing barriers related to adherence to treatment.
D. Continue to pursue increased opportunities through CalAIM Community Supports (launched in Q1 2022). Renew and expand opportunities to connect members with ECM and Community Supports available for SMI, SUD and the unhoused. Support is provided to appropriate members prior to discharge to boost optimal outcomes and drive improvement in the readmission rate.
E. Created a Bed Day Reduction Strategy Sub Workgroup to be led by CalOptima Health Medical Directors with the participation of UM and CM staff.
F. As part of the enhanced post discharge process the following interventions present an opportunity for improvement:
    1. Coach members on how to convene a telehealth PCP or specialty follow-up visit within 30 days post discharge.
    2. Coach members on early self-identification of risk to address signs and symptoms.
    3. Coordinate communication with all treating providers.

Section 5: Quality of Clinical Care

5.1 Quality Oversight

5.1.1 Potential Quality Issues (PQIs)

Background: PQIs are clinical investigations of providers to determine if the care provided meets evidence-based and community standards. Investigations include the review of all provider types in the CalOptima health provider network, including physicians, mid-level practitioners, hospitals, home health agencies, etc. Information, which is specific to the case and may include medical records and a response to the issue, is obtained and is summarized by a nurse. A medical director reviews the information, levels the case according to the severity of the findings and makes a recommendation for action, which ranges from “no action” to presenting the case to the Credentialing and Peer Review Committee (CPRC). Some cases are sent to contracted external specialists for expert review. Cases presented to CPRC may result in a recommendation that includes such actions as a best practice letter or an 805 reporting to the appropriate state board.

Program Goals:

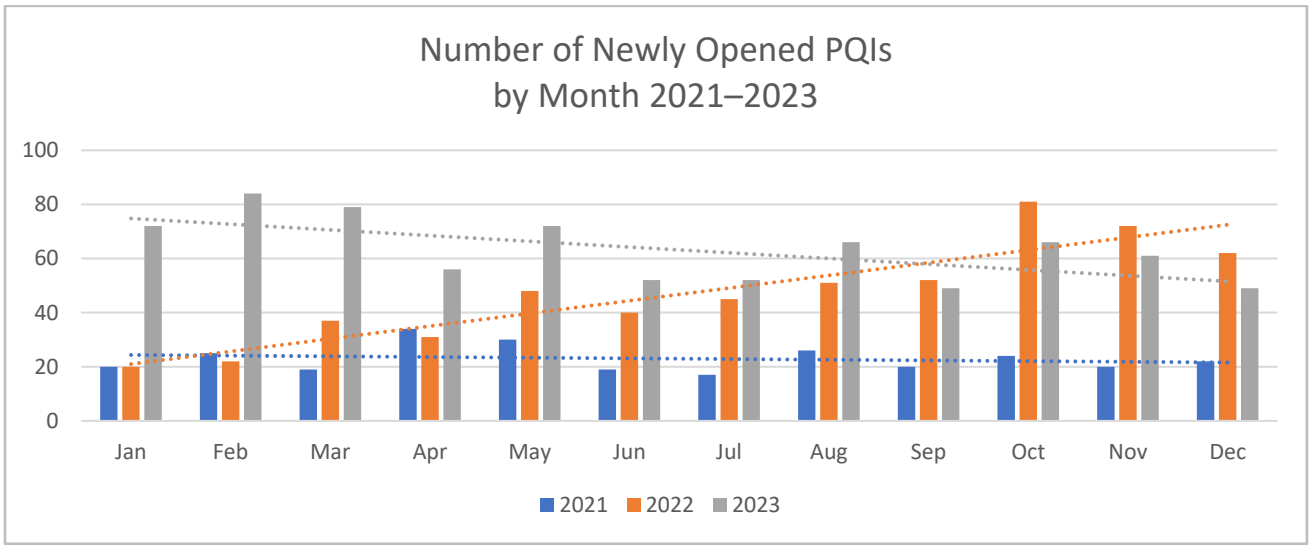
A. PQI case initially reviewed by the medical director within 90 days of opening the case.
B. Declined Grievances reviewed by the medical director in 30 days.
C. We have defined Declined Grievances as grievances that have a quality-of-care component, but the member chooses not to file a formal grievance and are investigated as a PQI.

Actions/Interventions:

Planned Activities	Description	Date of Completion
New System for Documenting PQI Cases	In 2023, CalOptima Health started the planning for the implementation of a new care management system. As part of this implementation, the vendor, ZeOmega, worked closely with CalOptima Health to develop a PQI module of their system, Jiva.	Implemented in Q1 2024
Review of Quality-of-Care PQIs	In Q4, CPRC recommended the de-credentialing of an OB/GYN physician as the result of a PQI investigation. This physician is currently under-going the Fair Hearing Process for final determination.	In process
Change of Severity Leveling	The policy, GG.1611: Potential Quality Issue Process, was modified to remove the two severity levels of H1 (occurred in a hospital) and HDS (Healthcare Delivery System) because neither of these explained the severity of the issue. The severity levels that remain are: **S0**-Service-related issue, unable to verify. **S1**-Service-related issue, verified, resulting in inconvenience or dissatisfaction to the member. **0**-No quality of care or quality of service issue identified. **1**-Mild clinical judgment or operational issue with or without an adverse outcome. **2**-Moderate clinical judgment or operational issue with or without an adverse outcome. **3**-Severe clinical judgment or operational issue with or without an adverse outcome.	10/01/2023

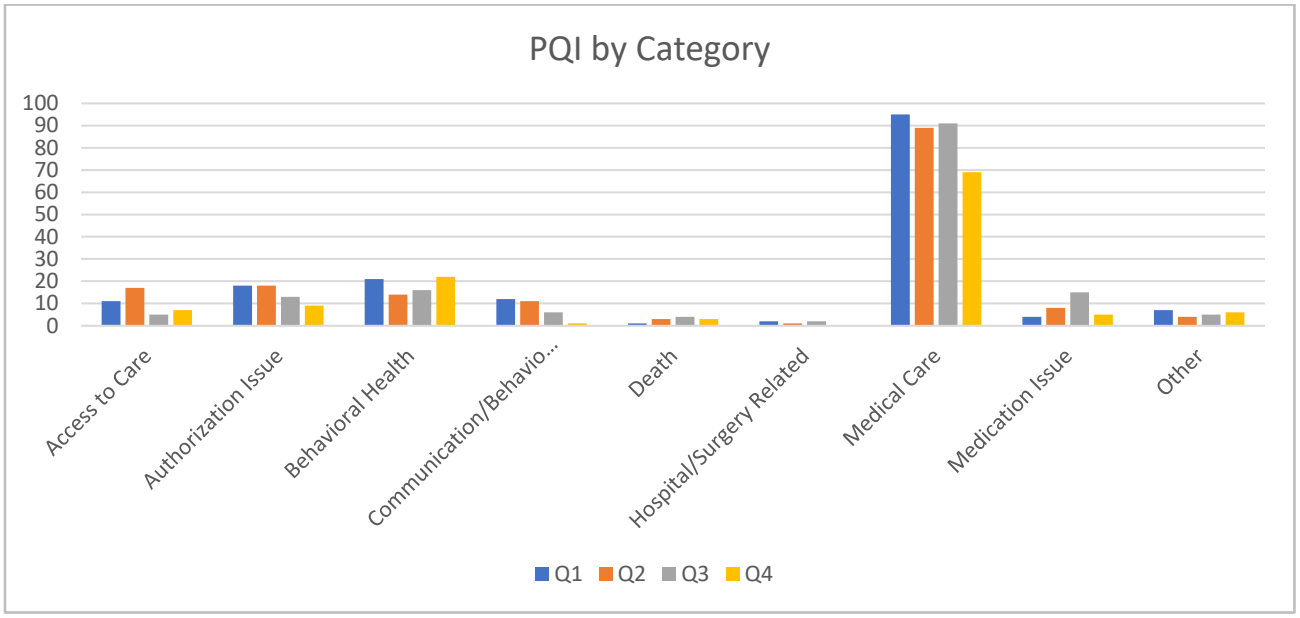
Results:

Number of Newly Opened PQIs by Month 2021 to 2023



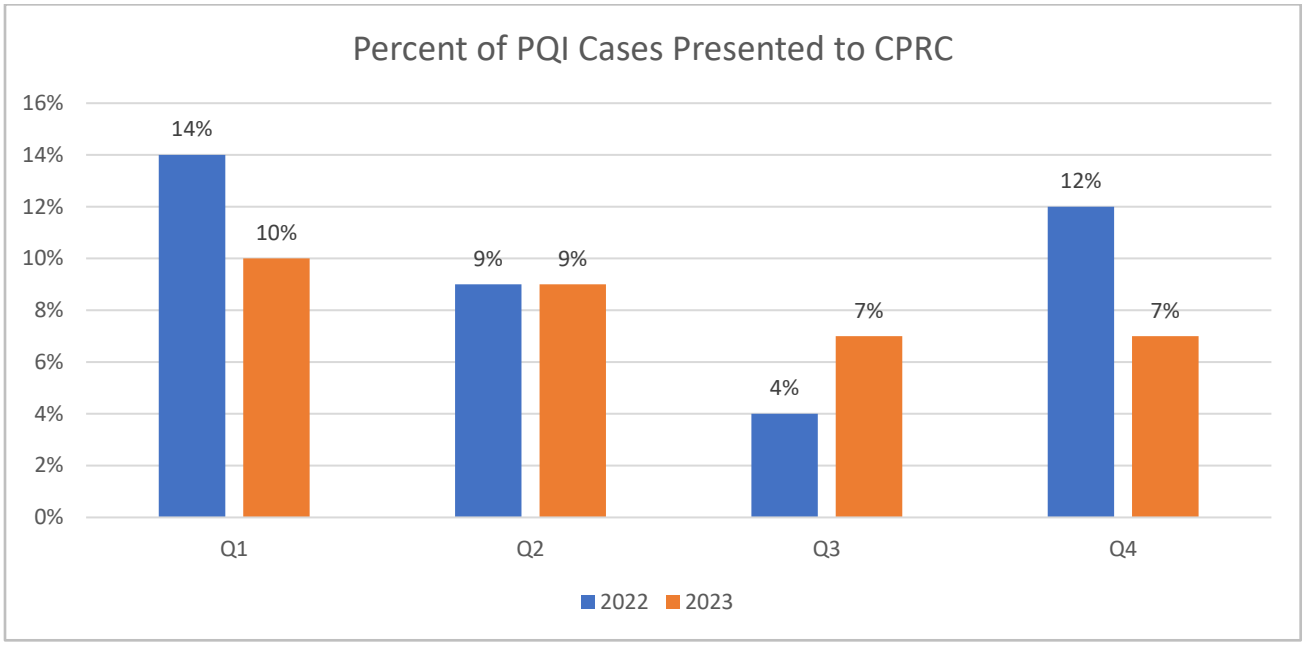
In 2023, the number of cases opened each month declined from Q4 of 2022. The increase in Q4 2022 was due to the implementation of a new process for the PQI review of Declined Grievances.

PQIs by Category



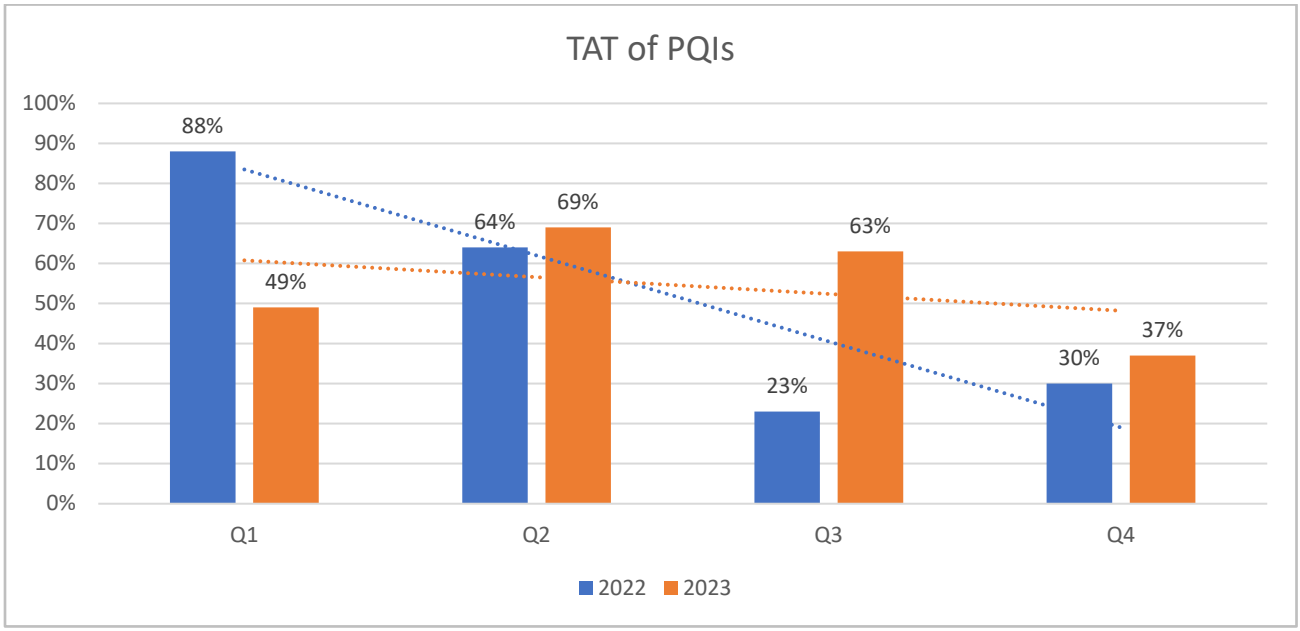
In 2023, medical care continued to be the largest category of PQI.

Percent of PQI Cases Presented to CPRC



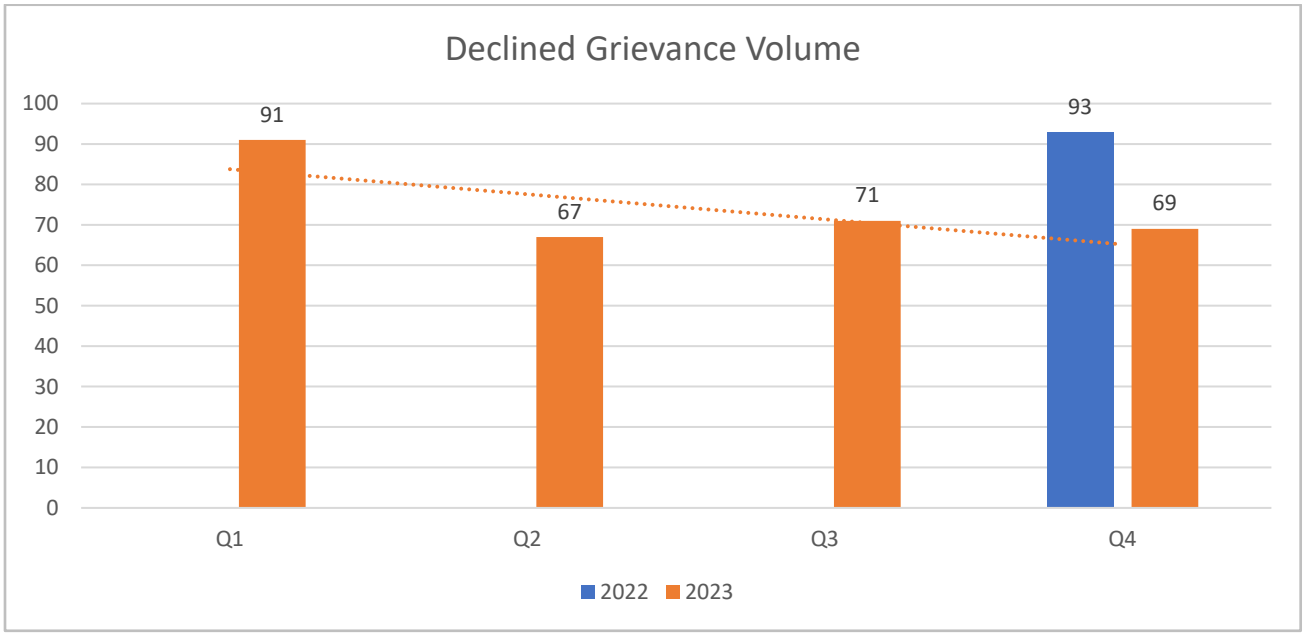
In 2023, 7%-10% of all PQIs were presented at CPRC. This was slightly less than 2022, which ranged from 4% to 14%.

Percent of PQIs Sent to Medical Director for Review in 90 days



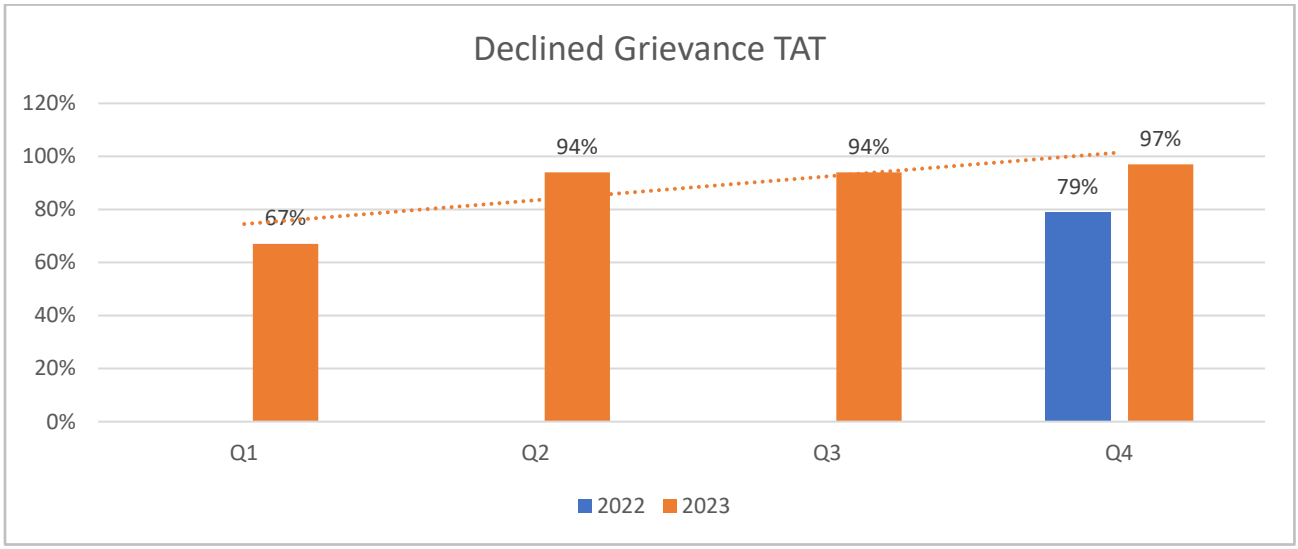
The TAT of PQIs sent for Medical Director for review has fluctuated quarter-by-quarter. Quarters 2 and 3 performed better at 63%-69% than quarters 1 and 4 at 49% and 37% respectively.

Declined Grievance Volume



The volume of Declined Grievances that resulted in a PQI investigation declined in Q2 2023 and remained stable thereafter.

Declined Grievance Turn-Around Time (TAT)



The TAT of Declined Grievances that resulted in a PQI investigation improved in Q2 and remained greater than 94% thereafter.

Quantitative Analysis:

A. The overall volume of PQIs increased in 2023. This change was the result of two major issues. In Q4 2022, we began reviewing Declined Grievances as PQI investigations. We also had new medical directors that identified a higher volume of PQI cases.
B. Even though the number of PQI cases increased, the percentage of quality-of-care cases identified for CPRC review remained stable.
C. Quarter-over-quarter, the greatest complaint category for PQIs leveled as quality-of-care was Medical Care: Mismanaged Care.
D. Both the volume and the TAT of Declined Grievances improved beginning in Q2. The reason for this improvement was improved clinical analysis of which referrals are actually a PQI by the nursing staff.

Qualitative Analysis/Barriers:

A. The major barriers for PQI investigations were regarding increased volume and without an increase in staffing to accommodate the change.
B. The implementation of the PQI review of Declined Grievances added significant volume to our workload requiring the work of one full-time registered nurse. This assignment took away from completing the investigations of other PQIs timely. While additional staffing was requested beginning in Q4 2022, the staff were not approved for hire until Q3 2024.
C. We had many new medical directors added at CalOptima Health in 2023. The new medical directors opened PQIs in instances where only a best practice letter and no additional investigation is needed. This process change contributed to an increase in volume of PQIs and reduced TAT compliance.

Conclusion and Next Steps:

A. The volume of PQIs has increased significantly in 2023. In Q1 2024, we anticipate the hire of two additional staff to support this function. It is anticipated that with the additional staff, we will be able to reduce the backlog of PQI cases and the TAT for review by the medical director.

B. We have been using a care management system that is member-centric for the management and storage of PQI cases. The staff work with the medical directors via email and folders for their review of the PQI cases. Implementation of the Jiva system is anticipated for Q1 2024 and will allow the medical directors to review the PQIs within the system. In addition, the system is expected to be physician-centric to better meet the needs of the PQI Investigations.

5.1.2 Facility Site Review (FSR) and Medical Record Review (MRR)

Background: To ensure compliance with DHCS contractual requirements, CalOptima Health is required to perform initial and subsequent PCP site reviews, consisting of a Facility Site Review (FSR) and a Medical Record Review (MRR), using the DHCS FSR and MRR tools and standards. FSRs are conducted to ensure that all contracted PCP sites have sufficient capacity to provide appropriate primary health care services and can maintain patient safety standards and practices. The FSR confirms the PCP site operates in compliance with all applicable local, state, and federal laws and regulations. MRRs are conducted to review medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.

Program Goals:

A. Conduct Initial FSRs and verify each contracted PCP site has a passing score. If corrective action plans (CAPs) are issued, the site must correct all deficiencies to close CAP prior to adding the provider(s) to the CalOptima Health Provider Network and assigning members to the provider(s).
B. Conduct Initial MRR after the PCP is assigned members (90–180 days) if members are assigned).
C. Conduct subsequent site reviews, consisting of an FSR and MRR, at least every three years, beginning no later than three years after the initial FSR, and at least every three years thereafter.
D. Utilize DHCS' most current FSR and MRR tools and standards when conducting site reviews.
E. Properly document and monitor the site review status of each contracted PCP site.
F. Follow the established DHCS timeline for CAP notification and completion.
    1. Critical Element (CE) CAPs are due within 10 business days
    2. FSR and MRR CAPs timelines decreased from 45 to 30 days
G. Monitor and evaluate the Critical Element criteria for all PCP sites between each regularly scheduled site reviews.
H. Review the number of medical records according to the number of PCPs and population served.

Action/Interventions:

Description	Date of Completion
Complete Initial FSR and MRRs per DHCS requirements.	Ongoing
Complete Periodic FSR and MRRs within established DHCS timelines.	Ongoing
Close all issued FSR and MRR CAPs within established DHCS timelines.	Ongoing

Results:

Type of Reviews	The Number of FSRs, MRRs and CAPs Completed by Month											
MY2023	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep.*	*Oct*	*Nov*	*Dec*
Number of Initial FSRs Completed	3	2	3	6	4	2	1	3	5	3	4	4
Number of Initial MRRs Completed	3	2	6	3	9	3	5	4	4	1	0	1
Number of Periodic FSRs Completed	14	15	11	2	1	2	8	16	17	17	5	8
Number of Periodic MRRs Completed	16	15	22	4	6	3	2	18	15	20	6	9
Number of CE CAPs Issued	10	14	15	14	16	6	6	17	7	13	4	10
Number of FSR CAPs Issued	14	14	11	12	6	4	10	17	14	18	7	8

	FSR and CAP Timeliness											
MY2023	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep.*	*Oct*	*Nov*	*Dec*
% of Periodic FSRs Completed by Due Date	55% (N=11)	89% (N=18)	100% (N=6)	0 % (N=2)	N/A (N=0)	N/A (N=0)	83% (N=6)	100% (N=14)	86% (N=14)	94% (N=17)	80% (N=5)	90% (N=10)
Percentage of CE CAPs Closed by Due Dates	80% (N=10)	64% (N=14)	87% (N=15)	86% (N=4)	69% (N=16)	100% (N=6)	83% (N=6)	94% (N=17)	100% (N=7)	92% (N=13)	100% (N=4)	60% (N=10)
Percentage of FSR CAPs Closed by Due Dates	79% (N=14)	79% (N=14)	91% (N=11)	67% (N=12)	100% (N=6)	75% (N=4)	80% (N=10)	82% (N=17)	71% (N=14)	95% (N=18)	86% (N=7)	83% (N=8)

Quantitative Analysis:

A. Initial FSRs and MRRs: Initial FSRs and MRRs were completed within established DHCS timelines. All CAPs issued were closed before provider(s) were added to the CalOptima Health provider network and assigned members.
B. Periodic FSR and MRRs: In January 2023, Periodic FSRs that were completed within 3 years from the previous FSR increased.
C. CE and FSR CAPs: The percentage of CE and FSR CAPs closed within established DHCS timelines ranged from 60%–100% in 2023.
D. MRR CAPS: The percentage of MRR CAPs closed within established DHCS timelines ranged from 63%–100%. The average percentage of MRR CAPs closed on time was 84%.

Qualitative Analysis/Barriers:

A. Rescheduling of audits to dates after the assigned due dates. At times, provider offices will cancel their scheduled audit and not be available until after the assigned due date. Reasons

for rescheduling include staffing issues at sites, COVID cases, and non-compliant providers/staff. Periodic FSRs are scheduled three months in advance, it is difficult to find available days to reschedule.

B. Since September 2023, two of the five QI Nurse Specialists were on leave. The workload is divided between the remaining three QI Nurse Specialists.
C. Loss of a QI Nurse Specialist position required to successfully complete CAPs and assist with CAP processes and procedures. Additionally, per DHCS CAP timelines, CE CAPs are due within 10 business days. FSR and MRR CAPs timelines decreased from 45 to 30 days on July 1, 2022. Outreach to the sites regarding outstanding CAPs include emails, faxes, and phone call reminders. Sites will submit CAP paperwork and supporting documents by the required due dates but when incomplete, the CAP closed date is missed.
D. Updates to DHCS FSR and MRR criteria and Standards implemented July 1, 2022. Prior to the updates, periodic FSRs and MRRs could be completed by one QI Nurse Specialist in one day. With the updates, it requires one QI Nurse Specialist two separate days or two QI Nurse Specialists one day.

Conclusion and Next Steps:

A. Recommendations include additional staff including an QI Nurse Specialist-LVN position and filling the open QI Nurse Specialist-RN position.
B. Keeping open days on calendars to have days to complete rescheduled audits and continue to meet three-year turnaround time.

5.1.3 Physical Accessibility Reviews (PARS)

Background: To ensure compliance with DHCS contractual requirements, CalOptima Health is required to access the level of physical accessibility of provider sites that serve a high volume of Seniors and Persons with Disabilities (SPDs).

Program Goals:

A. Conduct Initial PARS for primary care provider (PCP) sites in conjunction with the DHCS requirements for Initial Facility Site Reviews (FSRs).
B. Conduct Initial PARS for high-volume specialty (HVS) sites when a newly contracted high-volume specialty provider joins the CalOptima Health Provider Network.
C. Conduct Periodic PARs for PCP and HVS sites in accordance with the DHCS three-year cycle requirements for FSR and medical record review (MRR) audits.
D. Use DHCS PARS (Attachment C) to access the physical accessibility of provider sites.
E. Document level of access results met per provider site as either Basic Access or Limited Access.

Actions/Interventions:

Description	Date of Completion
Conduct Initial PARS for PCP sites in conjunction with Initial FSRs.	Ongoing
Conduct Initial PARS for HVS site when a newly contracted provider joins the CalOptima Health Provider Network.	Ongoing
Conduct Periodic PARS for PCP and HVS sites at least every three years.	Ongoing
Document level of access results as Basic or Limited.	Ongoing

Results:

PARS	Months											
MY2023	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*
Number of PARS	51	43	39	27	34	24	16	24	21	30	24	24
Results with Basic Access	27	20	13	9	15	13	13	6	5	11	6	10
Results with Limited Access	24	23	26	18	19	11	3	18	16	19	18	14
Percentage of PARS with Basic Access	53%	47%	33%	33%	44%	54%	81%	25%	24%	37%	25%	42%
Percentage of PARS with Limited Access	47%	53%	67%	67%	56%	46%	19%	75%	76%	63%	75%	58%

Quantitative Analysis:

A. Initial and Periodic PCP and HVS PARS were conducted according to DHCS requirements. The range of PARS completed each month ranged from 16–51. There are a greater number of sites with Limited Access than Basic Access.

Qualitative Analysis/Barriers:

A. The results of FSR Attachment C are informational and unlike FSR Attachments A (Site Review Survey) and B (Medical Records Review Survey) do not require corrective action. Although efforts to enhance access for the SPD population are encouraged and additional information to make changes to better accommodate this population is offered, very few sites want to make changes/updates to their facilities.

Conclusion and Next Steps:

A. Staff will continue to monitor PARS and track and trend performance to identify opportunities for improvement.

5.1.4 Provider Credentialing

Background: The Credentialing department is responsible for ensuring all practitioners are appropriate qualified to provide care to our members. Providers must be appropriately licensed and experienced in their field. This is accomplished by applying rigorous standards that verify

practitioner's license, education, training, experience, certification, malpractice history, work history, and quality of care attributes. To become a participating provider in the CalOptima Health network, each provider must meet the minimum qualifications, as outlined by DHCS, NCQA, and CMS.

Program Goals:

A. Credential and recredential CCN and BH providers
B. Initial credentialing of non-BH providers to be completed 180 days from attestation date
C. Initial credentialing of BH providers to be completed 60 days from attestation date
D. Recredentialing to be completed within 36 months of last credentialing date

Actions/Interventions:

Planned Activities	Description	Date of Completion
Credentialing Verification Organization (CVO)	Issue a RFP to contract with the CVO to ensure compliance and timeliness of the initial credentialing and recredentialing files.	Q2, 2023
Credentialing Consulting Services	Consulting Group to review the credentialing process to identify gaps and improve the overall workflow.	Q2-Q3, 2023
Auditor Positions	Hiring of two auditors to help with the ongoing monitoring, auditing of internal files, oversight of delegated entities and the CVO.	1/14/2024 and 1/28/2024
Temporary Positions	Bring in temp positions to help with the management of the inboxes, the increase of BH providers and other duties	Continuous
Manager Position	Hiring of Credentialing Manager	8/14/2023
Staff Training	Engaged Symplr (Cactus Provider Management Platform) for additional Cactus training for the credentialing staff.	10/23/23-10/25/2023, 10/30/2023, 11/01/2023
Credentialing Application Updates	Revise credentialing applications to make them easier for providers and staff to navigate.	7/01/2023, as needed

Results:

The tables below depict the 2022/2023 Credentialing report for CalOptima Health.

CalOptima Health Credentialing Statistics (CCN Delegated Groups and CCN Non-Delegated)

	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Initials	239	204	205	255
Recredentials	771	688	659	682
Total	1,010	892	864	937

Credentialing Statistics – CCN Delegated Groups

	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Initials	179	148	144	182
Recredentials	634	598	508	581
Total	813	746	652	763

Credentialing Statistics – CCN Non-Delegated

	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Initials	60	56	61	73
Recredentials	137	90	151	101
Total	197	146	212	174

Quantitative Analysis:

A. In 2023, 253 practitioners completed the initial credentialing process, and 579 practitioners completed the re-credentialing process.
B. Of those re-credentialed, 98.6% of those were re-credentialed successfully and timely. The number of those re-credentialed in 36-month timeframe was 571.
C. Initial CCN providers credentialed show an increase from years 2021–2023. Increase occurred mostly with Behavioral Health providers.

Qualitative Analysis/Barriers:

A. In January 2023, Governor Newsom changed the credentialing turnaround time (TAT) for providers who provide mental health and substance abuse services from 180 days to 60 days.
B. DHCS has created provisions for providers to be added to the provider network if they are pending Medi-Cal enrollment. This requires the team to develop new process and workflows were tracking.
C. With the implementation of CalAIM, there has been an increase in credentialing (or vetting) non-traditional providers (i.e., doulas, etc).
D. Increased number of BH providers with a 60-day TAT
E. Multiple staff changes in the Credentialing department
F. The team did not have a Credentialing Manager for the first seven months of 2023.

Conclusion and Next Steps:

A. CalOptima Health has worked with the consultant to identify strengths and opportunities for improvement. A work plan was developed and interventions will be considered for implementation in 2024.
    1. Strengths:
        a. Staff has adapted to changing priorities for credentialing files.
        b. Staff has been cross trained and are well rounded in multiple types of files to credential.
    2. Opportunities for Improvement:

a. Promote communication to improve credentialing provider approval notification
b. Desktop procedures
c. Credentialing Requirements Spreadsheet

B. Contract with a CVO and implement a process to conduct verifications of credentials on behalf of CalOptima Health.
C. Contract with a vendor to obtain a single integrated provider lifecycle management system for credentialing, contracting and provider data management.

5.1.5 Provider Preventable Conditions (PPCs)

Background: CalOptima Health is required by DHCS to report PPC events in accordance with Title 42, Code of Federal Regulations (C.F.R), Section 438.3(g) and DHCS guidance, including All Plan Letter (APL) 17-009: Reporting Requirements Related to Provider Preventable Conditions. PPCs primarily occur in the hospital but may occur in other clinical locations. PPCs are identified by the medical directors when they are reviewing inpatient medical records and through claims review. When a PPC is identified, it is reported to DHCS via their web portal, and investigated as a PQI.

Program Goal: To appropriately identify the PPC for reporting to DHCS and quality-of-care issues.

Actions/Interventions: Ongoing identification of PPCs through monthly review of claims data performed by a PQI nurse.

Results:

A. In 2023, two PPCs were identified; one was a vascular catheter-associated infection and the second was a deep vein thrombosis. A PQI investigation was conducted for both PPCs, and both cases were leveled “0” defined as “No quality of care or quality of service issue identified.”

Quantitative Analysis:

A. The number of PPCs identified in 2023 increased over 2022, in which only one PPC was identified. In 2021, no PPCs were identified;in 2020, seven were identified.
B. PPC review requires obtaining hospital medical records to determine if the diagnosis was present on admission, which would exclude the incident as a PPC.

Qualitative Analysis/Barriers:

A. In 2021, the nurse supervisor (RN) had been responsible for the review of claims reports for PPCs. This individual left the Quality Improvement department, and the assignment was given to an LVN. In retrospect, it is believed that the LVN didn’t have the clinical expertise to perform this function. In 2023, the function was transferred to a RN to manage.

Conclusion and Next Steps:

A. To ensure that the claims reports are adequately reviewed for PPCs, Quality Improvement staff will need to ensure that the RN has adequate bandwidth to perform the reviews. It is

believed that an additional RN will be hired and trained in Q1 2024, which should provide adequate support for the PPC review.

5.1.6 Incident Reports

Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and Nursing Facilities (NFs) Critical Incidents

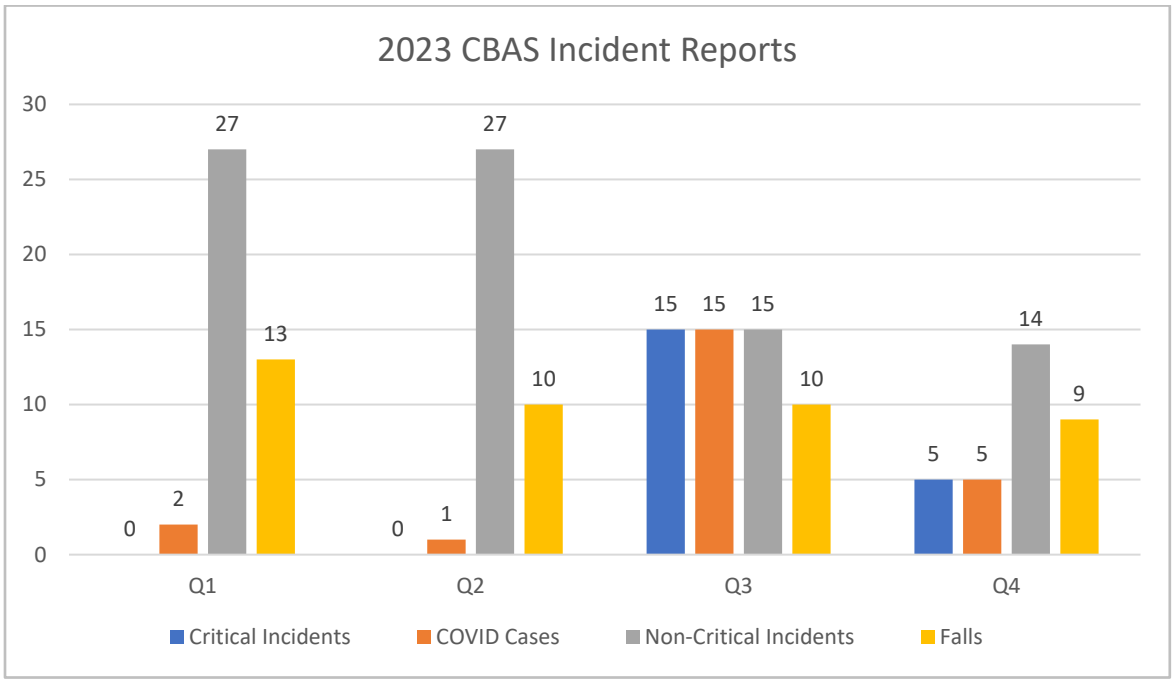
Background: As a requirement from DHCS, CalOptima Health CBAS, MSSP and Nursing Facilities report critical incidents. CBAS centers report other types of incidents, such as falls. The reports are reviewed by nurses in QI and a PQI investigation is opened, if warranted.

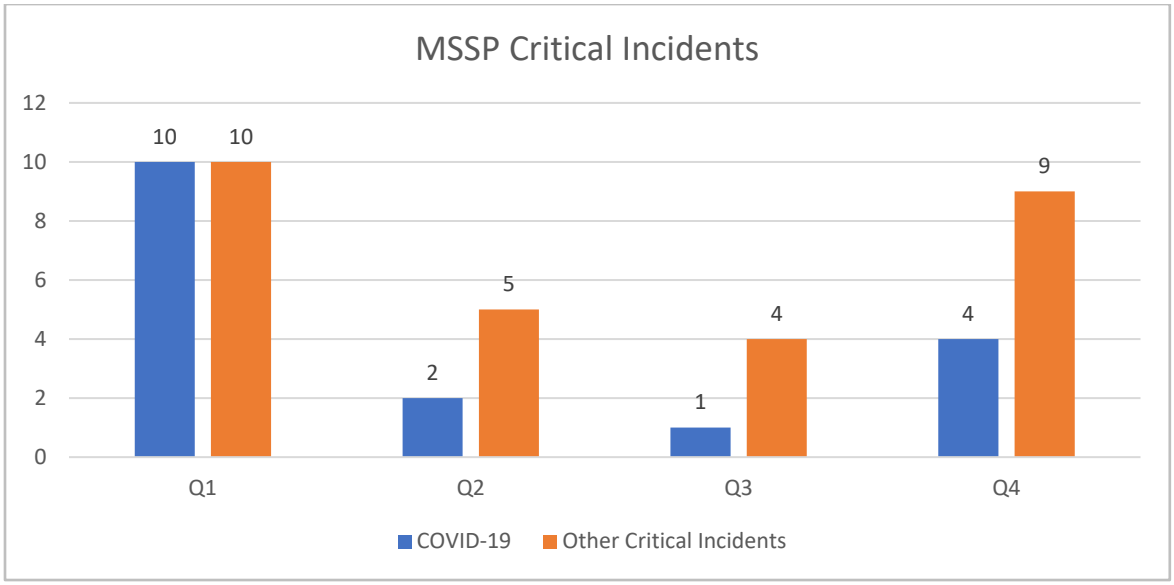
Program Goal(s): The Incident Reporting process is a tool for CalOptima Health to provide quality oversight for our members of these programs. Identification and investigation of Critical Incidents through the PQI process leads to clinical review by a medical director and action as needed. QI ensures that all non-COVID-19-related Critical Incidents have been reported to Adult Protective Services (APS).

Actions/Interventions:

Planned Activities	Description	Date of Completion
Critical Incident Reporting by Nursing Facilities	It was found that none of the contracted Nursing Facilities had reported Critical Incidents in 2023. Letters were sent to the Director of Nursing and Administrator of each Nursing Facility explaining the requirement and providing them with information on how to submit the reports.	Anticipated completion date January 2024.
Critical and Non-Critical Reporting by CBAS Centers	CBAS Centers submit reports of Critical and Non-Critical incidents to the QI department. In Q3 2023, Critical Incidents reports included COVID cases.	Ongoing
Critical Incident Reporting for MSSP	Social Workers at CalOptima Health report Critical Incidents when identified.	Ongoing
Report non-COVID-19-related Critical Incidents	Critical Incidents are reported as they occur to APS and quarterly in a report to DHCS.	Ongoing
COVID-19 related Incidents	If it is identified that a possible outbreak of COVID-19, or other communicable disease, is identified at any facility, QI will report it to the Orange County Health Care Agency.	Ongoing

Results:





Quantitative Analysis:

A. CBAS
   1. The number of Critical Incident reports had declined since the beginning of COVID-19 pandemic.
   2. As of Q3 2023, COVID cases were added in the Critical Incident report totals for CBAS Centers.
   3. In Q1 and Q2, no Critical Incidents were reported, but non-Critical Incidents were much greater than in Q3 and Q4. The overall number of Incidents reported dropped in Q4.

B. MSSP

1. Both COVID-19 reported cases and Critical Incidents were greater in Q1 and Q4.
2. No reports were received for Nursing Facilities.

Qualitative Analysis/Barriers:

A. In 2023, it was found that none of the Nursing Facilities had reported Critical Incidents. As a result, a letter was sent to each of the Nursing Facilities along with CalOptima Health's policy GG.1815: Long-Term Services and Supports Quality of Care Reporting that stipulates the requirement from the DHCS for this reporting to the Health Plan. Some of the Nursing Facilities called CalOptima Health after receiving the letter. Those that called stated that they were not aware of the requirement. Additional and ongoing education of the Nursing Facilities may be required.
B. All the MSSP Critical Incidents were reported by the Social Workers in the LTSS Department at CalOptima Health and were related to a personal caregiver or family member, so no PQI investigation was needed.

Conclusion and Next Steps:

A. The reporting of Critical Incidents from the Nursing Facilities was not successful. With the letter outlining the reporting requirements and ongoing education and updates being sent to Nursing Facilities, the number of Critical Incident Reports sent to CalOptima Health should increase.
B. The reporting of Critical Incidents from the CBAS Centers was successful.

5.1.7 Encounter Data

Background: CalOptima Health's HNs must submit complete, timely, reasonable, and accurate Encounter data that adheres to the guidelines specified in the Companion Guides for facility and professional claim types and data format specifications. A HN submits Encounter data through the CalOptima Health File Transfer Protocol (FTP) site.

CalOptima Health semi-annually measures a HN's compliance with performance standards with regards to the timely submission of complete and accurate Encounter data, in accordance with Policy EE.1124 health Network Encounter Data Performance Standards. CalOptima Health utilizes retrospective Encounter data to conduct its evaluation. The measurement year is the 12 month calendar year. CalOptima Health provides each HN with a HN Encounter Data Scorecard to report a HN's progress check score and annual score relating to the status of the Health Network's compliance with Encounter data performance standards.

Goals:

A. Medi-Cal
    1. A Shared Risk Group (SRG) shall be compliant with at least five of the eight Encounter data performance standards during each measurement year;
    2. A Physician Hospital Consortium (PHC) or Health Maintenance Organization (HMO) shall be compliant with at least six of the eight encounter data performance during each measurement year; and
    3. A pediatric PHC shall be compliant with at least five of the eight encounter data performance standards during each measurement year.
B. OneCare

1. A Physician Medical Group (PMG) shall be compliant with at least three of the four encounter data performance standards during each measurement year.

Results:

Medi-Cal Encounter Performance Summary of Health Networks for CY 2022 Annual

Encounter Performance Summary of Health Networks
CY 2022 Annual

	Completeness								Accuracy		Timeliness		
	Inpatient Match	ER Match	PMPY[1]			Lab Services PMPY	Radiology Services PMPY	PCP/ Member Match	Rejected- Records[1]		Encounter Timeliness	Total	Goal
			Ages 0 to 2	Ages 3 to 19	AGED Mbrs				Prof	Fac			
HMO04 - Kaiser	97%	90%	5.9	3.9	4.5	8.3	2.0	100%	0%	1%	94%	7	8
HMO15 - Heritage	87%	91%	3.3	2.2	4.8	19.2	3.0	100%	1%	1%	92%	7	8
HMO16 - Monarch	90%	88%	5.5	2.9	5.1	14.0	2.3	100%	0%	2%	93%	7	8
HMO17 - Prospect	90%	93%	4.8	3.4	4.9	17.5	2.6	100%	0%	1%	95%	7	8
PHC20 - CHOC	96%	94%	5.3	3.2				90%	0%	0%	95%	6	6
PHC21 - Family Choice	86%	89%	5.3	3.0	4.8	12.4	1.9	100%	0%	1%	90%	7	8
PHC58 - AMVI Care	88%	86%	4.4	2.6	3.2	9.6	1.8	100%	0%	1%	83%	7	8
Standard	75%	75%	4.0	1.5	6.0	2.5	0.6	75%	5%	5%	75%		8
Average	91%	90%	4.9	3.0	4.5	13.5	2.3	99%	0%	1%	92%	7	
SRG64 - Noble		*49%*	4.1	2.2	4.5	9.6	1.6	100%	0%		93%	5	6
SRG65 - Talbert		*48%*	4.1	2.5	4.0	12.4	2.4	100%	0%		94%	5	6
SRG66 - ARTA		*47%*	3.9	2.4	3.7	10.1	1.7	100%	0%		92%	5	6
SRG69 - Alta Med		*45%*	4.0	3.0	4.6	12.2	2.2	100%	0%		93%	5	6
SRG82 - UCMG		*48%*	5.6	3.0	4.3	9.4	1.4	100%	0%		95%	5	6
Standard			4.0	1.5	6.0	2.5	0.6	75%	5%		75%		6
Average		47%	4.3	2.6	4.2	10.7	1.9	100%	0%		93%	5	

[1]Must meet all standards
ER Gap Scores are informational only for SRG Health Networks
HMO/PHC must meet 6 to avoid a CAP
SRG must meet 5 to avoid a cap

Medi-Cal Encounter Performance Summary of Health Networks for CY 2023 Semi-Annual

Encounter Performance Summary of Health Networks
CY 2023 Semi-Annual

	Completeness								Accuracy		Timeliness		
	Inpatient Match	ER Match	PMPY[1]			Lab Services PMPY	Radiology Services PMPY	PCP/ Member Match	Rejected- Records[1]		Encounter Timeliness	Total	Goal
			Ages 0 to 2	Ages 3 to 19	AGED Mbrs				Prof	Fac			
HMO04 - Kaiser	98%	98%	6.2	3.2	4.9	9.8	2.0	100%	0%	1%	98%	7	8
HMO15 - Heritage	94%	95%	2.9	1.8	4.5	21.0	3.0	100%	1%	1%	97%	7	8
HMO16 - Monarch	93%	90%	4.7	2.2	4.2	12.7	2.3	100%	0%	3%	97%	7	8
HMO17 - Prospect	93%	95%	5.0	2.2	4.8	19.5	2.6	100%	0%	2%	98%	7	8
HMO83 - Family Choice	97%	96%	5.6	3.0	5.3	14.7	1.9	100%	0%	0%	98%	7	8
PHC20 - CHOC	87%	94%	5.5	2.3				65%	0%	0%	100%	5	6
PHC58 - AMVI Care	93%	93%	4.7	1.9	2.4	9.8	1.8	100%	0%	1%	98%	7	8
Standard	75%	75%	4.0	1.5	6.0	2.5	0.6	75%	5%	5%	75%		8
Average	94%	94%	4.9	2.4	4.0	14.6	2.3	95%	0%	1%	98%	7	
SRG64 - Noble		*96%*	4.0	2.0	4.3	10.2	1.7	90%	0%		96%	5	6
SRG65 - Talbert		*96%*	3.9	1.8	4.2	13.0	2.5	100%	0%		98%	5	6
SRG66 - ARTA		*97%*	3.3	1.6	2.9	11.2	1.7	78%	0%		98%	5	6
SRG69 - Alta Med		*96%*	3.8	2	4.5	11.4	2.1	100%	0%		98%	5	6
SRG82 - UCMG		*96%*	5.4	2.6	3.6	9.4	1.3	100%	0%		97%	5	6
Standard			4.0	1.5	6.0	2.5	0.6	75%	5%		75%		6
Average		96%	4.1	2.0	3.9	11.0	1.9	94%	0%		97%	5	

[1]Must meet all standards
PHC20 CHOC Lab and Radiology Services are informational only
ER Gap Scores are informational only for SRG Health Networks
HMO/PHC must meet 6 to avoid a CAP
SRG must meet 5 to avoid a cap

Semi Annual PMPY is annualized. Dates of Service = 1/1/2023 - 6/30/2023; Dates of Submission for Accuracy and Timeliness = 2/1/2023 - 7/31/2023

OneCare Encounter Performance Summary of Health Networks for CY 2023 Semi-Annual

Encounter Performance Summary of Health Networks
CY 2023 Semi-Annual

	Completeness		Accuracy	Timeliness		
	PMPY		Rejected-Records	Encounter Timeliness		
	Overall Encounters	E&M Visits	Prof		Total	Goal
HMO15 - Heritage	★ 25.8	★ 9.4	★ 1%	★ 98%	4	4
HMO16 - Monarch	★ 24.4	★ 7.5	★ 0%	★ 99%	4	4
HMO17- Prospect	★ 23.1	★ 7.0	★ 0%	★ 99%	4	4
PMG21 - Family Choice	16.1	★ 6.2	★ 0%	★ 100%	3	4
PMG52 - Talbert	★ 21.0	5.8	★ 0%	★ 99%	3	4
PMG64 - Noble	19.1	★ 6.3	★ 0%	★ 98%	3	4
PMG66 - Arta	17.2	★ 6.7	★ 0%	★ 99%	3	4
PMG69 - Alta Med	★ 28.0	★ 7.1	★ 0%	★ 99%	4	4
PMG82 - UCMG	17.5	★ 6.3	★ 0%	★ 98%	3	4
Standard	20.0	6.0	5%	90%		4
Average	21.4	6.9	0.0	99%	3.4	

Must meet 3 to avoid CAP

Quantitative Analysis:

A. For Medi-Cal, while the Health Networks did not meet all the Encounter Data Performance Standards, the HNs met their minimum required numbers of standards to be considered compliant. Performance remained the same for all HNs between the CY 2022 Annual Scorecard to the CY2023 Semi-Annual Scorecard, with the exception of CHOC as their number of met standards went from 6 to 5.
B. For OneCare, all HNs met the minimum three required Encounter Data Performance Standards and were compliant. Four HNs met all the Encounter Data Performance Standards. No available trending is available for OneCare since CY2022 data would include OneCare Connect encounters and the OneCare Connect Program sunset at the end of 2022.

Qualitative Analysis/Barriers:

A. There are several reasons why CalOptima Health would not store a record of an encounter or a claim.
    1. The service provider does not send the encounter or claim to the HN.
    2. The HN denies or rejects the encounter or claim and the service provider does not resubmit.
    3. The HN does not send the encounter to CalOptima Health.
    4. CalOptima Health rejects the encounter, and the HN does not resubmit.
B. Overall, the HNs sending complete, timely, reasonable, and accurate encounter data as measured by monthly reports and the Encounter Data Scorecards.

Conclusion and Next Steps:

A. The annual scorecard will be published in July 2024.
B. Staff will continue to monitor monthly data submissions and communicate any observed concerns promptly to the Health Networks.

5.1.8 External Quality Review (EQR) Recommendations

Background: In April 2023, Health Services Advisory Group, Inc. (HSAG), the External Quality Review Organization (EQRO) for DHCS, completed the 2021–22 EQR technical report. HSAG provided recommendations for improvement for CalOptima Health related to the EQR findings.

EQR Recommendations:

A. Address the findings from the 2022 DHCS Audits & Investigations Division (A&I) Medical Audit of CalOptima by implementing the actions recommended by A&I.
B. For both Well-Child Visits in the First 30 Months of Life measures, assess the factors, which may include COVID-19, that resulted in CalOptima Health performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors. As part of this assessment, CalOptima Health should determine whether the member-focused interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.

Actions/Interventions:

EQR Recommendations	Actions Taken
Audit Findings	• Added PSA oversight to the current Key Performance Indicator (KPI) dashboard for monitoring and oversight. • Added the Comprehensive HRA form to the website, developed a blood lead screening refusal form and provided training to the HNs and Providers. • Added the Comprehensive HRA form to the website, developed a blood lead gap report, updated the provider portal with alerts and conducted training for the HNs and Providers. • Updated internal desktops requirements, provided training to the HNs and updated audit tools. • Conducted training for staff and hired additional staff to improve the staff-to-case ratio. • Updated the Delegation Oversight dashboard to include turnaround times to be monitored on a quarterly basis for potential CAP issuance, provided training to the HN, and the HN implemented daily/quarterly monitoring. • Developed new processes to ensure declined potential quality of care grievances are reviewed by a Medical Director and provided training to staff. • Developed a process to ensure QI and UM correspond prior to the QIHEC meetings ensuring any compliance issues are discussed at the committee meeting.

EQR Recommendations	Actions Taken

Well-Child Visits in the First 30 Months of Life	• A root cause analysis was performed in the first half of 2023, identifying relevant issues, and developing successive strategies for improvement for implementation in the remainder of the calendar year.
	• Developed three strategies
	  ○ Engage with providers to encourage use of newborn codes for well-care visits in the first 28 days of life.
	  ○ Promote early Medi-Cal enrollment of newborns through outreach to pregnant members and new moms in collaboration with community partners and providers.
	  ○ Collaborate with all HNs to ensure supplemental data is submitted throughout the year.
	• Implemented the following actions:
	  ○ Live call campaigns to W30-2+ non-compliant list.
	  ○ First and second birthday card reminders
	  ○ Text message campaigns
	  ○ Health Guide 0-2 years newsletter mailings
	  ○ Member newsletter articles
	  ○ Targeted mailings with well-child visit flyers
	  ○ Integrated voice recognition (IVR) robocall campaigns
	  ○ Development of W30 member detailed gap reports for health network distribution

Conclusion and Next Steps:

A. Audit CAPs were accepted and closed.
B. Well-Child Visits in the First 30 Months of Life met the minimum performance level for MY 2022.
C. CalOptima Health will continue to monitor for compliance.

5.2 Keeping Members Healthy

5.2.1 Health Education

Background: During the COVID-19 pandemic, CalOptima Health discontinued in-person group classes, yet findings from the Population Needs Assessment (PNA) and incoming referrals from providers indicated the need for increased nutrition and physical activity knowledge. In 2023, the Health Education team re-launched in-person classes to address member needs and provide education about healthy food choices, exercise, and how to attain or maintain healthy weight. Shape Your Life (SYL) offers seven sessions without any prerequisite. The class is offered in English and Spanish.

Program Goals:

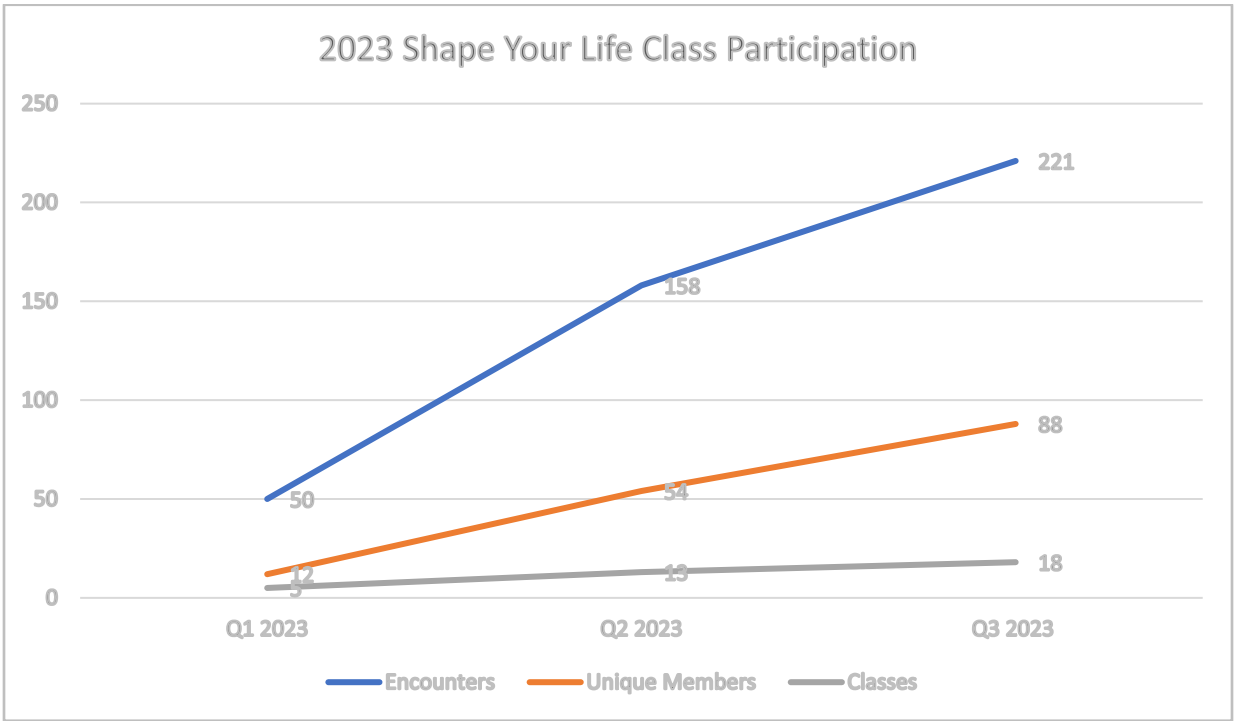
A. Resume SYL classes by Q2 2023
B. Increase class enrollment by 50% from Q2 to Q4.
C. At least 40% of the participants will increase their knowledge of basic nutrition when comparing data from pre- and post-class assessments.

Actions/Interventions:

Planned Activities	Description	Date of Completion
Establish new partnerships for class locations	Using member data, staff identified community locations near where CalOptima Health members live and worked with community partners to schedule SYL classes in those locations.	Assessment completed and partnerships formed Q2 and Q3
Increase SYL Program participation by 50% from Q2 to Q4.	The Health Education team works on establishing a collaboration with community locations including family resource centers to host the SYL class so that it's easily accessible to members and community residents.	10/01/2023

Results:

A total of 41 classes (6 cohorts, 7 classes each) were held between March and October 2023, reaching 121 unique participants, including 86 children and 35 parents.



Quantitative Analysis:

A. Resumed SYL classes by Q2 and increased class enrollment by 50% from Q2 to Q4. This goal was met.
    i. The Health Education team formed partnerships with community centers that have a high density of Medi-Cal participants to offer SYL class and reduce service accessibility barriers. All class locations combined, participation increased from 12 unique members in Q1 to 54 in Q2 and to 88 in Q3.
B. The goal to increase class participation to 50% was reached before the due date of October 1, 2023. This objective was met.

i. Results from the SYL post-class assessments show that 45% of the participants increased their knowledge of basic nutrition.

Barrier/Qualitative Analysis:

A. Offering consistent group health education classes at the same locations has been challenging due to lack of dedicated and accessible community spaces available for CalOptima Health use.
B. Barriers to quick communication with members continues to be a concern since all text messages must receive DHCS approval first. For example, if a class is cancelled, sending a mass text message to all participants would be helpful in communicating the message faster.

Conclusion and Next Steps:

A. After an extended hiatus due to the pandemic, SYL in-person classes resumed on March 2, 2023. Over the course of the year, there were a total of 41 classes taught throughout Anaheim, Orange, Santa Ana and virtually via Zoom. Member participation increased over the course of the year due to outreach efforts.
B. Next steps include increasing SYL promotion efforts and collaborating with new community partners where SYL classes can easily be accessed by members. Virtual classes will be offered throughout the year, providing another option for members to receive health education services.

5.2.2 Adult Wellness

5.2.2.1 Adult Preventive Screenings (CCS, BCS, COL)

Background: According to the American Cancer Society, 1 in 2 men and 1 in 3 women will develop cancer in their lifetime. Breast cancer is the second most common cancer for American women while cervical cancer is one of the most common causes of cancer death for American women. In addition, colorectal cancer is the fourth most common cancer in men and women and the fourth leading cause of cancer-related deaths in the United States.

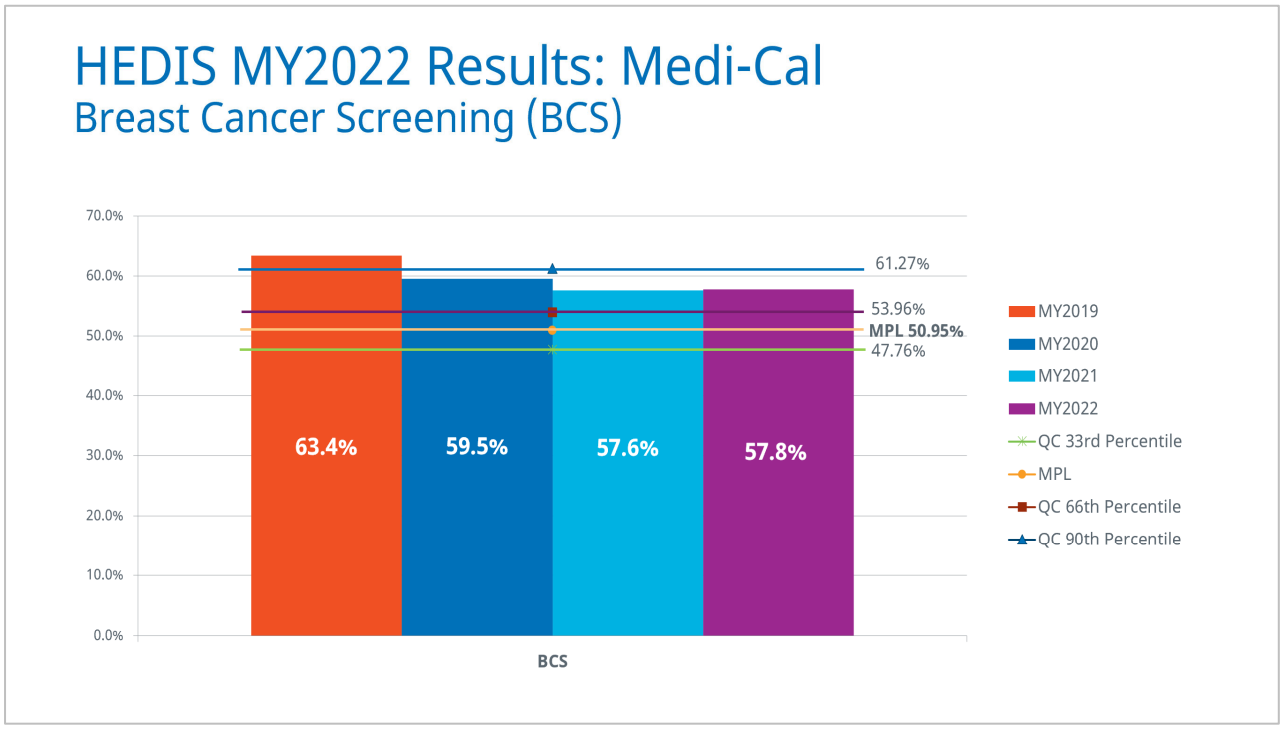
U.S. Preventive Services Task Force (USPSTF) has recommended screening for cervical, breast and colorectal cancers. Cancer screening tests can help find cancer at an early stage before symptoms appear. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower health care costs.

The following is an evaluation of the cancer screening performance measures for HEDIS. Cervical Cancer Screening and Breast Cancer Screening are part of DHCS MCAS for annual reporting by Medi-Cal managed care health plans. These measures are held to the MPL established by NCQA Quality Compass Medicaid 50th percentile. Breast Cancer Screening and Colorectal Cancer Screening measures are part of the CMS 5-Star quality rating system.

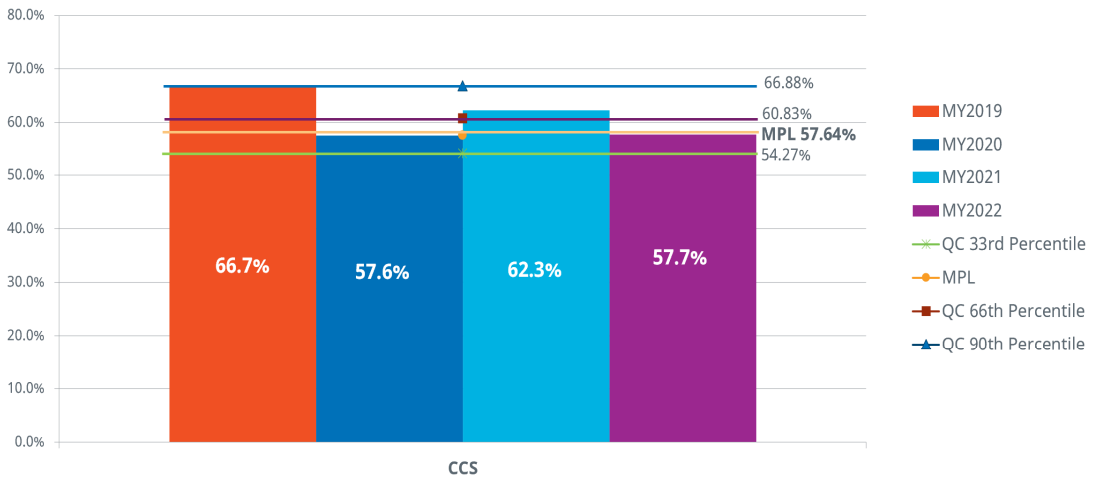
Goal(s):

Table below reviews the Medi-Cal and OneCare final rates for HEDIS MY2022 and goals for MY2022 and MY2023.

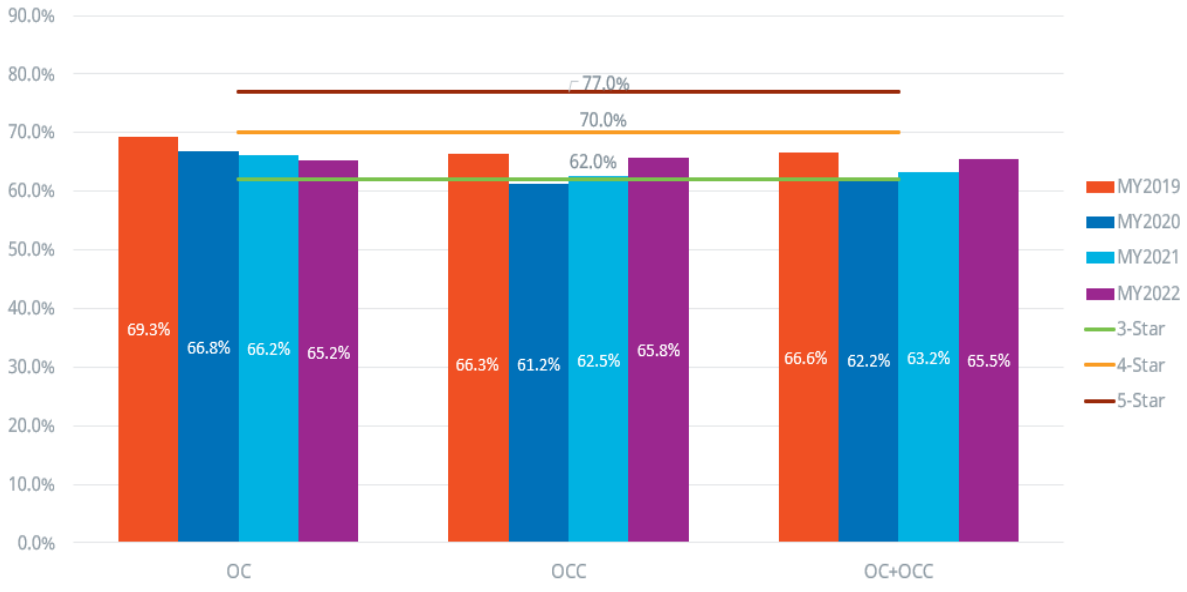
Acronym	Measure	MY2022 Medi-Cal Rate	MY2022 OneCare Rate	MY2022 Goal Met/Not Met	2023 Medi-Cal Goal	2023 OneCare Goal
CCS	Cervical Cancer Screening	57.73%	N/A	Medi-Cal: Not Met (59.12%)	62.53%	N/A
BCS	Breast Cancer Screening	57.81%	65.20%	Medi-Cal: Not Met (61.24%) OneCare: Not Met (69.00%)	61.27%	70.00%
COL	Colorectal Cancer Screening	N/A	64.23%	OneCare: Met (62.00%)	N/A	71.00%

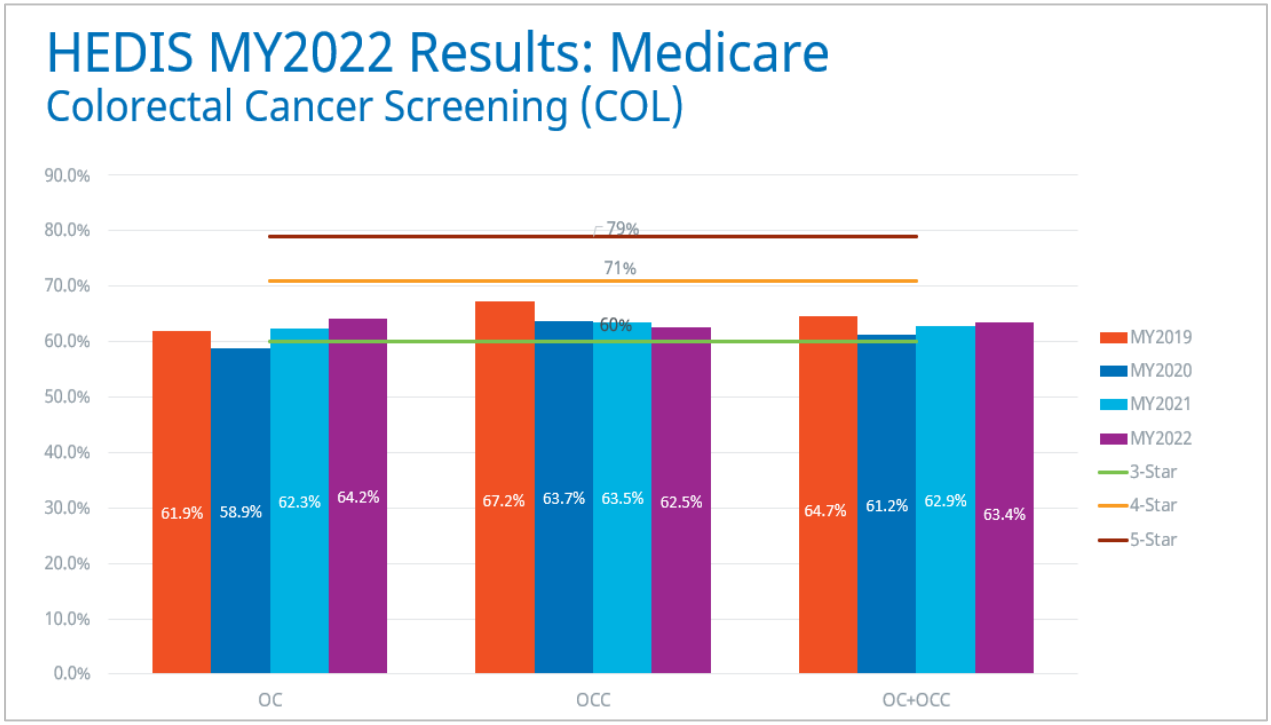


HEDIS MY2022 Results: Medi-Cal
Cervical Cancer Screening (CCS)



HEDIS MY2022 Results: Medicare
Breast Cancer Screening (BCS)





A. Goal methodology for MY2023 is set based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2021 reported performance results compared to the national percentile from the MY2021 NCQA Quality Compass. If the current reported rate reached NCQA Quality Compass percentile, then the goal was set to the next percentile. The OneCare goal setting for MY2023 is based on the MY2021 reported performance results compared to the Star Rating cutoff. If the current reported rate reached Star cutoff, then the goal was set to the next Star cutoff.
B. CalOptima Health's HEDIS MY2022 CCS hybrid rate for Medi-Cal was 57.73% and met the MPL of 57.64% but did not meet the MY2022 internal goal of 59.12%. CalOptima Health's HEDIS MY2022 BCS rate for Medi-Cal was 57.81% and met the MPL of 50.95% but did not meet the MY2022 internal goal of 61.24%. CalOptima Health's HEDIS MY2022 BCS administrative rate for OneCare was 65.20% and met the projected 3-Star of 62.00% but did not meet the MY2022 internal goal of 69.00%. CalOptima Health's HEDIS MY2022 COL hybrid rate for OneCare was 64.23% and met the project 3-Star of 60.00% and met the MY2022 internal goal of 62.00%.

Actions/Interventions:

Planned Activities / Intervention	Target Population	Barriers	Completion Status	Measure
Member Health Reward	Member	• Requires a signed/stamped attestation by the PCP or imaging center, which may prevent some members from participating in the health rewards • Late finalization of forms resulted in late promotion in the year perhaps impacting lower participation rates	In Progress	CCS BCS COL

Planned Activities / Intervention	Target Population	Barriers	Completion Status	Measure
Member Mailing	Member	• Incorrect or incomplete addresses • Members do not update their address with SSA • A significant percentage of mail is returned due to wrong addresses	Completed	CCS BCS COL
IVR	Member	• Member has a do-not-contact notice • Incorrect land line or cell phone number • Member does not listen to full message or does not listen to voicemail.	Completed	CCS COL
Text Messaging	Member	• Member has a do-not-contact notice • Incorrect cell phone number • Missing or member does not have cell phone number • Do not have verbal or written Telephone Consumer Protection Act (TCPA) consent for text messaging • Member has opted out of receiving text messages	Completed	CCS BCS
Telephonic Outreach	Member	• Member has a do-not-contact notice • Incorrect contact number • Member does not pick up phone call and does not return voicemail message that is left • Limited staff resources to make calls • Calls initiated for yearend push may not have enough time to complete screening	In Progress	BCS COL
Member Newsletter	Member	• Incorrect or incomplete addresses • Members do not update address with Social Security Office. • A significant percentage of mail is returned due to wrong addresses • Unable to measure member engagement	Completed	CCS BCS COL
Wellness Calendar	Member	• Unable to measure member engagement	Completed	BCS COL
Pay For Value (P4V)	Provider, HN	• Payment methodology is not aligned to the internal CalOptima Health goal	In Progress	CCS BCS COL
CalOptima Health Website	Community	• Unable to measure member engagement	In Progress	CCS BCS COL
Electronic Newsletter (Community Connections)	Community	• Unable to measure community engagement	In Progress	CCS BCS COL

Planned Activities / Intervention	Target Population	Barriers	Completion Status	Measure
Paid Digital Ads	Community	• Advertisement only in three threshold languages, English, Spanish and Vietnamese • Inadequate duration and intensity/exposure to potential opportunity to see the campaign • Limited by budget allotment	In Progress	CCS BCS COL
Paid Print Ads	Community	• Advertisement only in three threshold languages, English, Spanish and Vietnamese • Inadequate duration and intensity/exposure to potential opportunity to see the campaign • Limited by budget allotment	In Progress	BCS COL
Paid Social Media Ads	Community	• Advertisement only in three threshold languages, English, Spanish and Vietnamese • Inadequate duration and intensity/exposure to potential opportunity to see the campaign • Limited by budget allotment	In Progress	CCS BCS COL
Passive Social Media Ads	Community	• Advertisement only in three threshold languages, English, Spanish and Vietnamese • Inadequate duration and intensity/exposure to potential opportunity to see the campaign	In Progress	CCS BCS COL
Radio Ads	Community	• Advertisement only in two threshold languages, Spanish and Vietnamese • Inadequate duration and intensity/exposure to potential opportunity to see the campaign • Limited by budget allotment	In Progress	CCS COL
TV Ads	Community	• Advertisement only in one threshold languages, English • Inadequate duration and intensity/exposure to potential opportunity to see the campaign • Limited by budget allotment	In Progress	CCS BCS

Outreach Campaigns:

A. In February 2023, June 2023 and October 2023 text messaging campaigns were launched to a total of 224,798 Medi-Cal members due for cervical cancer screening. In February 2023, an automated phone call was received by 6,354 Medi-Cal members who were due for cervical cancer screening. Additionally, in April 2023 and November 2023, cervical cancer mailers were sent out to non-compliant members to engage them to complete a cervical cancer screening. In total 204,638 mailers were sent. A social media campaign both paid and unpaid was launched in January 2023 for Cervical Cancer Awareness month. Paid social media ads were targeted to cities that were identified as having a large non-compliant cervical cancer screening population. In collaboration with CalOptima Health's Communications department paid digital advertising, television advertising and radio advertising ran at different points during the MY2023 for cervical cancer screening

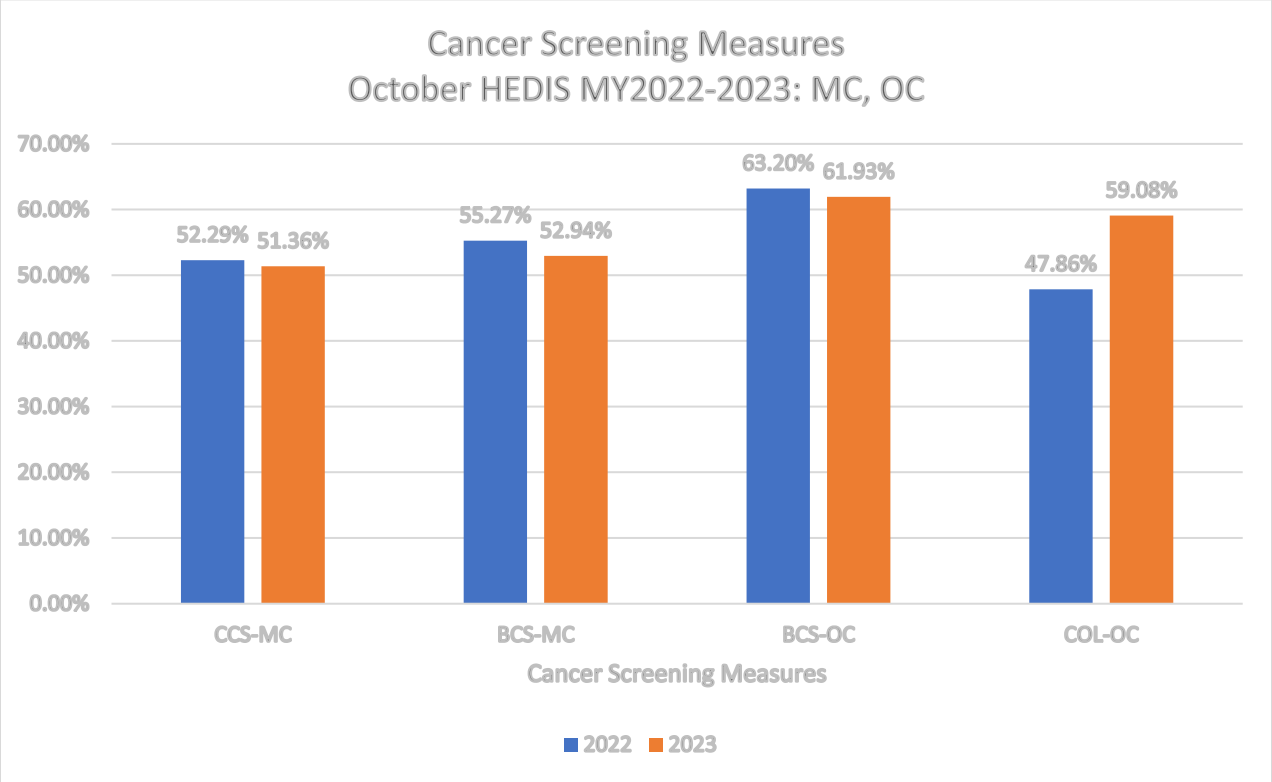
measure. Advertising ran in English, Spanish and Vietnamese as these are the top three languages spoken by CalOptima Health members. These ads further engaged members to complete cervical cancer screening tests.

B. In April 2023, June 2023 and October 2023, text messaging campaigns were launched to a total of 208,602 Medical members due for breast cancer screening. No texting campaign was launched for OneCare members due to member abrasions concerns at the point in time when campaign was scheduled. In June 2023, breast cancer mailers were sent out to non-compliant members to engage them to complete breast cancer screening. In total 28,973 Medi-Cal and 2,270 OneCare mailers were sent out. Additionally, in June 2023 a OneCare retention mailing was sent out to 17,026 OneCare members. Beginning July 2023, a telephonic outreach campaign began for 2,278 OneCare members. A social media campaign, both paid and unpaid, was launched in October 2023 for Breast Cancer Awareness month. Paid social media ads were targeted to cities that were identified as having a large non-compliant breast cancer screening population. In collaboration with CalOptima Communication Department paid digital advertising, print advertising, television advertising and radio advertising ran at different points during the MY2023 for breast cancer screening measure. Advertising ran in English, Spanish and Vietnamese as these are the top three languages spoken by CalOptima Health members. These ads further engaged members to complete breast cancer screening tests.

C. In February 2023, an automated phone call was received by 3,157 OneCare members that were due for colorectal cancer screening. No texting campaign was launched for OneCare members due to member abrasions concerns at the point in time when campaign was scheduled. In May 2023, colorectal cancer mailers were sent out to non-compliant members to engage them to complete colorectal cancer screening. In total 6,613 OneCare mailers were sent out. Additionally, in June 2023 a OneCare retention mailing was sent out to 17,026 OneCare members. Beginning July 2023, a telephonic outreach campaign began for 2,278 OneCare members. A social media campaign, both paid and unpaid, was launched in March 2023 for Colorectal Cancer Awareness month. Paid social media ads were targeted to cities that were identified as having a large non-compliant colorectal cancer screening population. In collaboration with CalOptima Health's Communications department paid digital advertising, print advertising ran at different points during the MY2023 for breast cancer screening measure. Advertising ran in English, Spanish and Vietnamese as these are the top three languages spoken by CalOptima Health members. These ads further engaged members to complete colorectal cancer screening tests.

Results:

CalOptima Health cancer screening rates for October HEDIS MY2022–MY2023 for Medi-Cal and OneCare are depicted below.



Claims/Encounters processed through October 2023

Quantitative Analysis:

A. Medi-Cal
   1. Cervical Cancer Screening (CCS): Figure 1 above compares CalOptima Health Medi-Cal CCS prospective rates for October HEDIS MY2022–MY2023. The rates are based on the administrative data and represent the claims/encounters process through the month of October for each respective year. As of October 2023, the CCS prospective rate was 51.36%, which is lower than the October 2022 prospective rate of 52.29% by 0.93 percentage points.
   2. Breast Cancer Screening (BCS): Figure 1 above compares CalOptima Health Medi-Cal BCS prospective rates for October HEDIS MY2022–MY2023. The rates are based on the administrative data and represent the claims/encounters process through the month of October for each respective year. As of October 2023, the Medi-Cal BCS prospective rate was 52.94%, which is lower than the October 2022 prospective rate of 55.27% by 2.33 percentage points.

B. OneCare
   1. Breast Cancer Screening (BCS): Figure 1 above compares CalOptima Health OneCare BCS prospective rates for October HEDIS MY2022–MY2023. The rates are based on the administrative data and represent the claims/encounters process through the month of October for each respective year. As of October 2023, the BCS prospective rate was 61.93%, which is lower than the October 2022 prospective rate of 63.20% by 1.27 percentage points.
   2. Colorectal Cancer Screening (COL): Figure 1 above compares CalOptima Health OneCare COL rates for October HEDIS MY2022–MY2023. The rates are based on the administrative data and represent the claims/encounters process through the

month of October for each respective year. As of October 2023, the COL prospective rate was 59.08% which is higher than the October 2022 prospective rate of 47.86% by 11.22 percentage points.

Qualitative Analysis/Barriers:

A. Members did not visit their PCP during MY2023 so were not educated or reminded of the cancer screenings they were due for.
B. Members may not complete their cancer screening because of discomfort associated with the procedure and/or fear of knowing the test results.
C. Members may not be aware of the importance of cancer screening and/or frequency of screening especially after having a previous screening with a negative result.
D. Appointment access could be limited due to scheduling ability and/or staff shortage resulting in long wait times for appointments.
E. Due to data lag of approximately 90 days the October 2023 prospective rate may not provide the most accurate rate of completion for the cancer screening measures.
F. Hybrid measures like Cervical Cancer Screening for Medi-Cal and Colorectal Cancer Screening for OneCare are hybrid measures that require medical record review therefore the actual final rate for MY2023 may be higher.

Disparity Analysis:

A. Analysis Methodology: Disparity analysis was conducted for cancer screening measures based on the HEDIS MY2022 top 10 race/ethnicity administrative data by denominator. This was then compared to HEDIS MY2021 top 10 race/ethnicity administrative data by denominator to observe any changes from the previous year.
B. Quantitative Analysis:
    1. Medi-Cal Cervical Cancer Screening: For CCS, rates are lowest for race/ethnicity group identified as No Response as compared to all other race/ethnic groups (41.21%) and dropped by 14.03 percentage points from the previous year (55.24%). When looking at the top three race/ethnicity groups by denominator count Vietnamese group had the highest rate at 65.82%, up from 65.65% from the previous year. While the group identified as White had the lowest rate at 47.47%, decreased from 48.69% from the previous year.
    2. Medi-Cal Breast Cancer Screening: For BCS, rates are lowest for race/ethnicity group identified as White as compared to all other race/ethnicity groups (46.36%) and dropped by 1.17 percentage points from the previous year (47.53%). When looking at the top three race/ethnicity groups by denominator count Vietnamese group had the highest rate at 67.74%, up from 66.03% from the previous year. While the group identified as White had the lowest rate at 46.36%, decreased from 47.53% from the previous year.
    One Care Breast Cancer Screening: For BCS, rates are lowest for race/ethnicity group identified as White as compared with all other race/ethnic groups (57.70%) and dropped 0.87 percentage points from the previous year (58.57%). When looking at the top three race/ethnicity groups by denominator count Hispanic group had the highest rate at 69.64%, up from 68.89% from the previous year. While the group identified as White had the lowest rate at 57.70%, decreased from 58.57% from the previous year.

3. OneCare Colorectal Cancer Screening: For COL, rates are lowest for race/ethnicity group identified as Filipino as compared to all other race/ethnic groups (51.16%) and dropped by 10.1 percentage points from previous year (61.29%). When looking at the top three race/ethnicity groups by denominator count Other group had the highest rate at 60.17%, up from 40.00% from the previous year. While the group identified as White had the lowest rate at 52.79%, decreased from 55.08% from the previous year.

Conclusion and Next Steps:

A. Continue Health Rewards for eligible CalOptima members for CCS, BCS and COL measures. In anticipation that in MY2024 the COL measure will be held to the MPL for MCAS, CalOptima Health will expand health reward offering to include COL member health reward for eligible Medi-Cal members. Continue to increase participation in the program and motivate members to schedule and complete cancer screenings.
B. The hybrid CCS measure reached MPL in MY2022 by a small margin. The new national benchmark was released in September 2023 and the MPL has decreased from 57.64% to 57.11%. Opportunity remains to increase the Hybrid CCS measure. To illicit member barriers for completing cervical cancer screening, CalOptima Health will initiate two-way texting campaign for CCS measure.
C. Also, CMS has announced that they are removing the hybrid reporting method for COL in MY2024 and transitioning the measure to electronic clinical data systems (ECDS) reporting in MY2024 which may have an impact on Star Ratings 2026. The measure should continue to be a high priority for quality initiatives and member engagement.
D. Have more direct collaboration with CCN providers and health network quality teams. This will include presenting cancer screening information to important stakeholders throughout the year.
E. Creation of member initiatives that identifies members that have multiple gaps in care that can be closed in one visit to minimize member abrasion. As well as look into disparity analysis to target race/ethnicity groups that have the highest need.
F. Collaborate with provider groups, federally qualified health centers (FQHCs), health networks that hold the most members and have low screening rates for improvement projects.
G. Will use disparity analysis to develop interventions to target higher risk members with health inequities caused by race/ethnicity.
H. CalOptima Health will retain CCS, BCS and COL measures on the 2024 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization by conducting multicomponent interventions (mailers, automated calls and text messaging) to increase demand for cancer screenings.
I. Will use disparity analysis to develop interventions to target higher risk members with health inequities caused by race/ethnicity.

5.2.2.2 CalOptima Health Comprehensive Community Cancer Screening Program

Background: In December 2022, the CalOptima Health Board of Directors approved the Comprehensive Community Cancer Screening and Support Program with an allocation from IGT 10 funds not to exceed $50.1 million over five years.

Program Goals: The goals of the program are to increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnosis rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members for breast, cervical, colorectal and lung cancer in certain smokers. To reach these goals the following pillars are prioritized:

A. Raising cancer awareness and engagement especially among high-risk members and county residents
B. Increasing member options to access cancer screenings and treatment centers
C. Improving member experience throughout their cancer care journey

Actions/Interventions:

Planned Activities	Description	Date of Completion
Assessment of Barriers and Opportunities	Sought community input regarding barriers and opportunities for cancer awareness and education, access to screenings and improved member experience through cancer treatment.	January to July 2023
Mammogram Pilot with City of Hope	Partnered with City of Hope to develop and implement a small mammogram pilot for CCN members who were overdue for a breast cancer screening.	May to July 2023
Website Development	Initiated development of a cancer screening webpage to be prominently placed on caloptima.org website so members can readily find information on cancer for every stage of their health journey.	June to December 2023
Cancer Data Dashboard	Initiated development of a cancer data dashboard to be used as an internal tool for cancer data to inform future pilots and interventions. Complete dashboard expected for January 2024.	August to December 2023
Board Actions	Sought Board approval to develop and implement a four-year Comprehensive Cancer Screening and Awareness campaign. Drafted a request for approval to seek Board approval of a Notice of Funding Opportunity to develop a grant program to support local organizations that aim to increase access to cancer screenings and improve member experience throughout cancer treatment.	November 2023 December 2023

Results:

The following table provides accomplishments by intervention/activity. Whereas most activities are programmatic and operational, the City of Hope Mammogram Pilot includes measurable outcomes. Thus, the remaining analysis will be focused on the mammogram pilot.

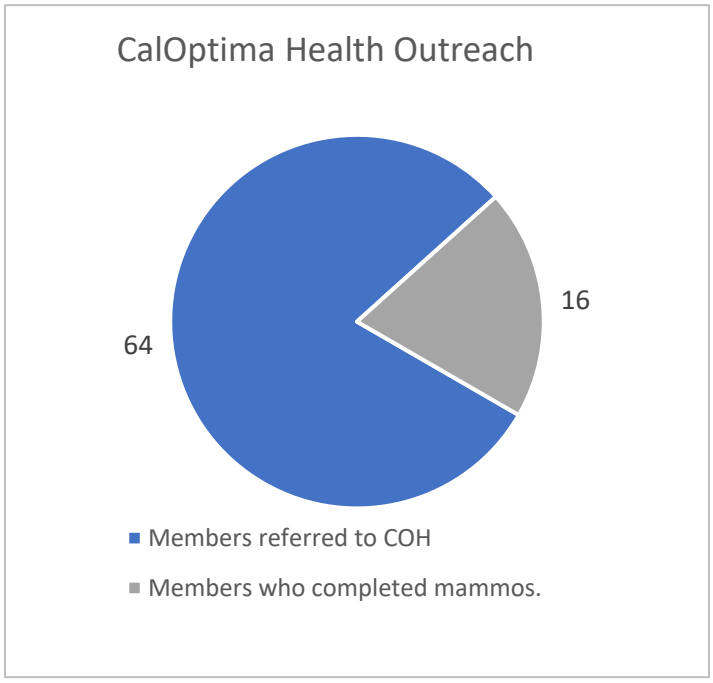
Planned Activities	Description	Date of Completion
Assessment of Barriers and Opportunities	• Held discovery meetings with UCI Chao Family Comprehensive Cancer Center, Orange County Cancer Coalition (comprised of 19 organizations) and the Coalition of Orange County Community Health Centers • Survey conducted by the Coalition of Orange County Community Health Centers to gather information across the Coalition membership related to breast and colon cancer screening, awareness/education, and treatment • Developed and implemented a survey to assess the capacity of contracted community health centers for mammography screenings and access to on-site mammography equipment	Q1-Q2, 2023
Mammogram Pilot with City of Hope	• Assembled a high-performing team for expedited pilot development and implementation • Developed pilot workflow and process for collaboration across organizations • Communicated with member assigned provider regarding the pilot. CalOptima Health's Health Educators reached out to 366 CCN members who were overdue for a mammogram screening with the goal to have at least 50 complete mammograms • Of 64 members referred to City of Hope, only 16 (32%) completed mammogram	Q2-Q3, 2023
Website Development	• Assembled an ad hoc team to support development of website concept • Researched and developed content to be vetted by Medical Management and submitted to Member Material Approval • Collaborated with Communications department for website design • Home page is live while other sections are in development for a full launch scheduled for January 2024	Q2-Q4, 2023
Cancer Data Dashboard	• Developed dashboard criteria • Drafted dashboard mockup • Collaborated with Quality Analytics to build dashboard • Dashboard expected to be completed by January 2024	Q3-Q4, 2023
Board Actions	• Comprehensive Cancer Screening and Awareness campaign COBAR approved in November 2023 by the CalOptima Health Board of Directors • Notice of Funding Opportunity request for approval drafted and submitted to Clerk of the Board for approval at the December 2023 Board of Directors meeting	Q4, 2023

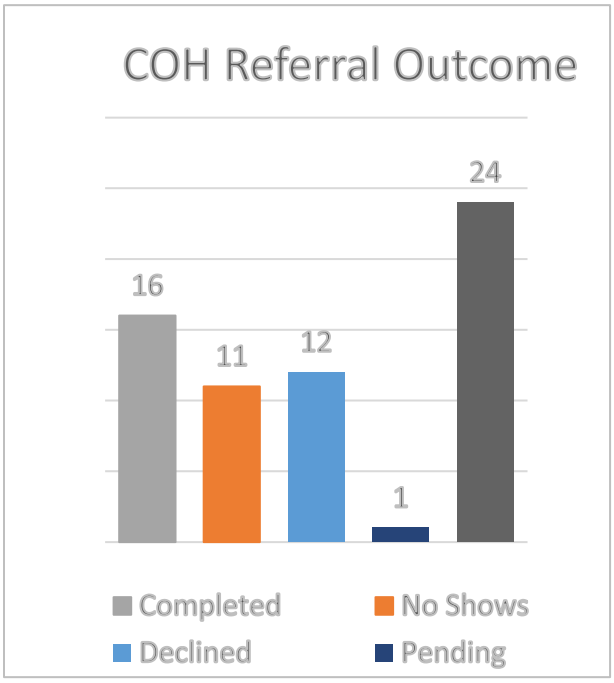
Quantitative Analysis: Mammogram Pilot with City of Hope

In May 2023, CalOptima Health launched a breast cancer screening pilot in partnership with City of Hope Lennar Foundation Cancer Center in Irvine. The pilot was designed for a small cohort of CCN members with the goal to complete 50 mammograms over two months. A secondary goal was to evaluate existing processes for improvement opportunities. The cohort initially focused on seven select providers with the highest rates of members overdue for a mammography screening. Once implemented, the pilot was extended to four months, expanded to six additional providers

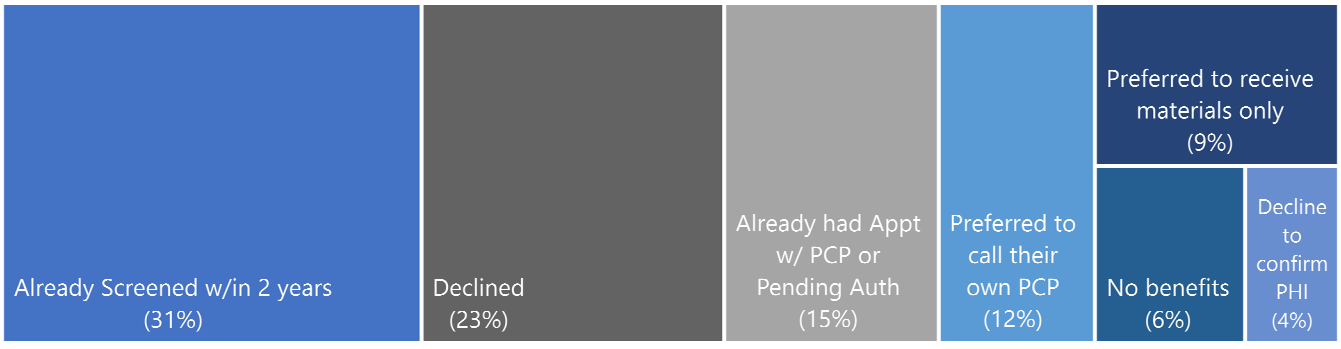
and had two phases. The following table provides outcome information on 366 CCN members outreached for participation in the pilot.

Goal	CalOptima Health Member Outreach					City of Hope Outreach Outcome			
Goal and % completed	*Members Called*	*Opted out/ declined/ ineligible*	*Referred to PCP**	*Unable to Contact (UTC)*	*Sent to City of Hope*	*Trans. Request*	*Appts. Scheduled*	*Mammo. Screening Completed*	*Additional Screening Indicated*
50 (32% of goal met)	366	137	8	153	64	22	27	16	2





For the 137 members who opted out of participation at point of outreach by CalOptima Health, the following reasons were noted by the health education team conducting the outreach:



Qualitative Analysis: Mammogram Pilot with City of Hope

Although only 32% of the completed mammogram goal was accomplished, the pilot provided a significant opportunity to evaluate existing processes for improvement and best practices for future pilot developments, including the importance of:

A. Having the ability to assemble a team within the PHM department with the adequate skill set and process knowledge to develop project plans, pilot implementation workflows and tools in an expediated manner.
B. Having pilot driven by senior leadership and Medical Directors with the right decision-making power for expediated approval and authorizations needed for internal process requests.
C. Having weekly huddles with pilot partners to communicate process improvement opportunities and discuss progress in real time.

Barriers documented through the pilot can be grouped by barriers related to program design and barriers related to member engagement and screening.

A. Program Design Barriers
    1. Initial pilot ideation happened between Medical Management and City of Hope, leaving out key staff that would be responsible for development and implementation.
    2. Dedicated staffing resources have not been assigned to the program; thus, health educators were pulled from their ongoing projects to be able to support development of workflows and other implementation tools.
    3. The pilot had a very aggressive implementation timeline, which did not allow sufficient time for meaningful provider engagement during the pilot development phase.
B. Member Engagement and Screening Barriers
    1. Lack of availability of screening appointments outside of traditional business hours
    2. Members' comfort level discussing mammogram screenings outside of their trusted primary care provider office
    3. A significant drop in members who agreed to participate at the point of the outreach call and declined participation when contacted for scheduling by City of Hope. (of 64 members sent to COH only 25% followed through with screening mammogram).

Conclusion and Recommendations: Mammogram Pilot with City of Hope

The pilot did not accomplish the measurable objective of having at least 50 members complete a screening mammogram. However, the learnings from the pilot were significant. Thus, the secondary goal of the intervention is deemed successful.

Based on analysis of data, key success and barriers, the staff involved in the pilot development and implementations offer the following considerations for future pilots.

A. Engage a cross-functional team early in the ideation and implementation phases of the pilot, including internal representation from Utilization Management and Provider Relations and external representation from primary care providers and their clinical management staff.

B. Engage health care navigator at PCP offices to conduct outreach calls and get members scheduled for mammogram screenings.
C. Ensure outreach and availability of screening appointments during non-traditional hours including evenings and weekends.

Next Steps:

The first year of the Comprehensive Community Cancer Screening and Support Program was focused on discovery, assessing barriers, brainstorming opportunities, taking a deep dive into cancer data, and seeking out approvals to be able to act on the areas of discovery. In 2024, the program is moving from discovery to actions that would have a more direct and meaningful impact on members, including the following:

A. Develop the Comprehensive Awareness and Education campaign in collaboration with internal and external stakeholders.
B. Release a Notice of Funding Opportunity and approving grant funding for organizations to work towards a shared goal of increasing awareness and access to cancer screening, decreasing late-stage cancer diagnosis rates and mortality, and/or improving quality and member experience during cancer screening and treatment.
C. Engage providers and their office staff through CCN Virtual Meetings and CME/CU learning opportunities.
D. Launch the Cancer Screening and Supports Website to ensure information regarding cancer is prominently placed in the CalOptima Health website for members to have easier access to information and resources.
E. Finalize a cancer data dashboard to inform focus interventions and program designs.
F. Continue partnering with cancer institutions to develop pilots and programs that align with the program goals.

5.2.3 Maternal Health

5.2.3.1 Prenatal and Postpartum Care (PPC)

Background: Each year, about four million women in the U.S. give birth, with one million women having one or more complications during pregnancy, labor and delivery or the postpartum period. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.

Joint guidelines published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) recommend a prenatal visit in the first trimester for all women. Babies of mothers who do not get prenatal care are three times more likely to have low birth weight and five times more likely to die than those born to mothers that get prenatal care. ACOG also recommends that all women have a comprehensive postpartum visit which provides an opportunity to address physical, mental, and emotional health early.

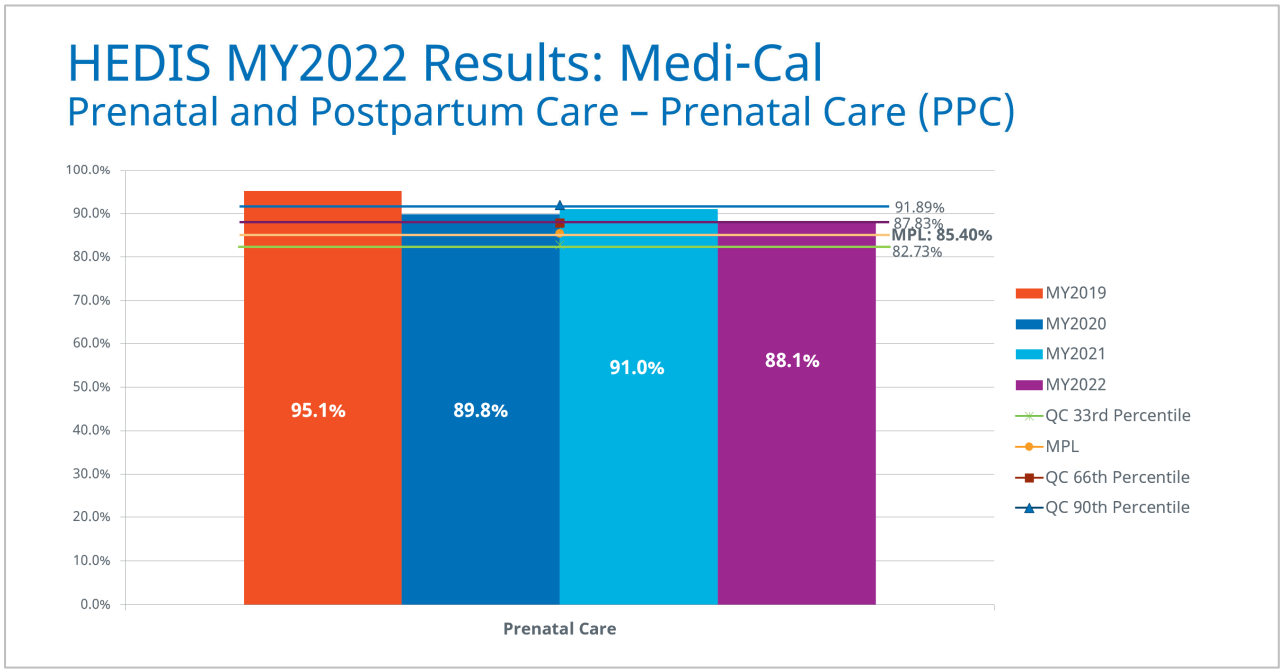
Prenatal and Postpartum Care (PPC) is a hybrid quality performance measure for HEDIS and is part of the DHCS MCAS that is held to a MPL established by NCQA Quality Compass Medicaid 50th percentile. The measure has two components that assesses the following for deliveries on or between October 8 of the year prior to the measurement year and October 7:

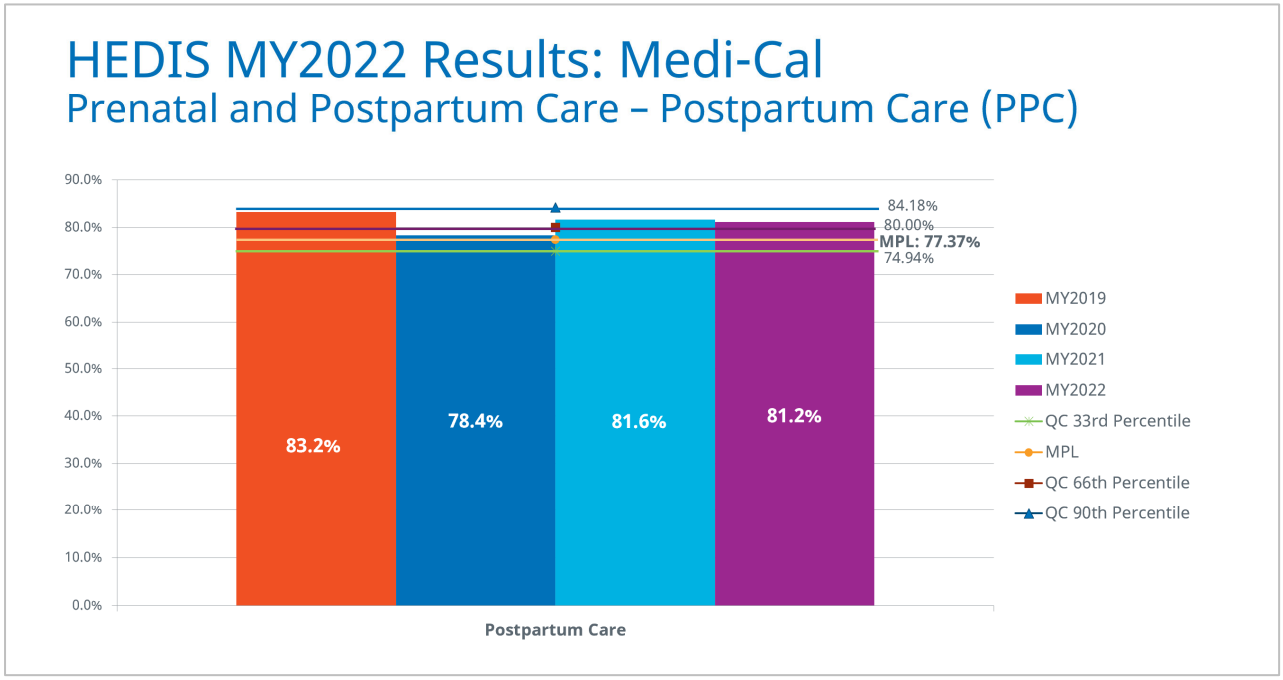
A. Timeliness of Prenatal Care (TOPC): the percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.
B. Postpartum Care (PPC): the percentage of deliveries that received a postpartum care visit on or between 7 and 84 days (1–12 weeks) after delivery.

Program Goal(s):

MY2023 Work Plan Goals

Acronym	Measure	MY2022 Medi-Cal Rate	2022 Medi-Cal Goal	MY2022 Goal (Met/Not Met)	2023 Medi-Cal Goal
TOPC *(hybrid)*	PPC: Timeliness of Prenatal Care	88.08%	90.75%	Goal Not Met	91.89%
PPC *(hybrid)*	PPC: Postpartum Care	81.15%	79.56%	Goal Met	84.18%





A. Table 1 reviews the goals for MY2022 and MY2023 and the Medi-Cal final rates for HEDIS MY2022.
B. Goal methodology for 2023 is set based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2021 reported performance results compared to the national percentile from the MY2021 NCQA Quality Compass. If the current reported rate reached NCQA Quality Compass percentile, then the goal was set to the next percentile.
C. CalOptima Health's HEDIS MY2022 TOPC Medi-Cal hybrid rate for was 88.08% and met the MPL of 85.40% but did not meet the internal MY2022 QI Work Plan goal of 90.75%. CalOptima Health's HEDIS MY2022 PPC Medi-Cal hybrid rate was 81.15% and met the MPL of 77.37% and met the MY2022 QI Work Plan goal of 79.56%.

Actions/Interventions:

List of MY2023 Medi-Cal Initiatives for Timeliness of Prenatal Care, Postpartum Care

Planned Activities / Intervention	Intervention Type	Barriers	Completion Status	Measure
Postpartum Care Health Reward	Member	• Requires a signed/stamped attestation by a provider which may prevent some members from participating in the health rewards. Members may have already visited the provider and would prefer not to go back to obtain provider signature/stamp.	In progress	PPC

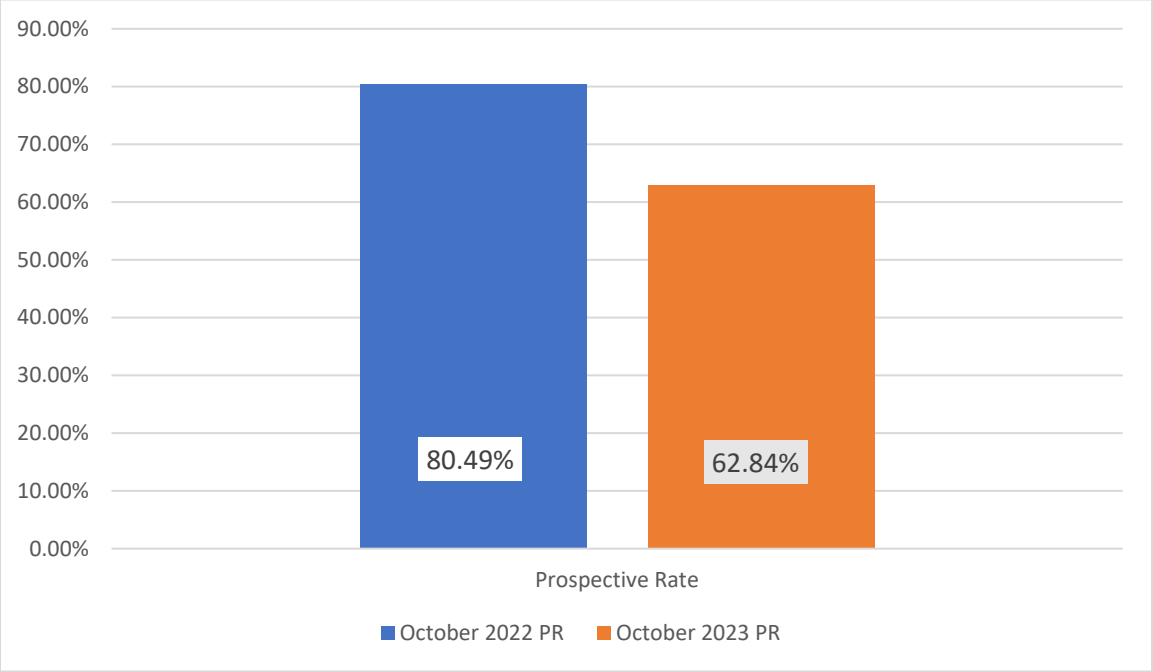
Planned Activities / Intervention	Intervention Type	Barriers	Completion Status	Measure
Provider notification of available Health Rewards which include Postpartum Care	Provider	• Potential for distribution not to reach all intended providers	Completed	PPC
Year-end push: Postpartum care reminder text message campaign	Member	• Only targeted a small portion of members in the PPC denominator. • Dependent on correct member contact data • Cannot outreach to members with a do- not-contact notice • Member has opted out of receiving text messages	Completed	PPC
Year-end push: Postpartum care reminder call campaign	Member	• Calls were initiated for year-end push may not have enough time to complete screening	Completed	PPC
Paid Digital and Social Media Ad	Community	• Education to the community at large and may not directly impact members • Limited to three languages English, Spanish and Vietnamese • Limited by budget	In Progress	TOPC PPC
PBS TV Ad for Maternal Health	Community	• Advertisement only in English • Unable to measure member impact or engagement	In Progress	TOPC PPC
Passive Social Media Ads	Community	• Advertisement only in three threshold languages, English, Spanish and Vietnamese • Inadequate duration and intensity/exposure to the campaign • Unable to measure member impact or engagement	In Progress	TOPC PPC
Member Newsletter	Member	• Incorrect or incomplete addresses • We depend on member addresses that are often not updated with Social Services Agency • A significant percentage of mail is returned due to wrong addresses • Unable to measure member impact or engagement	Completed	PPC
CalOptima Health Website	Member	• Unable to measure member engagement or impact	In Progress	TOPC PPC

Planned Activities / Intervention	Intervention Type	Barriers	Completion Status	Measure
Pay For Value (P4V)	Provider, HN	• Payment methodology is not aligned to the internal CalOptima Health goal	In Progress	TOPC PPC
Data Bridging of hospital admission and discharge data for the identification of deliveries to support timely postpartum messaging to members	Data	• Access to a select number of hospital data	In Progress	PPC
Coalition of OC Community Health Centers - CCN Clinical Quality Champion Pediatric Measures Presentation on measure, coding requirements.	Provider	• Meeting attendees may not be the practicing providers who would benefit from information	Completed	TOPC PPC

Results:

A. The figure below compares the prospective rates for October 2022 with the prospective rates for October 2023 for Timeliness of Prenatal Care (TOPC). Prospective rate (PR) refers to claims/encounters processed through October and represents administrative data. TOPC is a hybrid measure.

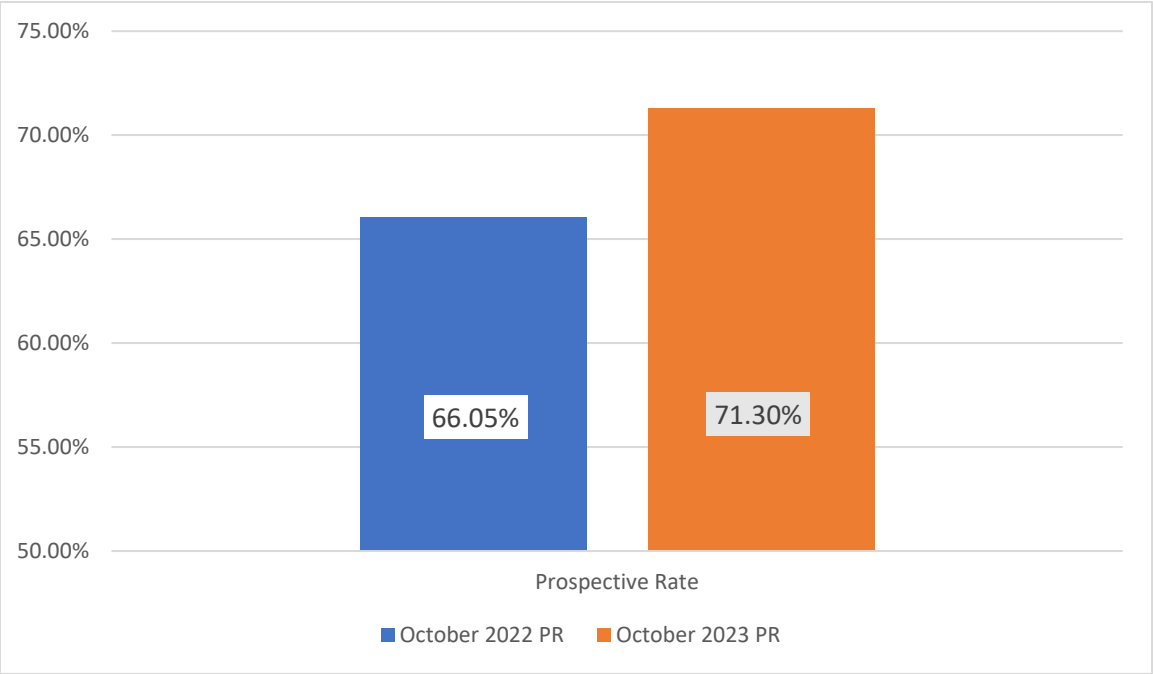
October 2022 and 2023 Prospective Rate for Timeliness of Prenatal Care, Medi-Cal



PR methodology includes continuous enrollment criteria. TOPC is a hybrid measure. Prospective rates are solely administration and do not take into account hybrid sample.

B. The figure below compares the prospective rates for October 2022 with the prospective rates for October 2023 for Timeliness of Prenatal Care (TOPC). Prospective rate (PR) refers to claims/encounters processed through October and represents administrative data. TOPC is a hybrid measure.

October 2022 and 2023 Prospective Rate for Postpartum Care, Medi-Cal



PR methodology includes continuous enrollment criteria. PPC is a hybrid measure. Prospective rates are solely administration and do not take into account hybrid sample.

Quantitative Analysis:

A. Timeliness of Prenatal Care (TOPC) is performing lower in October 2023 when compared to the same time last year. This represents a difference of 17.65%. TOPC is a hybrid measure and is pending the inclusion of medical record review findings.
B. Postpartum Care (PPC) is performing higher in October 2023 when compared to the same time last year. This represents an increase in performance rate of 5.25%
C. In MY2022, TOPC met the quality compass 50th percentile MPL rate of 85.40%. The MY2022 final rate was 88.08%. Final rates for MY2023 are pending and the measure is at risk of not meeting the MPL. Furthermore, in MY2022, CalOptima Health set an internal goal of 90.75% for TOPC. The internal goal was not met.
D. In MY2022, PPC met the quality compass 50th percentile MPL rate of 77.37%. The MY2022 final rate was 81.15%. Final rates for MY2023 are pending. Furthermore, CalOptima Health set an internal goal of 79.56% for PPC. The internal goal was met.

Qualitative Analysis/Barriers:

A. Delays of claims and encounter data present challenges for the timely identification of a pregnancy or a delivery, which impacts the modalities in which CalOptima Health can leverage communication to outreach members. In addition, the postpartum care measure is time sensitive. By the time a postpartum member is identified through claims data, it is likely that the member has a limited window of opportunity to complete a visit within the recommended HEDIS timeframe.
B. Prenatal and postpartum care have varying coding industry practices. As part of a discussion to identify preliminary root cause of the low rates with prenatal care, one health network found that examples of providers who practice bundling billing are providing prenatal visits but are not billing the office visit code. Subsequently, this still requires us to ensure that the prenatal visit was completed in the recommended timeframe.
C. CalOptima Health should consider cultural factors that may be contributing to gaps in timely prenatal and postpartum care. For example, some cultures may have social guidelines on when it would be appropriate to announce a pregnancy due to the fear of miscarriage. This can potentially be a factor for prenatal care sought in later stages of a pregnancy. In addition, some cultures observe a period known as “cuarentena” which is a period of 40 days after delivery where women focus on rest and recovery, potentially impacting postpartum visits.

Disparity Analysis:

A. Analysis Methodology: Disparity analysis was conducted for TOPC and PPC based on the HEDIS MY2022 top 10 race/ethnicity administrative data by denominator. This was then compared to HEDIS MY2021 top 10 race/ethnicity administrative data by denominator to observe any changes from MY2021.

MY2022 Timeliness of Prenatal Care by Race/Ethnicity based on Administrative Data

Admin Rate	Race/Ethnicity									
HEDIS MY2022	*Hispanic*	*Other*	*White*	*No Response*	*Vietnamese*	*Black*	*Filipino*	*Korean*	*Asian or Pacific Islander*	*Asian Indian***
Numerator	3,526	815	604	343	330	93	49	40	25	26
Denominator	4,306	1,010	780	442	440	118	64	52	35	28
Rate	81.89%	80.69%	77.44%	77.60%	75.00%	78.81%	76.56%	76.92%	71.43%	92.86%

Table displays the top 10 ethnicities with the highest denominator based on total HEDIS population and the completion rates of timely prenatal care, a hybrid measure. The total rate is based on administrative data and does not indicate the final HEDIS rate. Note: Includes Kaiser members.
***Indicates a group that met the TOPC MPL of 85.40% for MY2022.*

MY2022 Postpartum Care by Race/Ethnicity based on Administrative Data

Admin Rate	Race/Ethnicity									
HEDIS MY2022	*Hispanic*	*Other*	*White*	*No Response*	*Vietnamese***	*Black*	*Filipino*	*Korean*	*Asian or Pacific Islander***	*Asian Indian***
Numerator	3,204	746	530	313	357	80	49	40	28	22
Denominator	4,306	1,010	780	442	440	118	64	52	35	28
Rate	74.41%	73.86%	67.95%	70.81%	81.14%	67.80%	76.56%	76.92%	80.00%	78.57%

Table displays the top 10 ethnicities with the highest denominator based on total HEDIS population and the completion rates of postpartum care, a hybrid measure. The total rate is based on administrative data and does not indicate the final HEDIS rate. Note: Includes Kaiser members.
***Indicates a group that met the PPC MPL of 77.37% for MY2022.*

B. Quantitative Analysis:

1. Timeliness of Prenatal Care: when reviewing the top race/ethnicity groups by denominator, the following groups met the MPL: Asian Indian, Chinese, Cambodian and Japanese.
2. Compared with MY2021, Asian Indians increased their prenatal care rates by 11.61%. Chinese members represented a smaller denominator (n=18) than when compared with MY2021 (n=34) but achieved 100% compliance.
3. Compared with MY2021, the following groups performed at lower rates for prenatal care by 10% or more in MY2022: Alaskan Native/American Indian, Korean, and Laotian. Some of the differences in rates correspond to lower denominators in MY2022, but the Alaskan Native/American Indian and Korean group maintained fairly consistent denominators across the two years indicating that there are opportunities for interventions that can support these groups.
4. Timeliness of Prenatal Care: For TOPC, rates are lowest for race/ethnicity groups identified as Asian or Pacific Islander (71.43%), Vietnamese (75.00%), followed by White (77.44%) as compared with all other race/ethnicity groups. When looking at the top race/ethnicity groups by denominator count, the Hispanic group had the highest rate at 81.89%, down 1.03% from the previous year. Refer to Table 3 above.
5. Postpartum Care: When reviewing the top race/ethnicity groups by denominator, the following groups met the MPL: Vietnamese, Asian or Pacific Islander and Asian Indian.

6. Compared to MY2021, the following groups increased their postpartum rates: Hispanics increased by 4.02% and White group increased their rate by 3.73%. In contrast, the Vietnamese group decreased their postpartum rate by 3.76% and Korean rate decreased by 3.90%
7. With the exception of two groups, Filipino and Korean, all other groups demonstrated lower postpartum care rates when compared to timeliness of prenatal care rate.
8. Postpartum Care: For PPC, rates are lowest for race/ethnicity groups identified as Black (67.80%), White (67.95%), followed by Hispanic (74.41%) as compared with all other race/ethnicity groups. When looking at the top race/ethnicity groups by denominator count, the Asian or Pacific Islander group had the highest rate at 80.00%, down 1.25% from the previous year. Refer to Table 4 above.

C. Barriers
   1. Potential barriers to prenatal and postpartum care include member perception related to the importance of prenatal and postpartum care especially for multiparous women.
   2. Transportation and childcare issues are barriers to complete the necessary visits.

Conclusion and Next Steps:

A. Continue Health Rewards for eligible CalOptima members for postpartum care measures but with broader promotion and rewarding strategy.
B. CalOptima Health will continue to expand on the communication and engagement strategy to include multimodal approach via: Medi-Cal member newsletters, paid digital media campaigns, PBS TV campaigns, CalOptima Health website, and live calls. This year, CalOptima Health sent the first text campaign to remind members of postpartum care and will continue to explore how to send messages given the timely nature of the measure.
C. In April 2022, Medi-Cal expanded the postpartum benefit for medical care one year after delivery. It is too early to identify whether this expansion may have driven postpartum visit and experience.
D. Opportunities remain to review data sources and explore how health networks are obtaining newborn data timely based on hospital admission or discharge data. To support TOPC, opportunities remain to review data through pregnancy related diagnosis codes or increase pregnancy notification report submission.
E. Beginning MY2023, NCQA introduced race and ethnicity stratifications for TOPC and PPC. The purpose of this stratification is to allow health plans to review disparities and invest in strategies to reduce the disparities and improve outcomes. In the year to follow, CalOptima Health will begin to showcase this data and analyze as suggested by NCQA to further support health equity initiatives.
F. Opportunities remain to leverage the doula benefit to support positive birthing experiences for black and other birthing persons of color.
G. CalOptima Health is currently exploring collaborative efforts with the local health department to expand on maternal mental health. Postpartum depression can make it difficult to proceed with postpartum care, interfering with the ability to bond with the baby as well as breast feed.

H. CalOptima Health will retain TOPC and PPC on the 2024 QI Work Plan. CalOptima Health will continue to focus on maternal health and address lower rates to support both quality measures and the PHM DHCS Bold Goals centered around maternal health.
I. CalOptima Health will continue to inform members of transportation benefits.
J. Will use disparity analysis to develop interventions to target higher risk members with health inequities caused by race/ethnicity.

5.2.3.2 Maternal Health Programs (Bright Steps and CPSP Services)

Background: CalOptima Health provides coverage for approximately 7,500–8,500 deliveries annually. Most of the infants born through Medi-Cal continue to receive their health care through CalOptima Health.

To support healthy pregnancies and healthy babies, the California Department of Public Health implemented the Comprehensive Perinatal Service Program (CPSP). CPSP is a Medi-Cal benefit that provides a wide range of culturally competent services to pregnant individuals from conception through 60 postpartum. In addition to standard obstetric services, patients receive enhanced services in the areas of psychological, health education, and nutrition.

CPSP providers are approved through County of Orange Health Care Agency (OCHCA), as well as continued oversight. OCHCA notifies CalOptima Health to ensure CPSP providers can render services for CPSP allowable claims. CPSP is site-based and Orange County averages 54 sites. However, there are many Medi-Cal OB providers that are not CPSP approved. To allow all CalOptima Health pregnant and postpartum access to these enhanced services, the Bright Steps Program (BSP) was developed.

BSP is the CalOptima Health maternal health program for Medi-Cal members. This telephonic program provides nutrition, health education, psychosocial support, and referral/resources based on individual member's needs. Members are outreached to prenatally on a trimester basis, postpartum, and three additional times within one year of delivery. However, members that are working with a CPSP provider are not outreached until the 3rd trimester to reduce duplication of efforts.

Additionally, as of January 1, 2023, doula services are a covered Medi-Cal benefit. Doulas provide emotional and physical support provided during pregnancy, labor, birth, and the postpartum period, as well as support for and after miscarriage and abortion. Because BSP works with pregnant and postpartum members, the team has been involved in developing and implementing the strategy for getting doula services off the ground.

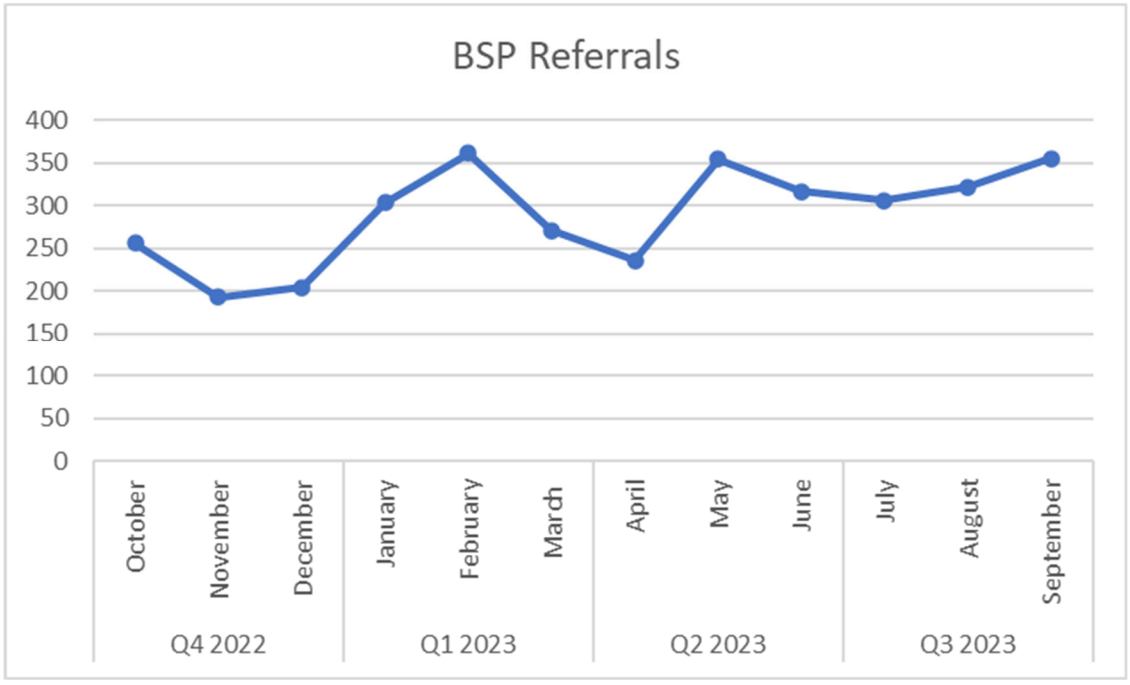
Program Goals: The goal of CalOptima Health's comprehensive maternity health program is to improve maternal health outcomes and eliminate maternal health inequities. To support this goal, we prioritized:

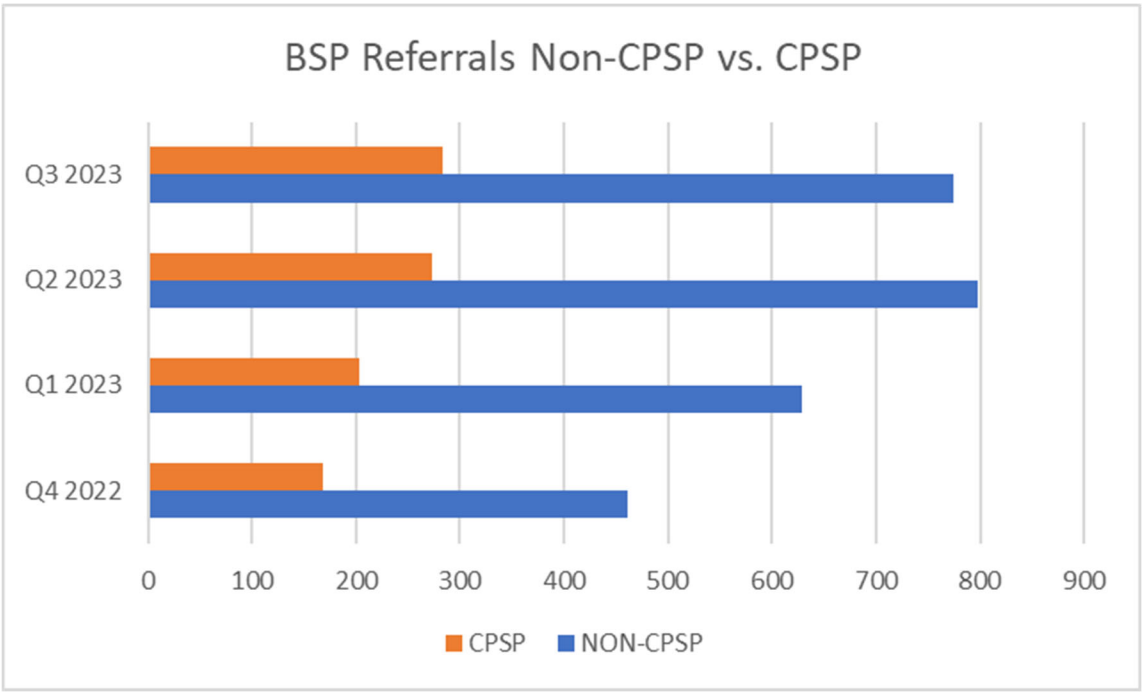
A. Provide education and referrals/ resources based on individual members' needs
B. Increase compliance for postpartum provider appointment (1-12 weeks after delivery)
C. Increase compliance for well-child visits for infant members
D. Increase maternal depression screenings and linking to mental health resources, when appropriate
E. Implement the Medi-Cal doula benefit

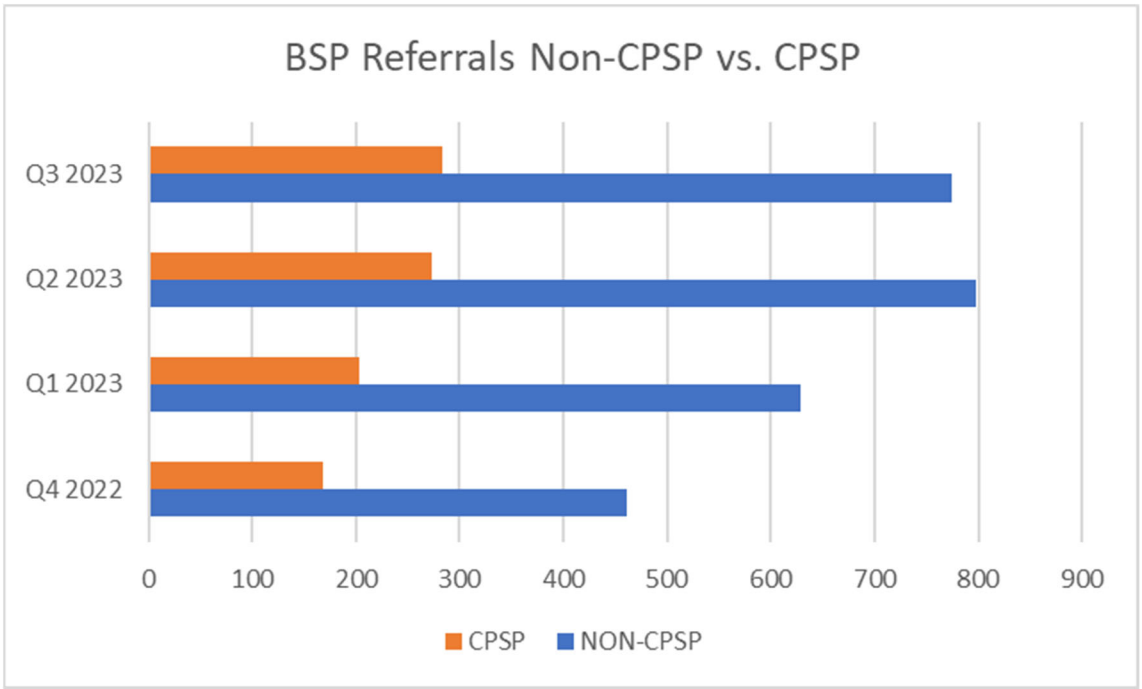
Actions/Interventions:

Planned Activities	Description	Date of Completion
Member Engagement *telephonic*	Telephonic assessments (trimester, postpartum, well-child, and maternal mental health)	Ongoing
Program Expansion	Implement well child extension into BSP	4/1/23
Program Expansion	Implement six-month postpartum maternal mental health screening	4/1/23
Member Engagement in-person	Host/Implement hands-on educational event with community partners	Events held June 2023 and December 2023
Member Self-Management Tools	Provide members with health education tools to support a healthy pregnancy and infant	Ongoing
Build network of doula providers	Conducted outreach to local doulas, provide education through CCN Virtual Meetings, virtual learning sessions, provide extensive technical assistance and support.	June 2023 and ongoing

Program Results:







Quantitative Analysis:

A. BPS was able to meet the previous year's goal by expanding the program from 12 weeks after delivery to one full year after delivery.
B. In this expansion, a member receives outreach at 6 and 11 months postpartum and is assessed for child development and milestones, feeding, family support, and more. Since BSP started serving members for the 12-month period, there have been 230 members assessed at the 6 months and 6 members assessed at 11 months.
C. The participation rate for BSP has fluctuated throughout the review period but is trending at an increased rate, with a total of 3,067 referrals, 1,741 unique participants completing at

least one assessment with a total of 3,066 BSP assessments completed to date for calendar year 2023.

D. CPSP providers have remained steady with only a few additions or removal of providers. Finally, as of November 2023, there are three doulas contracted with CalOptima Health Community Network.
E. There are no doulas yet contracted with the delegated Health Networks, but the Population Health Management and Health Network Relations departments are collaborating to provide ongoing support to the doulas and Health Networks.

Qualitative Analysis/Barriers:

A. Referrals are limited to providers that submit a Pregnancy Notification Report, so CalOptima Health is only able to outreach to approximately one-third of pregnant members each year.
B. Inability to contact members reduces the ability to offer members support during pregnancy and postpartum.
C. Doulas have faced a steep learning curve in navigating the Medi-Cal enrollment process, Managed Care Plan credentialing and contracting processes, and successfully billing and getting reimbursed for services provided.

Conclusion and Next Steps: CalOptima Health's Maternity programs have demonstrated positive impacts for our members and their babies, but there is more work to be done. More members would benefit from these services if they could be identified and screened earlier in their pregnancy and connected with appropriate resources to meet their needs. Doula services will continue to be an area of focus as it relates to growing the network and building awareness among hospitals, providers, and members. Next steps include the following:

A. Implement a risk stratification to include claims and encounters to better identify our members.
B. Expand doula recruitment efforts and engage hospitals, providers, and members with information about the doula benefit.
C. Implement a Maternal Depression Screening and Support Program

5.2.4 Pediatric/Adolescent Wellness

5.2.4.1 Preventive Care (W30, IMA, WCV)

Background: According to the CDC, well-child visits and recommended vaccinations are essential, and help make sure children stay healthy. Well-child visits are essential for tracking growth and development milestones, discussing any concerns about a child's health, and is the opportune time to get scheduled vaccinations to prevent illnesses. CalOptima Health focused on the following measures as aligned with the DHCS Medi-Cal MCAS and held to the benchmarks established by the NCQA Quality Compass.

A. Childhood Immunization Status-Combination 10 (CIS-Combo10)
B. Immunizations for Adolescents-Combination 2 (IMA-Combo2)
C. Well-Child Visits in the First 30 Months of Life (W30), two reported rates:
    1. Well-Child Visits in the First 15 Months (W30-First 15 Months)
    2. Well-Child Visits for Age 15 Months–30 Months (W30-15 to 30 Months)
D. Child and Adolescent Well-Care Visits (WCV-Total)

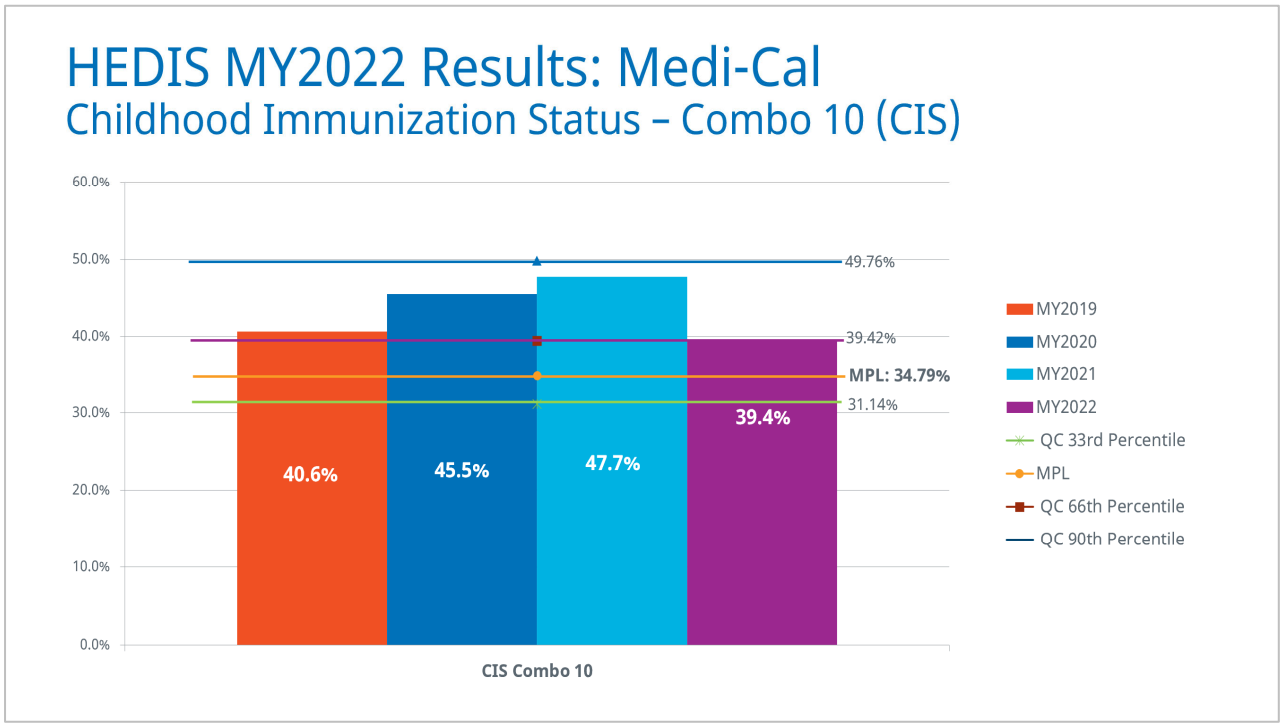
Source: Centers for Disease Control and Prevention (March 2023). Well-Child Visits and Recommended Vaccinations. https://www.cdc.gov/vaccines/parents/visit/vaccination-during-COVID-19.html

Goals:

QI Work Plan Goals

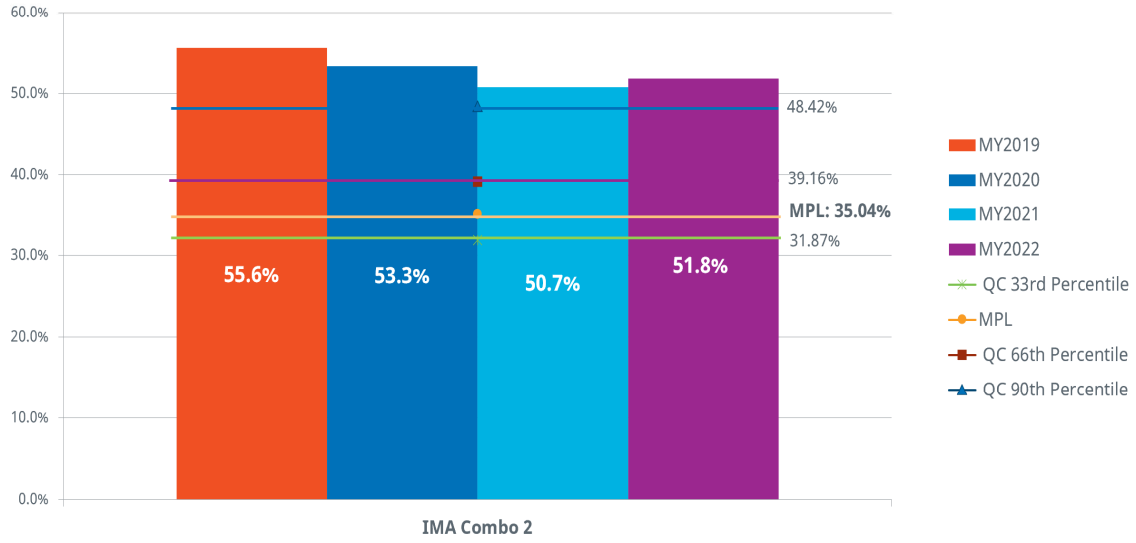
Acronym	Measure	MY2022 Medi-Cal Rate	2022 Medi-Cal Goal	MY2022 Goal Met/Not Met	2023 Medi-Cal Goal
CIS-Combo10 *(hybrid)*	Childhood Immunization Status	39.42%	49.58%	Not Met Goal	49.76%
IMA-Combo2 *(hybrid)*	Immunizations for Adolescents	51.82%	50.61%	Met Goal	48.42%
W30-First 15 Months *(admin)*	Well-Child Visits in the First 30 Months of Life	55.78%	54.92%	Met Goal	55.72%
W30-15 to 30 Months *(admin)*	Well-Child Visits in the First 30 Months of Life	71.20%	74.42%	Not Met Goal	69.84%
WCV-Total *(admin)*	Child and Adolescent Well-Care Visits	51.49%	58.83%	Not Met Goal	57.44%

Goal is based on goal setting methodology based on performance in HEDIS MY2021. October 2023 Prospective Rate is all claims and encounters processed through 10/31/2023. Prospective Rate methodology includes continuous enrollment criteria.



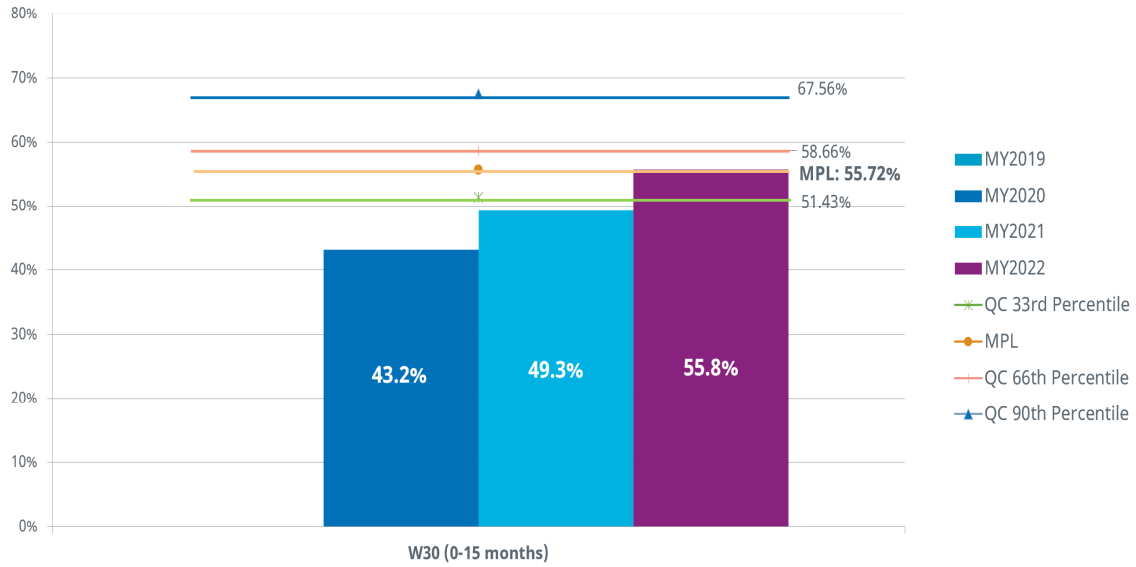
HEDIS MY2022 Results: Medi-Cal

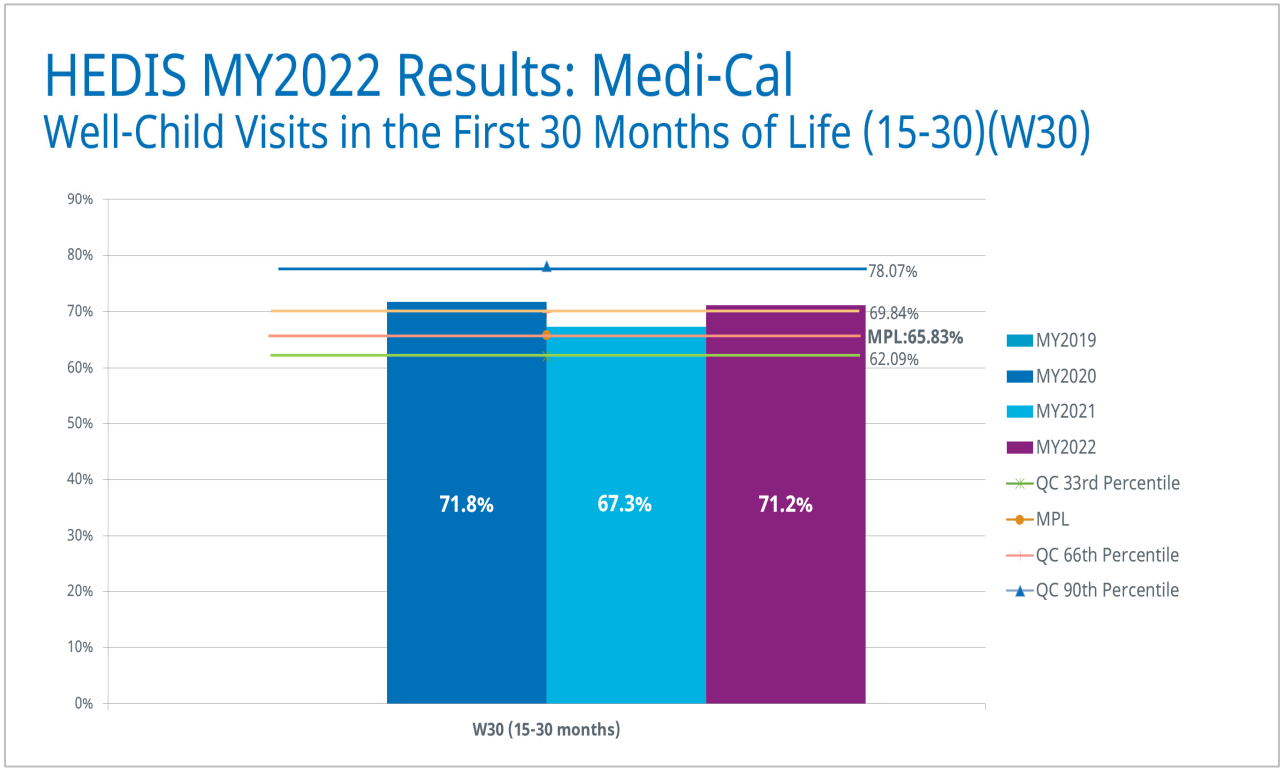
Immunizations for Adolescents – Combo 2 (IMA)

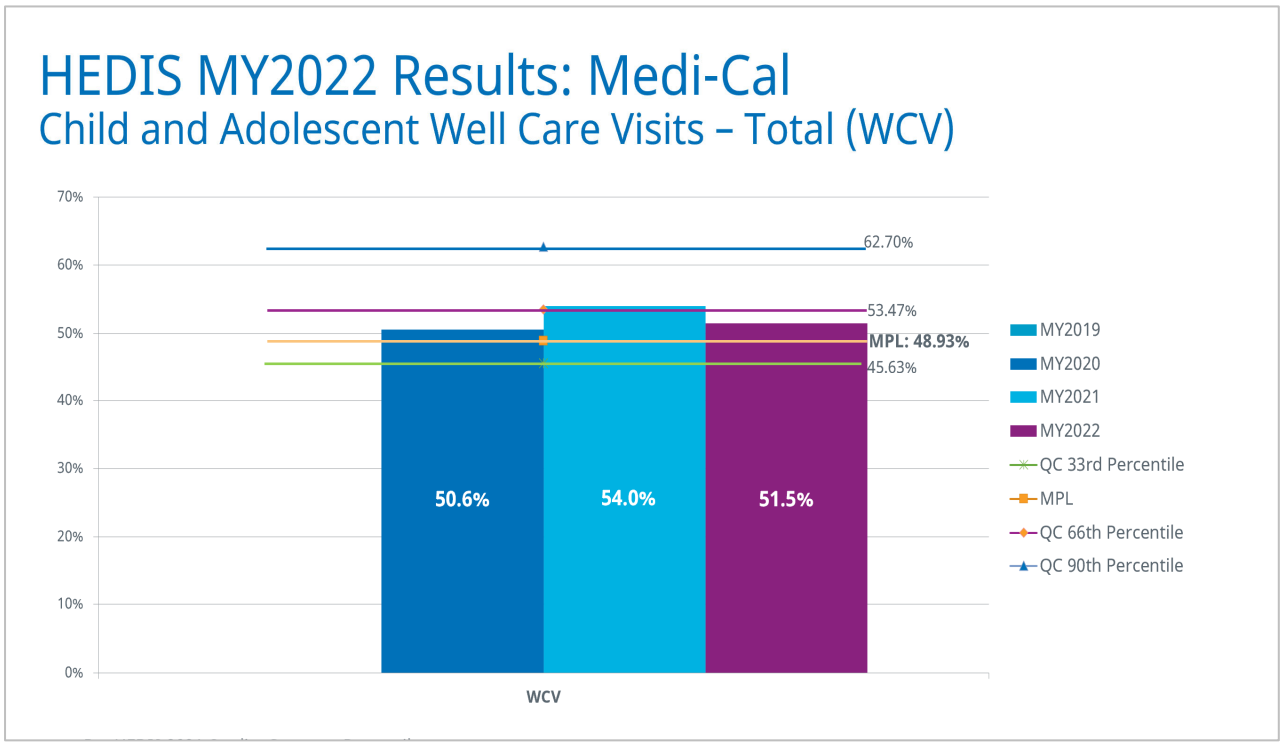


HEDIS MY2022 Results: Medi-Cal

Well-Child Visits in the First 30 Months of Life (0-15)(W30)







A. The table above reviews the goals for MY2022 and MY2023 and the Medi-Cal final rates for HEDIS MY2022.
B. Goal methodology for 2023 is set based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2021 reported performance results compared to the national percentile from the 2021 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, then the goal is set to the set percentile.

C. CalOptima Health's HEDIS MY2022 Medi-Cal rates: CIS-Combo 10 hybrid rate was 39.42% and met the MPL of 34.79% but did not meet the internal goal of 49.58%. IMA-Combo 2 hybrid rate was 51.82% and met the MPL of 35.04% and met the internal goal of 50.61%. W30-First 15 Months administrative rate was 55.78% and met the MPL of 55.72% and met the internal goal of 54.92%. W30-15 to 30 Months administrative rate was 71.20% and met the MPL of 65.83% and did not meet the internal goal of 74.42%. WCV-Total administrative rate was 51.49% and met the MPL of 48.93% but did not meet the internal goal of 53.83%.

Actions/Interventions: Below is a summary of activities and interventions planned, in progress of implementation, or completed implementation in calendar year 2023. The intervention impacts member, provider, health network, community, or data as noted.

List of MY2023 Medi-Cal Initiatives

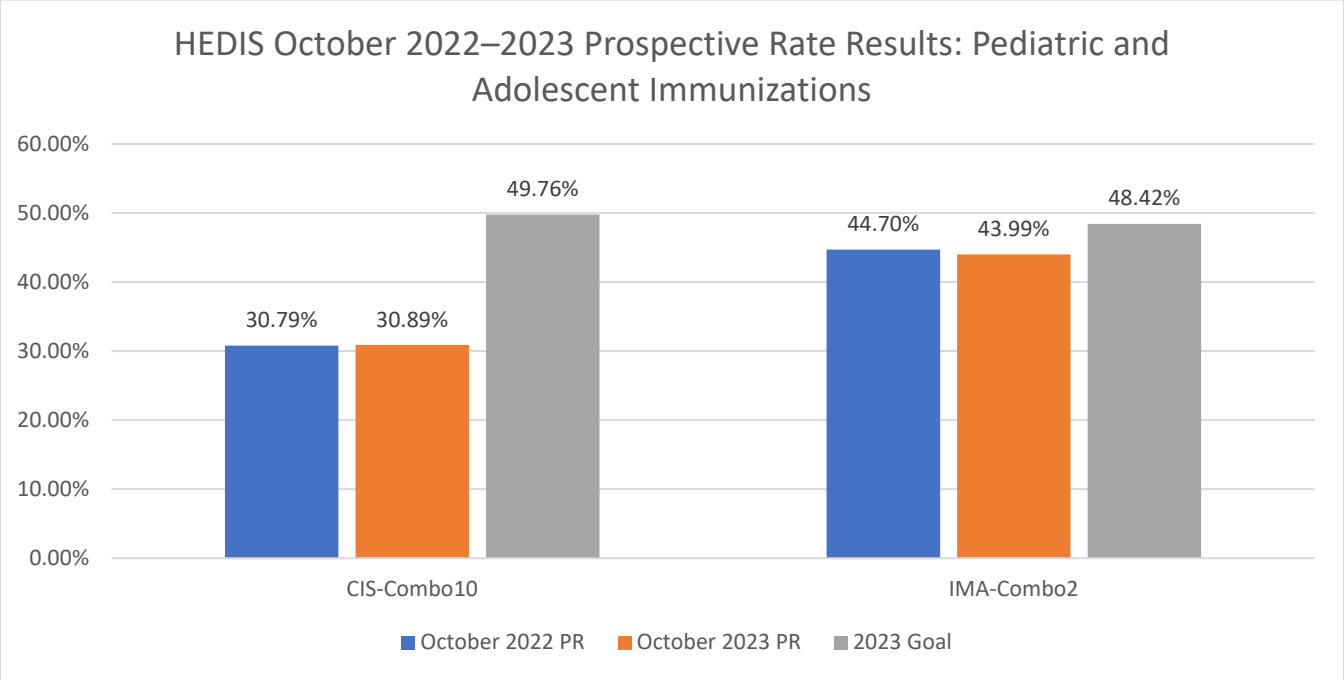
Planned Activities / Intervention	Intervention Type	Barriers	Completion Status	Measure
Well-Child Visits in the First 30 Months of Life Member Detail Report	Data, Health Network	• Reports are only accessible through health network's FTP • Reports are not available for CalOptima Health Community Network • Provider Portal build is delayed	In Progress	W30
Sharing Final MY2022 Results with Health Networks	Health Network	• Not all health networks confirmed receipt of final results • Unable to confirm if health network took any actions or next steps	Completed	W30
Interactive Voice Response (IVR) Campaigns	Member	• The outreach population is limited to members who provided a landline phone number or provided TCPA* consent for cellphone outreach. • Member has a do-not-contact notice • Incorrect landline or cellphone number • Member does not listen to full message or does not listen to voicemail	Completed	W30, WCV
Member Mailing (e.g., Health Guides, Birthday Cards, Member Newsletters)	Member	• Incorrect or incomplete addresses • Member did not update address with Social Security Administration office	In Progress	CIS, IMA, W30, WCV
Telephonic Outreach (e.g., Pediatric Call Campaign)	Member	• Incorrect, missing or disconnected phone number • Member's voice message inbox is full	Completed	W30, CIS

Planned Activities / Intervention	Intervention Type	Barriers	Completion Status	Measure
		• Member's parent or guardian refuse to confirm HIPAA to move forward with the call • Limited staff resources to make calls • Calls were initiated for year-end push, may not have enough time for member to complete visits		
Text Messaging Campaigns	Member	• The outreach population is limited to members who have a valid phone number for cellphone outreach • Member has a do not contact notice • Member decline TCPA consent for outreach • Incorrect cell phone number • Missing or member does not have cellphone number • Member has opted out of receiving text messages	Completed	W30, WCV
Provider Education (e.g., quality measure tip sheets)	Provider, Health Network	• Limited to health networks and providers who access CalOptima Health communication feeds	Completed	W30, WCV
CalOptima Health Community Network (CCN) Virtual Learn Presentation Pediatric Quality Measures	Provider, Health Network	• Limited to CCN providers. • Small reach	Completed	W30, WCV
Provider Report Cards	Provider	• Limited to CCN providers who were identified as low performing	Completed	W30, WCV
Targeted Quality Marketing Campaigns (e.g., Digital, Social Media, Radio, and TV advertisements)	Community	• Advertisements only available in three threshold languages (English, Spanish and Vietnamese) • Unable to evaluate direct impact on CalOptima Health members	Completed	CIS, IMA, W30, WCV

**TCPA stands for Telephone Consumer Protection Act 47 U.S.C. § 227, which defines the parameters of allowable outreach to cellphones. The law restricts telemarketing certain phone calls, text messages, and facsimiles. It also places restrictions on the use of automatic dialing systems and artificial or prerecorded voice messages*

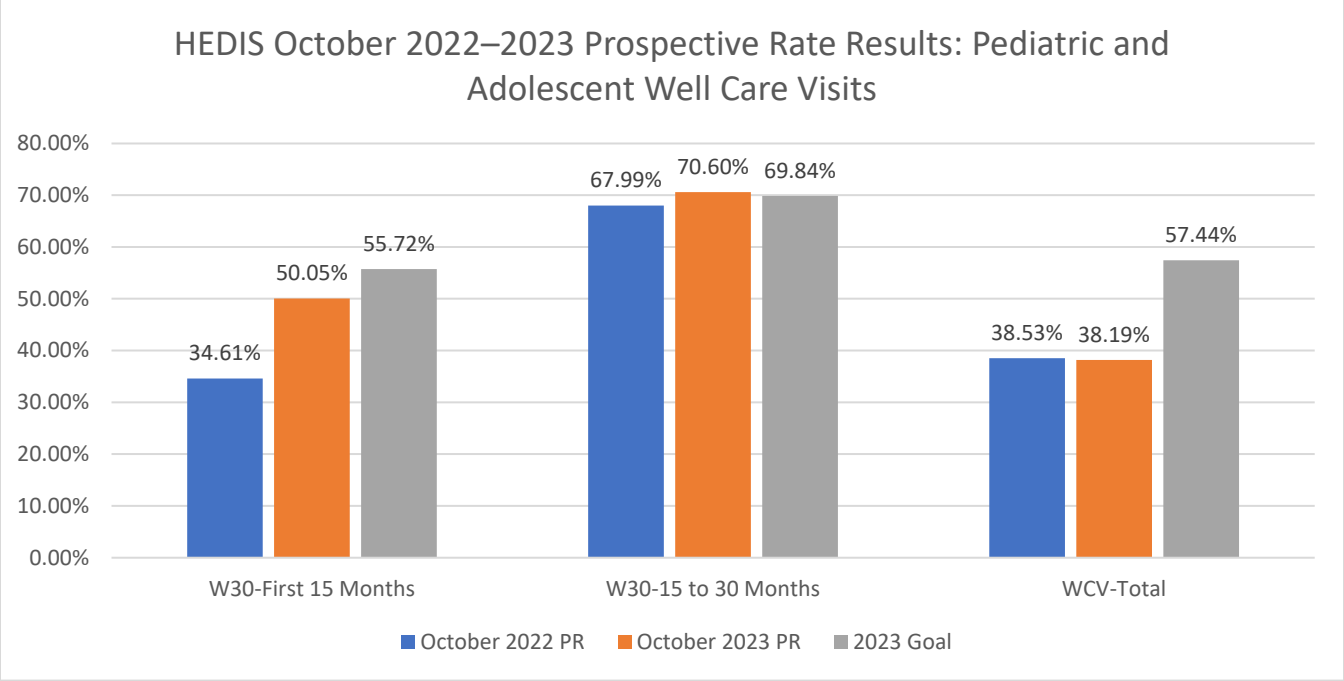
Results: The graph below displays the rate for October 2023 Prospective Rate compared to October 2022 Prospective Rate. The 2023 QI Workplan goal for each respective measure is provided.

Medi-Cal Pediatric and Adolescent Immunization Measures



Data source: October 2022 Prospective Rate, October 2023 Prospective Rate, Goal from 2023 QI Workplan. Prospective Rate methodology includes continuous enrollment criteria.

Medi-Cal Pediatric and Adolescent Well-Care Visits Measures



Data source: October 2022 Prospective Rate, October 2023 Prospective Rate, Goal from 2023 QI Workplan. Prospective Rate methodology includes continuous enrollment criteria. W30-0 to 15 Months prospective rate methodology was revised in 2023 to include mom and baby data chase logic.

Quantitative Analysis:

A. Compared with October 2022 Prospective Rates, the October 2023 Prospective Rate measures higher for CIS-Combo 10, W30-First 15 Months, and W30-15 to 30 Months. However, it should be noted the W30-First 15 Months data methodology was revised in 2023 to include the mom and baby chase logic, which links well-child visits billed under mom's subscriber identification. This may account for the +15.44% increased rate compared with last year.
B. Among these pediatric and adolescent immunization and well care visit measures, only W30-15 to 30 Months met the goal (+0.76%). Goal was not met for all other measures.
C. IMA-Combo 2 (+9.68%), W30-15 to 30 Months (+3.84%) met the minimum performance level (MPL), 50th percentile. CIS-Combo 10 is mostly likely meet the MPL also (-0.01%) by the end of the year. Further attention is needed to impact the well care visits measures (W30-First 15 Months and WCV-Total).

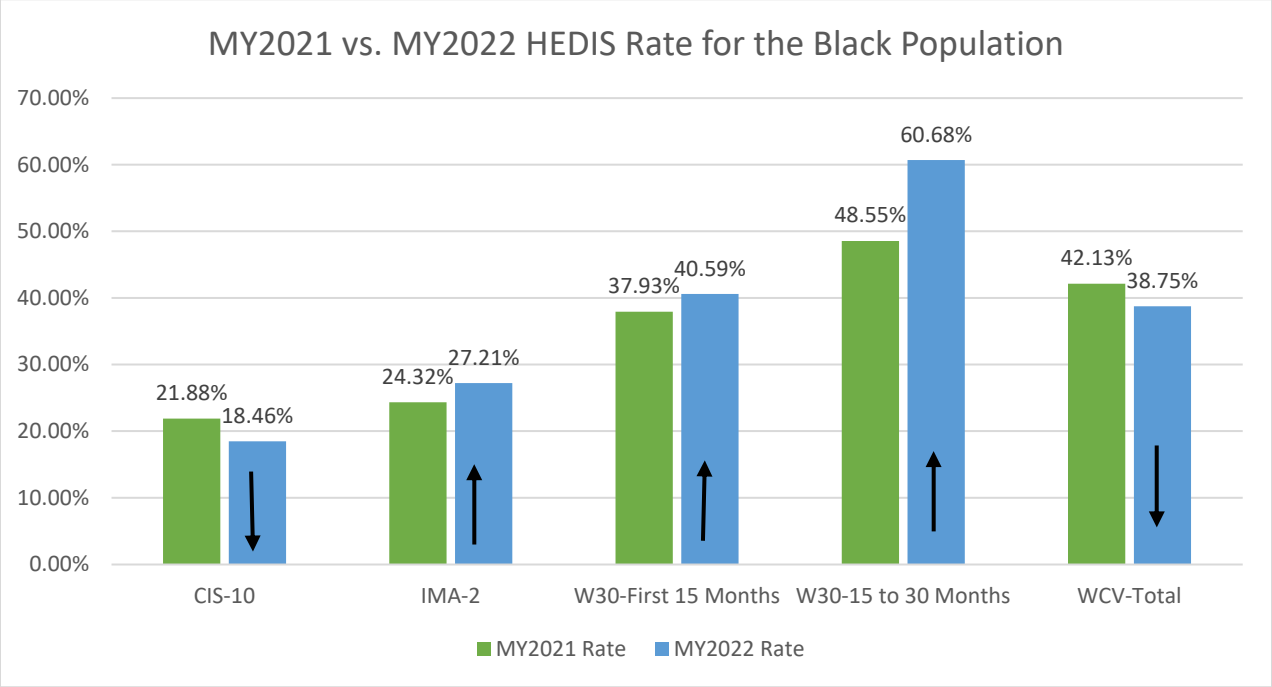
Qualitative Analysis/Barriers:

A. There has been an increase in vaccine hesitancy as reported by members, clinics and providers, especially with the availability and recommendation of the COVID and Respiratory Syncytial Virus (RSV) vaccine.
B. Rotavirus vaccine administration has a 3-dose and a 2-dose antigen series. If the antigen series is not specified, then HEDIS engine defaults to 3-dose series which may mistakenly show member as being incomplete for rotavirus vaccine.
C. Despite the efforts to increase the accessibility to gap lists for health networks, clinics and providers to outreach to members and to reconcile data, members not updating their contact information (phone number and mailing address) continues to be a challenge.
D. Staffing shortages have impacted appointment availability, which has made it more difficult for members to attend their well-care visits and have their vaccinations administered timely.
E. Since the WCV measure is a large population (N=326,539), it is difficult to impact the measure compared to metrics with a smaller population.
F. IVR campaigns allow outreach to a large population but has a low success rate (under 40%) of reaching the end user and is limited to members who provide TCPA consent or have a landline phone number. Only ~36% of the pediatric and adolescent population meet the IVR outreach criteria.
G. Text messaging campaigns allow outreach to a large population, with a high success rate (over 95%) of reaching end user but is limited to members who have a cellphone on file and did not opt out of contact. Only ~65% of the pediatric and adolescent population meet the text messaging outreach criteria.
H. W30 measure continues to be a challenge as members age out of the measure throughout the year. The telephonic year end call campaign initial outreach population was 1,035 members, but through the span of the campaign, members aged out or was unreachable (e.g., wrong phone number), which yielded a 59.00% successful outreach rate, with 722 unique members reached.

Disparity Analysis:

A. Analysis Methodology: In alignment with the 2022 QI Evaluation, HEDIS MY2022 was used to evaluate if ethnicities previously identified using HEDIS MY2021, had an improvement in their rates.

B. Results



C. Quantitative Analysis:
   1. The Black population was identified as having the highest opportunity for improvement across all measures. There was improvement in the Black population for IMA-Combo 2 (+2.89%), W30-First 15 Months (+2.66%) and W30-15 to 30 Months (+12.13%).
   2. CIS-Combo 10 (-3.42%) and WCV (-3.38%) rates decreased in MY2022 for the Black population.

D. Qualitative Analysis/Barriers:
   1. All members, regardless of ethnicity, who fall in the denominator for the quality metric were included in activities and interventions. Additional efforts are placed on members who are still due for the well-care visits and/or immunizations throughout the year.
   2. Overall, there has been a decrease in CIS-Combo 10 and WCV rates across most ethnicities.
   3. Vaccine hesitancy continues to be an issue and has increased over the year.

E. Conclusion:
   1. Conduct a disparity analysis for populations and develop ethnicity-specific interventions for subpopulations who historically performed lower or showed no change from past interventions and may benefit from a new intervention.

Conclusion and Next Steps:

A. Creation of member initiatives that identifies members that have multiple gaps in care that can be closed in one visit to minimize member abrasion. As well as look into disparity analysis to target race/ethnicity groups that have the highest need.
B. There should be special attention as to the root cause of significantly lower rates for WCV and targeted interventions planned in calendar year 2024.
C. Continue to connect with health networks, clinics, and provider offices to understand their challenges, successes, and current process with well-care visits and vaccinations. Develop a

best practice guide or quality metrics reference sheet for providers to better operationalize and close gaps.

D. Recommendation to work with providers to open their schedules to allow for well-care visits and vaccinations to be prioritized.
E. Modify text messaging campaign cadence to regularly outreach to members to provide age-tailored health education and appointment reminders.
F. Live-person telephonic call campaigns should continue to be used to outreach to members as it has less outreach limitations. Call campaigns should be conducted on a regular cadence to connect with members before they age out of the W30 and CIS measure. This will aid in the reminder for parents or guardians to schedule their child's next well-child visit and other preventative care (e.g., vaccinations, blood lead test).
G. Regularly monitor provider office HEDIS rates and outreach to offices to participate in improvement projects.
H. For providers contracted with CalOptima Health Community Network, consider aggregating their full membership gap list from all their contracted health networks, to be on one singular list. This would minimize the need for providers to obtain their gap list separately from each network.
I. Collaborate with internal member-facing departments to share gap lists to provide health education to members at each touchpoint, e.g., Facets warning message pop-up for Customer Service Representatives for inbound calls from members.
J. In conclusion, all measures, CIS-Combo 10, IMA-Combo 2, W30-First 15 Months, W30-15 to 30 Months, and WCV-Total should be retained for 2024 QI Workplan.

5.2.4.2 Blood Lead Screening

Background: According to the CDC, exposure to lead can cause serious health effects such as damage to the brain and nervous system, as well as intellectual and behavioral problems. Because children who are exposed to lead often have no obvious symptoms, lead poisoning often goes unrecognized.

Per the CDC[1] there is no safe blood lead level. Screening for lead is the best way to detect lead exposure. If not found early, the health effects of lead poisoning may be permanent.

California regulations[2] recommend that children enrolled in Medi-Cal receive blood lead test at both 12 and 24 months of age and receive catch up testing if testing was not completed as recommended.

Lead Screening in Children (LSC) is the quality performance measure for HEDIS. LSC is part of the DHCS MCAS for annual reporting by Medi-Cal MCPs. Beginning MY2022, MCPs were held to the minimum performance level (MPL) established by NCQA Quality Compass Medicaid 50th percentile for LSC. In addition, through All Plan Letter (APL) 20-016 (revised): Blood Lead Screening in Young Children, DHCS issued regulatory requirements for MCPs to ensure timely lead screenings in accordance with the California regulations.

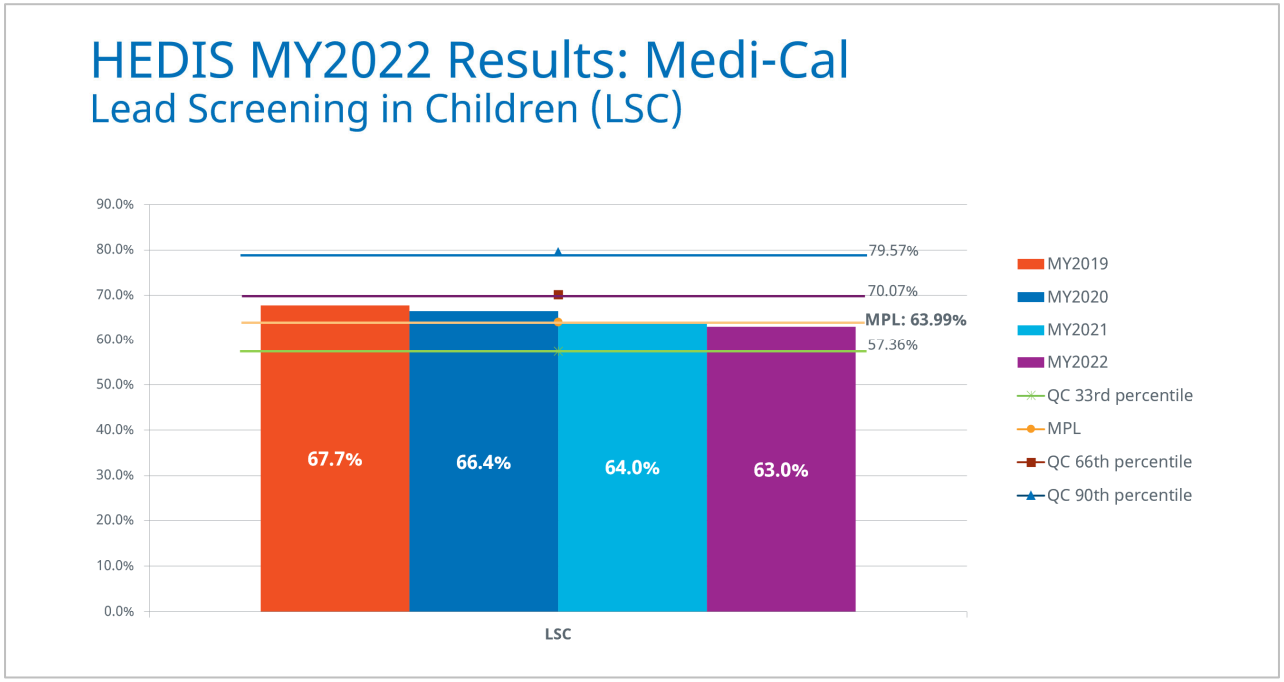
[1] Centers for Disease Control and Prevention. (2022). Health Effects of Lead Exposure. Retrieved from: https://www.cdc.gov/nceh/lead/prevention/health-effects.htm
[2] Title 17 California Code of Regulations section 37100.

Lead Screening in Children: A hybrid HEDIS and MCAS measure that assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Program Goal(s):

MY2023 Work Plan Goals

Acronym	Measure	MY2022 Medi-Cal Rate	2022 Medi-Cal Goal	MY2022 Goal Met/Not Met	2023 Medi-Cal Goal
LSC *(hybrid)*	Lead Screening in Children	63.02%	63.99%	Goal Not Met	63.99%



A. The tables above review the CalOptima Health measure goals for MY2022 and MY2023 and the Medi-Cal final rates for HEDIS MY2022.
B. Goal methodology for the 2023 Medi-Cal goal is set based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2022 reported performance results compared with the national percentile from NCQA Quality Compass.
C. The 2022 QI Work Plan internal goal of 71.53% was based on the available MY2021 quality compass 50th percentile. In MY2021, LSC was a reported measure and was not held to an MPL until MY2022. The MY2022 MPL of 63.99% was released until later in the 2022 year and is much lower than the MY2021 MPL of 71.53%. CalOptima Health's HEDIS MY2022 LSC hybrid rate for Medi-Cal was 63.02% and did not meet the MPL of 63.99% nor the 2022 QI Work Plan goal of 71.53%. In alignment with the goal methodology, the 2023 Medi-Cal goal is to meet the MPL rate of 63.99%.

Action/Interventions:

List of MY2023 Medi-Cal Lead Screening in Children Initiatives

Planned Activities/Intervention	Intervention Type	Barriers	Completion Status
Monthly Report of members that have not tested for lead in accordance with recommended testing intervals.	Health Network/ Provider	• Contracted providers and HNs are required to attest to the receipt of this report, but unable to measure impact	In Progress
Quarterly DHCS Supplemental Report that identifies members that have not tested for lead in accordance with recommended testing intervals.	Health Network/ Provider	• Contracted providers and HNs are required to attest to the receipt of this report, but unable to measure impact	Completed
Well-Child Visits EPSDT Text Message to 0-30 Months Old; includes blood lead screening and COVID language. (2-way) Campaign conducted twice in 2023	Member	• Dependent on correct member contact data • Campaign only for members who have cell phone on file • Campaign required TCPA consent, which limited the number of members outreached	Completed
Health Guide 0-2 Newsletter mailing, inclusive of blood lead screening cover letter, BLS fact sheet, and well-child visits flyer.	Member	• Dependent on correct member mailing data • 4.23% return mail rate • Delays in internal processes contributed to mailing launch	Completed
Lead Screening in Children IVR Campaign Campaign conducted twice in 2023	Member	• Dependent on correct member contact data • Information may not be as impactful as a live call from a staff	Completed
Bright Steps Program Well-Child Follow-Up Calls at 6 and 12 Months of Age + Lead Screening education to members who participate in BSP Program	Member	• Will not see impact of this program until 2024 when these children fall into the HEDIS denominator • Education is dependent on successful member outreach	Completed
Pediatric Call Campaign	Member	• Dependent on correct member contact data • Calls initiated for year-end push may not have enough time to complete screening. • Limited staff resources to make calls	Completed
Shared Final MY2022 Results for W30 and LSC with Health Networks.	Health Network		Completed

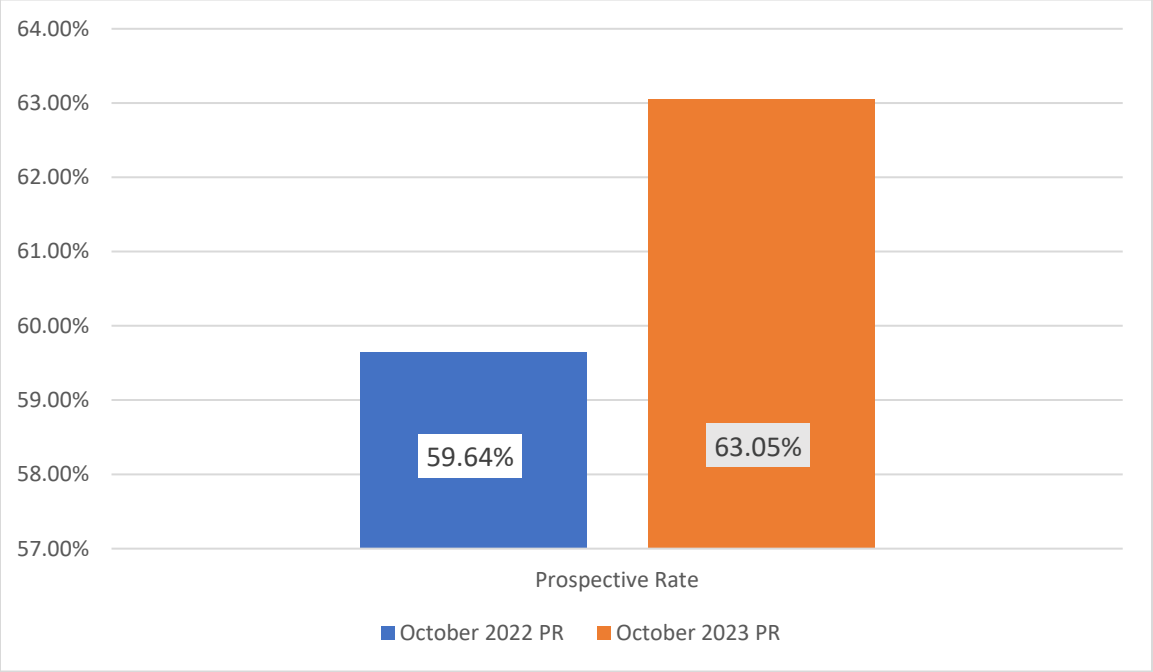
Pediatric Call Campaign to close W30 and LSC gaps in care - CCN Only	Member	• Dependent on correct member contact data	Completed
Blood Lead Screening text message campaign (1-way)	Member	• Dependent on correct member contact data	Completed
CE/CME: 2023 Update: The Prevention of Childhood Lead Poisoning: Why Health Care Providers Should Counsel on Lead and Screen for Lead Exposure	Provider	• CE/CME held during afternoon hours may impact provider ability to attend • Limited number of providers and health care professionals attended	Completed
Blood Lead Testing Guide	Provider	• Potential for distribution not to reach all intended providers • Finalization of the guide at the end of Q3 may have resulted in limited time to promote information to make an impact in lead screening rates	Completed
CCN Virtual Meetings: Pediatric Quality Measures - Overview of Lead Testing Best Practices and Resources	Provider	• Targeted limited number of providers	Completed
CCN Virtual Meetings: Pediatric Provider Report Cards, emailed to offices who did not attend in person.	Provider	• Sent via secure email which has a different look and thereby may deter providers from opening messaging. Steps taken to mitigate this impact.	Completed
Blood Lead Poster Campaign for Provider Offices (targeting members)	Provider		In Progress
Pay4Value Program	Health Network	• Focused on HEDIS and may create provider confusion as this differs from clinical guidelines that seek at least two tests by the time a child is 2 years old	In Progress
Blood Lead Screening PBS TV Ad	Community	• May not directly target the parent/guardian of CalOptima Health members • Advertisement only in English • Inadequate duration and intensity/exposure to potential opportunity to see the campaign • Limited by budget allotment	Completed

Provider notification of blood lead screening requirements and management resources.	Provider	• Potential for distribution not to reach all intended providers	Completed
Passive Social Media Ads/Posts	Community	• Targets small audience which may not be CalOptima Health members • Inadequate duration and intensity/exposure to potential opportunity to see the campaign	Completed
Paid Digital and Social Media Ad	Community	• Education to the community at large and may not directly impact members • Limited by budget	Completed
Provider notification of Anticipatory Guidance requirement and Blood Lead Refusal form tool	Provider	• Potential for distribution not to reach all intended providers	Completed
Testing Your Child for Lead: What You Need to Know Medi-Cal Newsletter Article	Member	• Dependent on correct member mailing data	Completed
Make Sure Your Pediatric Patients are Screened for Lead Provider Newsletter Article	Provider	• Potential for distribution not to reach all intended providers	Completed
Lead Testing Radio Ad	Community	• Education to the community at large and may not directly impact members • Advertisement not available in all threshold languages • Limited by budget allotment	Completed
Coalition of OC Community Health Centers – HCCN Clinical Quality Champion Pediatric Measures Presentation – presentation on lead requirements, preliminary root causes of untested members	Provider	• Meeting attendees may not be the practicing providers who would benefit from information	Completed

Results:

The figure below compares the prospective rates for October 2022 with the prospective rates for October 2023. Prospective rate (PR) refers to claims/encounters processed through October and represents administrative data. LSC is a hybrid measure.

October 2022 and 2023 Prospective Rate for Lead Screening in Children, Medi-Cal



PR methodology includes continuous enrollment criteria. LSC is a hybrid measure. Prospective rates are solely administration and do not take into account hybrid sample.

Quantitative Analysis:

A. LSC is performing better in October 2023 when compared with the same time last year by 3.41%.
B. Beginning MY2022 LSC was held to the MPL. In MY2022, LSC did not meet the MPL rate of 63.99%
C. Final rates for MY2023 are pending, however preliminary results point that we are on track to meet the MPL for MY2023.
D. 2023 QI Work Plan goal was to comply with the reporting requirements of APL 20-016 (revised). MCPs must identify, at least on a quarterly basis, all child members under the age of 6 years who have no record of receiving a blood lead test as required by California regulations. Objective was met.
E. 2023 QI Work Plan goal was to implement a process to identify the number of children that refuse blood lead testing. This objective was not met. However, CalOptima Health developed and made the Anticipatory Guidance and Blood Lead Refusal form available for providers on the CalOptima Health website. This document is intended to support providers with the documentation of blood lead refusals as required by APL 20-016 (revised).

Qualitative Analysis/Barriers:

A. The objective to provide CalOptima Health providers and health networks with reports of members who have no record of receiving a blood lead test was met. In 2023, the report underwent revisions to support health networks with data to further support the sharing of information with providers. To align with the cadence of other quality reporting and support timely data sharing, in September 2023 CalOptima Health shifted to provide this report monthly.

B. Lack of procedure codes directly related to the refusal of blood lead tests creates challenges in the availability of data and thereby, the implementation of a mechanism to identify lead testing refusals. Consequently, documentation of any refusal in the member medical record must be a manual process. With different providers using different electronic medical records and some providers still relying on paper charts, there is no appropriate mechanism for which CalOptima Health can gather data on refusals without placing an administrative burden to providers and other health care professionals. Our focus will continue to be to support member testing as recommended.
C. In 2023, CalOptima Health engaged in discussions with HNs related to understand the barriers preventing members from testing for lead. Among the feedback, some noted that the recall of Magellan Diagnostics lead testing products were detrimental to the LSC rate but are now seeing an improvement in 2023. Lead testing products resumed at the end of Q1 2022, however, it is possible that supply availability posed challenges. In addition, some network providers have a preference to continue to issue lab orders rather than point of care testing in their office. CalOptima Health encourages providers who submit lab orders to establish follow-up protocols to ensure testing is completed and provide reminders for members with completion gaps.
D. Parents or guardians of children may opt not to complete a lead screening because they may be unaware of the importance of blood lead testing or the recommended testing cadence at 12 and 24 months of age.
E. Parents or guardians may also have concerns related to the physical discomfort associated with testing. Testing for lead in a lab requires a venous sample.
F. The LSC HEDIS measure specifications do not align with the AAP/Bright Futures recommendations or state regulations for testing at 12 and 24 months of age. In addition, testing recommendations differ for children with Medicaid and commercial insurance. Medicaid providers also caring for children with commercial insurance may be confused on the clinical guidelines that differ.
G. Multiple interventions (e.g., text, call, mail) are driven by member contact information. Incorrect member data poses challenges to communicate important information related to lead and lead testing thereby reducing the outreach effectiveness.
H. The Health Guide 0-2 Newsletter mailing interventions was slated for launch early in March 2023 to support early member education efforts on lead. The mailing process required additional resubmissions which contributed to delays which resulted in mailings sent closer to the end of Q2. This contributed to the sharing of information that was later than anticipated.
    1. Effective September 2023, CalOptima Health revised policy GG.1666 to include TCPA guidance. Under this revised guidance, the provision of a member phone number implies consent for outreach via text to facilitate behavior change and support clinical and quality outcomes. This guidance allowed CalOptima Health to expand on member outreach via text.
I. LSC is a hybrid measure that requires medical record review therefore the actual final rate for MY2023 may be higher.

Conclusion and Next Steps:

A. Multiple interventions (e.g., texts, call campaigns) are member driven. There are opportunities to continue a multiprong approach to address barriers at the provider and systemic level.
B. CalOptima Health shifted blood lead reports to monthly cadence to support earlier data sharing, but it is too early to determine if the shift contributed to increased lead screening rates.
C. Opportunities remain to have direct collaboration with providers, community clinics, health networks and their quality teams. This includes presenting lead testing and lead testing rates to partners throughout MY2024.
D. Opportunities remain to create targeted member initiatives that focus on closing lead testing gaps among racial/ethnic groups with increased disparities.
E. CalOptima Health is exploring collaborative efforts with the local health department to expand on lead testing efforts. In addition, CalOptima Health will continue the pursuit of a collaborative blood lead poster campaign for providers.
F. In MY2024, CalOptima Health will launch two health rewards for blood lead testing at 12 and 24 months. This is intended to support providers with testing in alignment with the clinical guidelines and support member awareness of testing recommendations.
G. CalOptima Health will retain the LSC measure on the 2024 QI Workplan. Low-income communities face the burden of geospatial barriers that increase the risk of lead exposure. LSC is interconnected with other quality measures such as well-child visits. Retaining LSC will ensure that we continue to strive for quality and invest in addressing the importance of risk exposure and its health consequences.

5.2 Managing Members with Emerging Risk

5.3.1 Behavioral Health

5.3.1.1 Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Background: According to an article published in the National Institutes of Health (NIH) National Library of Medicine, there has been an increase in the prescribing of antipsychotic medications in children and adolescents ages 1-17 (Eveliina Varimo, 2020). CalOptima Health recognizes the potential risk associated with these medications as it relates to their members. These risks can lead to lifelong metabolic disorders, such as diabetes and cholesterol diagnosis. It is important to ensure that regular metabolic monitoring is a regular standard of care in the management of children on antipsychotic medications.

The APM measure monitors ongoing use of antipsychotic medications by children and adolescents increases the risk of developing diabetes and high cholesterol, which can extend into adulthood. Metabolic monitoring can help ensure early detection and management of these potential complications.

Measure Description: The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

A. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
B. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
C. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Goals:

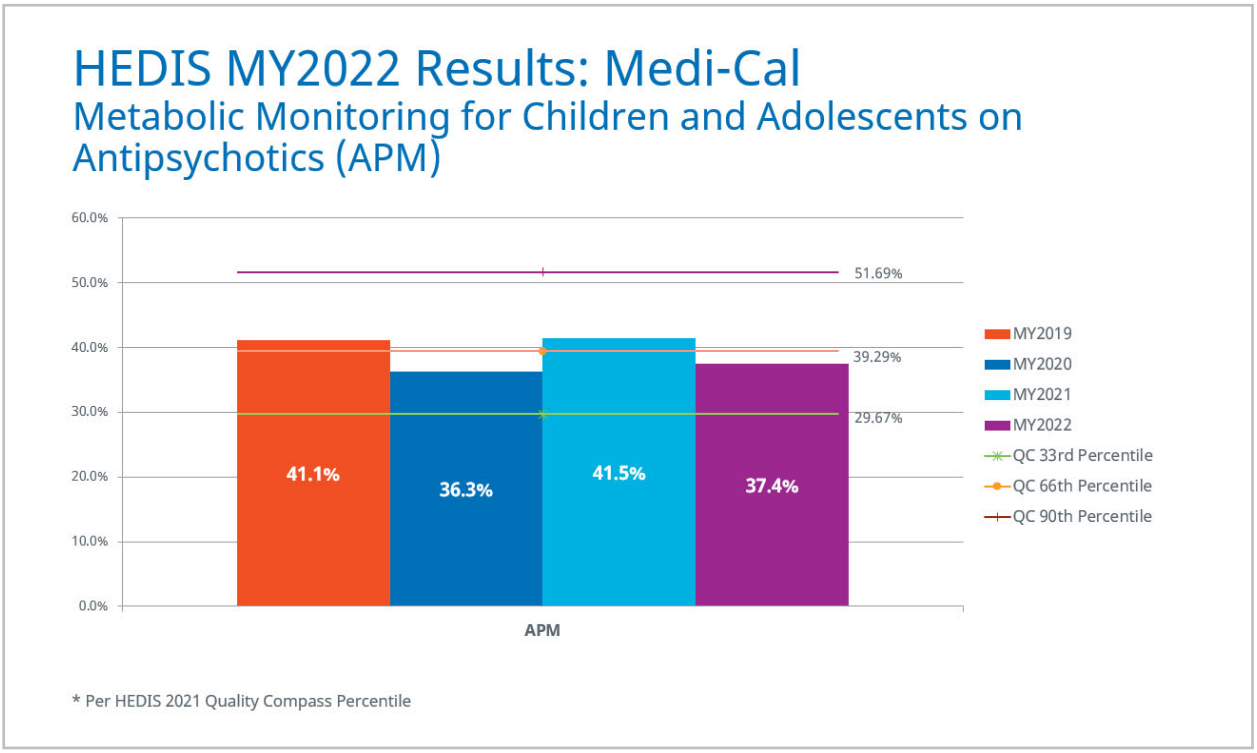
Measure	2023 Medi-Cal Goal	MY2022 Medi-Cal Rate	MY2022 Goal Met/ Not Met
Blood Glucose Monitoring	Blood Glucose-All Ages: 54.36%	57.3%	Goal Met
Cholesterol Testing	Cholesterol-All Ages: 36.17%	39.9%	Goal Met
Blood Glucose and Cholesterol Monitoring	Glucose and Cholesterol Combined-All Ages: 34.30%	37.4%	Goal Met

Actions/Interventions:

A. The BHI Quality Team monitored prescribing providers who showed as noncompliant for follow-up testing with members. The interventions will be focused on targeting the prescribing providers, as well as the primary care providers.
B. Member outreach will be conducted monthly via a text messaging campaign, through a contracted vendor. This intervention will target members identified, that have not completed their yearly follow-up metabolic testing. These messages will be sent in the member's threshold language.
C. Providers identified with a high rate of noncompliance will be sent a Provider Tip Tool sheet and Best Practices letter, to alert providers about the importance of metabolic monitoring of members that been prescribed antipsychotic medications. Members are at a higher risk of developing chronic metabolic disorders while taking these types of medications. The APM HEDIS measure addresses three data elements:
    1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
    2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
    3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Planned Activities/Intervention	Intervention Type	Barriers	Completion Status
Provider Tip Tool Sheet	Provider	Provider Data Integrity, Dissemination Method	In Progress
Member list for Provider	Provider	Provider Data Integrity, Dissemination Method, PHI risk	In Progress
Provider Best Practices Letter	Provider	Provider Data Integrity, Dissemination Method	In Progress
In-Person Provider Outreach	Provider	Provider Data Integrity, Dissemination Method	In Progress
Text Messaging Campaign	Members	Lengthy approval process (DHCS)	In Progress

Results:



Quantitative Analysis:

The final rate was 37.4% for Total Blood Glucose and Cholesterol Monitoring, which met the intended goal 34.30%. The decline from the previous year is due to measure APM not actively being a monitored measure prior to 2023.

Quantitative Analysis/Barriers:

A. Dissemination process is being modified to optimize provider outreach.
B. Updating data directly to the provider portal
C. Text messaging campaign in process of finalization

Conclusion and Next Steps:

For the upcoming year 2024 the BHI Quality Team will be actively monitoring measure APM to track and trend provider follow-up testing for children ages 1–17 that have been prescribed antipsychotic medications. The following interventions will be disseminated in 2024:

A. The BHI Quality team is in the process of developing a pilot program for APM measure. The department will be working collaboratively with the Provider Relations department, to identify the best strategies to target the top 10 prescribing providers with in-person visits. The second part of the intervention will target the next top 50 prescribing providers identified with a mailed intervention that will include a Provider Tip Tool Sheet and Provider Best Practices Letter.
B. BHI will be working with quality analytics to further identify data elements needed to address the members PCPs for further intervention outreach.
C. Future state in 2024 we are working closely with ITS to deliver this member information electronically via the CalOptima Health Provider Portal. The use of modern technology will allow CalOptima Health to deliver this important information best practices to providers in a timely matter, while streamlining workflows and processes in the BHI Quality department.

5.3.1.2 Follow-Up Care for Children Prescribed ADHD Medication

Background: CalOptima Health's program monitors the percentage of children with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who have at least three follow-up care visits within a 10-month period. The measure focuses on two phases. The Initiation Phase requires that the first follow-up visit occurs within 30 days of the initial ADHD medication being dispensed. The Continuation Phase includes those members that remained on medication for at least 210 days and attended at least two additional follow-up visits withing nine months following the Initiation Phase.

Goals: To increase chances to meet or exceed HEDIS goals though effective interventions that are aligned with current practice and technological options.

Measure	2023 Medi-Cal Goal	MY2022 Medi-Cal Rate	MY2022 Goal Met/Not Met
Follow-Up Care for Children Prescribed ADHD Medication	• Initiation Phase: 42.77% • Continuation and Maintenance Phase: 51.78%	• Initiation Phase: 42.4% • Continuation and Maintenance Phase: 46.8%	Medi-Cal: Not Met

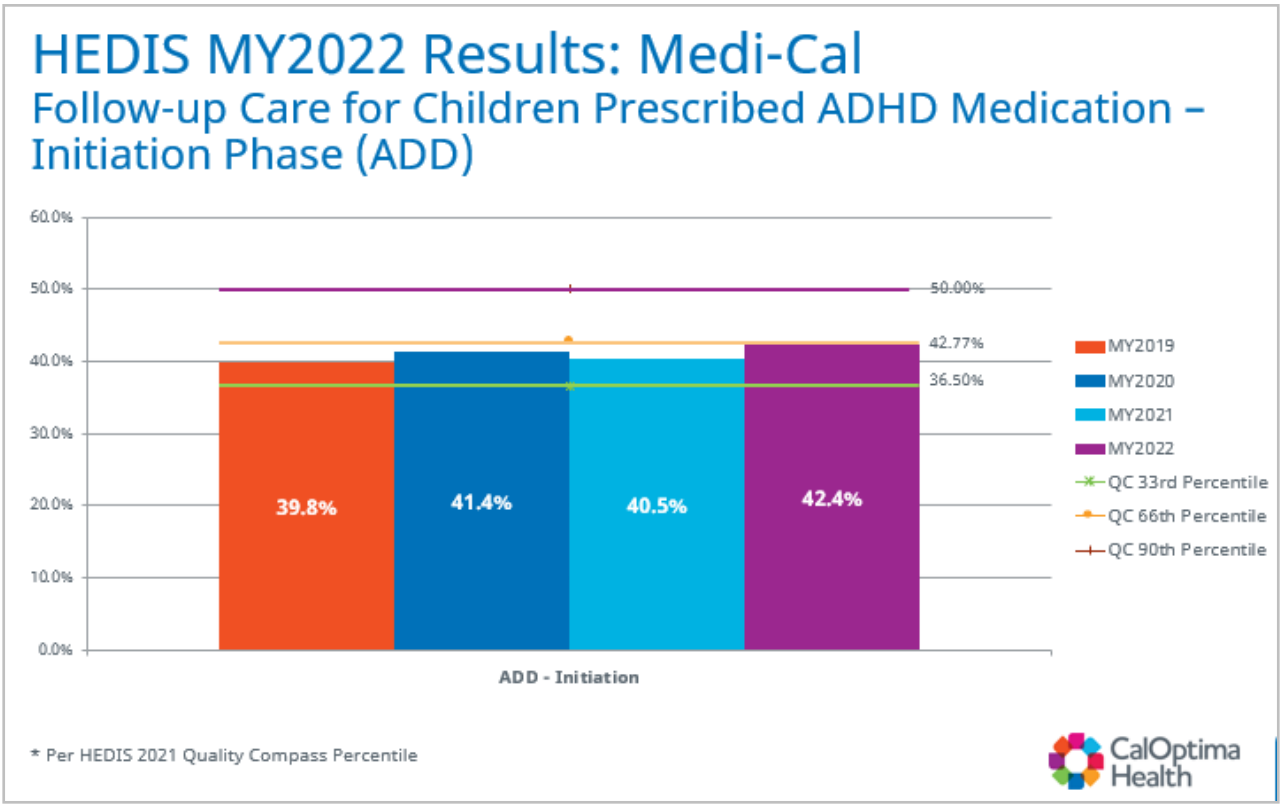
Action/Interventions:

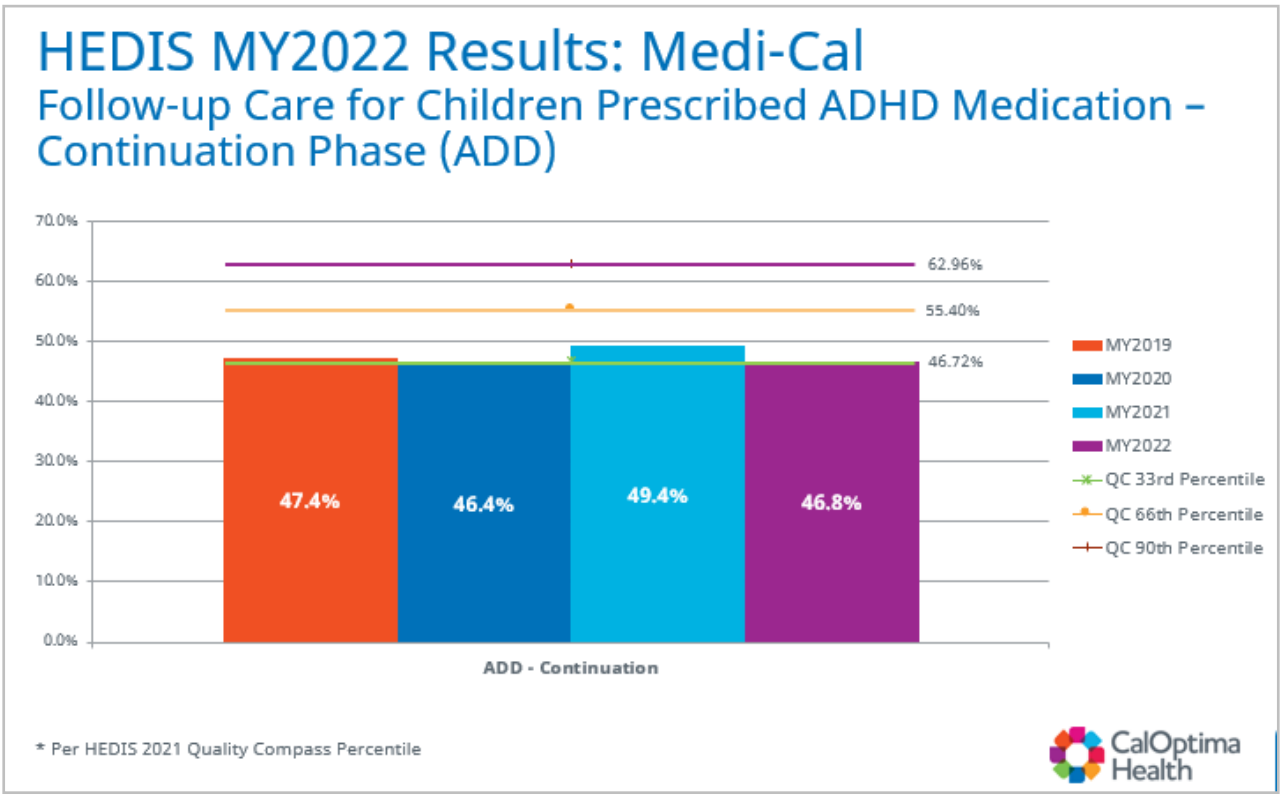
A. BHI Quality Team tracked and trended providers who showed as noncompliant for follow-up visits with members. Providers with high frequency of non-compliance were sent a letter to educate on the ADD measure requirements and the importance of follow-up visits with members prescribed ADHD medications.
B. BHI Quality Team continued to track members monthly that filled an initial ADHD medication and conducted member outreach to ensure a 30-day follow-up appointment had been scheduled.

C. BHI Quality Team submitted an article for the Spring 2023 edition of the CalOptima Health's member newsletter to educate on the importance of attending follow-up visits with a provider.

Planned Activities / Intervention	Intervention Type	Barriers	Completion Status
Provider Best Practice Letter	Provider	Provider Data Integrity, Dissemination Method	Completed
Provider Tip Tool Sheet	Provider	Provider Data Integrity, Dissemination Method	Completed
Member Outreach	Member	Member Data Integrity	In Progress
2023 CalOptima Health Spring Member Newsletter	Member	None	Completed
Text Messaging Campaign	Members	Lengthy approval process (DHCS)	In Progress (12/2023)

Results:





Quantitative Analysis:

A. CalOptima Health's 2022 HEDIS Initiation Phase final rate was 42.4%, which did not meet the intended goal of 42.77%. The Initiation Phase has demonstrated slight change over the past four years.
B. The 2022 HEDIS Continuation Phase final rate was 46.8%, which also did not meet the intended goal of 55.40%. Continuation Phase has demonstrated a slight decrease over the past four years.

Qualitative Analysis/Barriers:

A. The provider letter was faxed to the number on record. We are aware that the fax may not always go to the intended provider to whom the letter was faxed.
B. Provider availability is still a barrier for members to get an appointment scheduled with the 30-day follow-up requirement. This may be due to the national shortage of behavioral health providers.
C. Text messaging campaign in process of finalization 12/2023.

Conclusion and Next Steps:

A. The BHI quality team will continue to send letters to providers who are not meeting the ADD requirements.
B. The BHI quality team will explore opportunities to continue member outreach to identify barriers and assist members with appointment scheduling if necessary.
C. ADD materials will be updated yearly and the team will distribute new materials to providers and members as part of the outreach effort.
D. Future state in 2024 we are working closely with ITS to deliver this member information electronically via the CalOptima Health Provider Portal. The use of modern technology

will allow CalOptima Health to deliver this important information best practices to providers in a timely matter, while streamlining workflows and processes in the BHI Quality Department.

5.3.1.3 Follow-Up After Emergency Department Visit for Substance Use (FUA) and Mental Illness FUM

Background: CalOptima Health's program assesses the percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported in this program, the percentage of ED visits for which the member received follow-up within 30 days of the ED visit, as well as the percentage of ED visits for which the member received follow-up within 7 days of the ED visit.

CalOptima Health's program also assesses the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm diagnoses and who had a follow-up visit for mental illness. Two rates are measured in this program, the percentage of ED visits for which the member received follow-up care within 30 days of ED visit, as well as the percentage of ED visits for which the member received follow-up care within 7 days of ED visit.

Goals: To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.

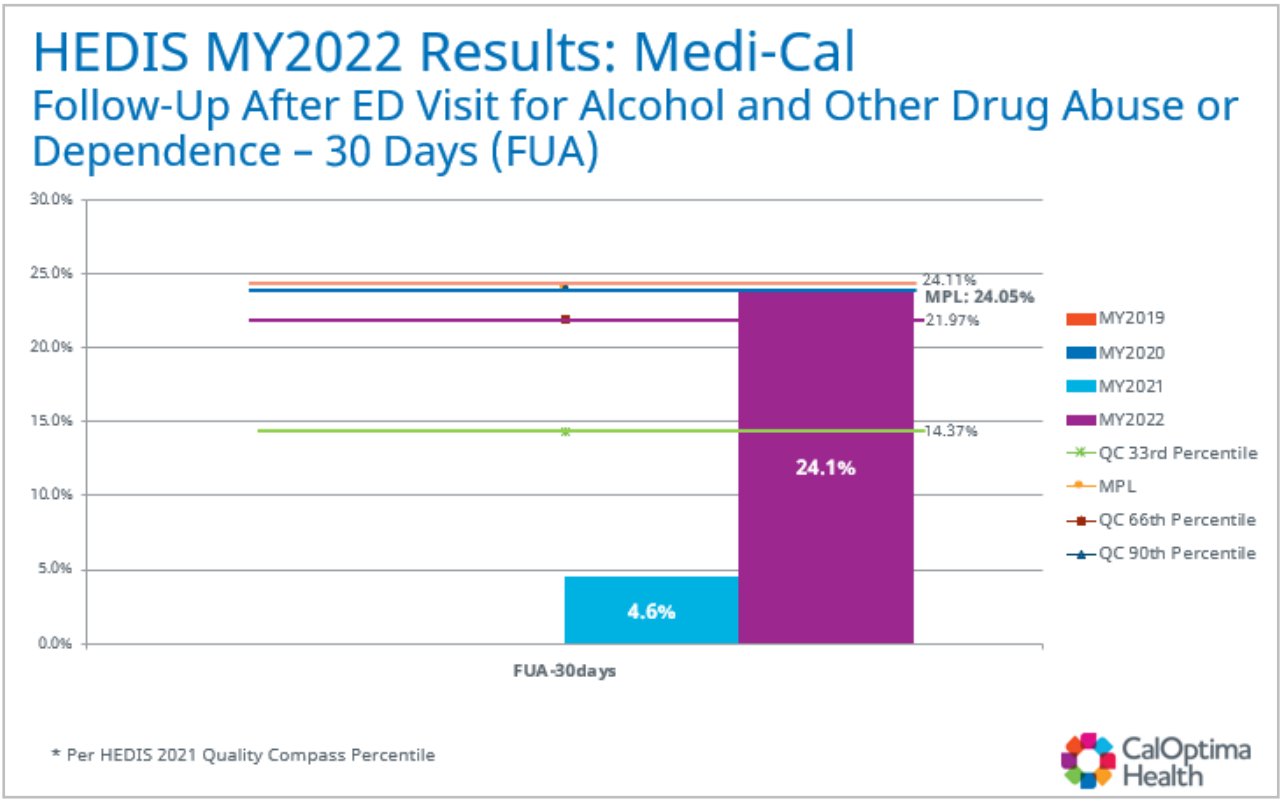
Acronym	Measure	2023 Medi-Cal Goal	MY2022 Medi-Cal Rate	MY2022 Goal Met/Not Met
FUA	Follow-Up After Emergency Department Visit for Substance Use	• 30 Days: 21.24% • 7 Days: 8.93%	• 30 Days: 24.1% • 7 Days: 13.0%	Medi-Cal: Not Met
FUM	Follow-Up After Emergency Department Visit for Mental Illness	• 30 Days: 54.54% • 7 Days: 31.97%	• 30 Days: 58.8% • 7 Days: 35.5%	Medi-Cal: Met

Actions/Interventions:

Planned Activities/Intervention	Intervention Type	Barriers	Completion Status	Measure
Track real-time ED data for participating facilities on contracted vendor.	Data	Provider Data Integrity	In Progress	FUA, FUM
Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit.	Data, HN, Provider	Provider Data Integrity	Completed	FUA, FUM
Participate in educational events on provider responsibilities on related to follow-up visits.	Provider	Internal Collaboration TBD	In Progress	FUA. FUM

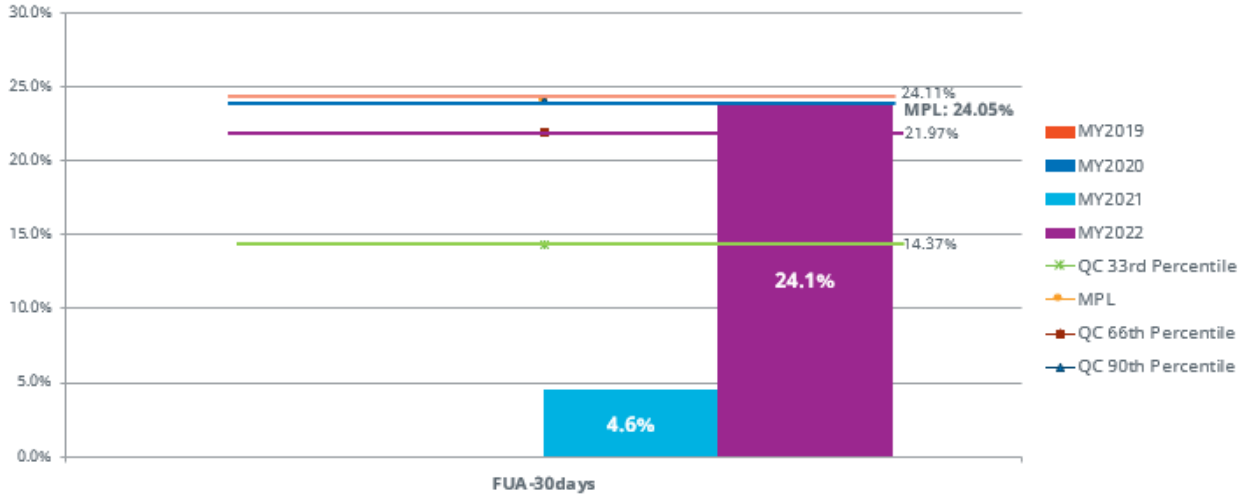
Planned Activities/Intervention	Intervention Type	Barriers	Completion Status	Measure
Utilize CalOptima Health NAMI Field-Based Mentor Grant to assist members connection to a follow-up after ED visit.	Member, Community	Internal Collaboration TBD	In Progress	FUA, FUM
Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	Member, Provider	Internal Completion TBD	In Progress	FUA, FUM

Results:



HEDIS MY2022 Results: Medi-Cal

Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days (FUA)

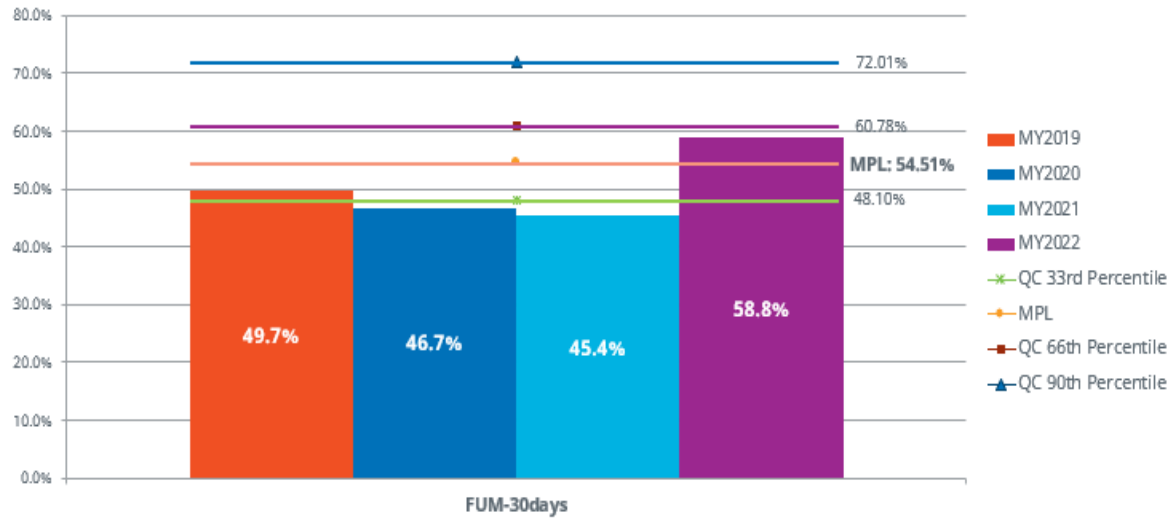


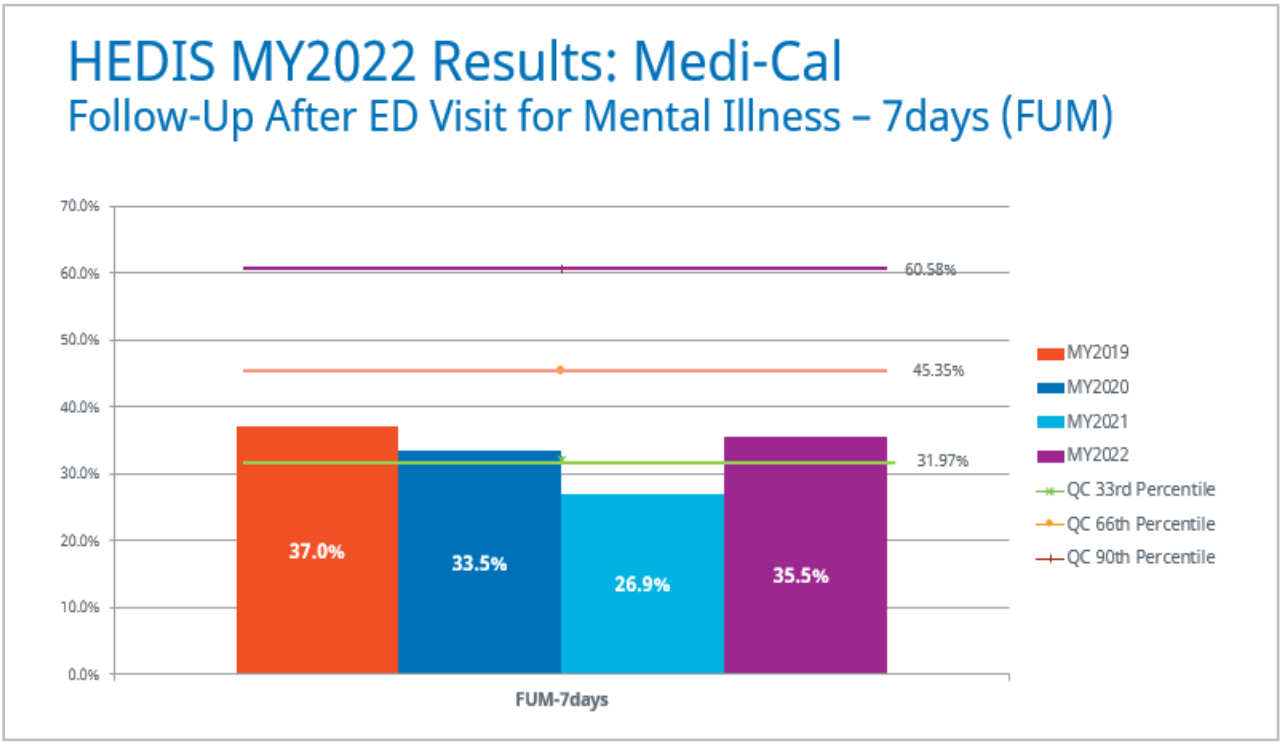
* Per HEDIS 2021 Quality Compass Percentile

CalOptima Health

HEDIS MY2022 Results: Medi-Cal

Follow-Up After ED Visit for Mental Illness – 30 days (FUM)





Quantitative Analysis:

A. FUA
   1. The final 30-day rate for MY2022 was 24.1%, which met the intended goal of 24.05% The final 7-day rate was 13.0%, which did meet the intended goal of 8.93%.
   2. RY 2023 data demonstrates an increase in members attending follow-up visits post ED visits. This pattern appears to be continuing into MY2023.

B. FUM
   1. The final 30-day rate for MY2022 was 58.8%, which met the intended goal of 54.51% The final 7-day rate was 35.5%, which did meet the intended goal of 31.97%.
   2. RY 2023 data demonstrates an increase in members attending follow-up visits post ED visits. This pattern appears to be continuing into MY2023.

Qualitative Analysis/Barriers:

A. Data provided by vendor did not always show the Principal Diagnosis as being one of Mental Illness or intentional Self-harm.
B. No STFP BH folder was in place to share the ED data with the health networks.

Conclusion and Next Steps:

A. Current ED reports provided by vendor have been modified and updated so that they show the Principal Diagnosis as being one of Mental Illness or intentional self-harm.
B. Text message campaign has been developed and will be sent by 11/17/2023 to members who meet the FUA criteria. The text message will serve as a reminder to members who have recently visited the ED, to make sure they schedule a follow-up appointment.
C. SFTP Files/Folders have been established to share BH ED data with health networks.

D. BHI is in the process of piloting a program to conduct member outreach to engage and assist CalOptima Health Community Network (CCN) and CalOptima Direct (COD) members in providing linkage and support in scheduling follow up visits.

5.3.1.4 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Background: CalOptima Health's program assesses the percentage members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Members with severe mental illness who use antipsychotics are at increased risk of diabetes. In the United States, diabetes is among one of the leading causes of death. Lack of care for individuals with diabetes who use antipsychotic medications can lead to deteriorating health and death. Screening and monitoring of these conditions are important.

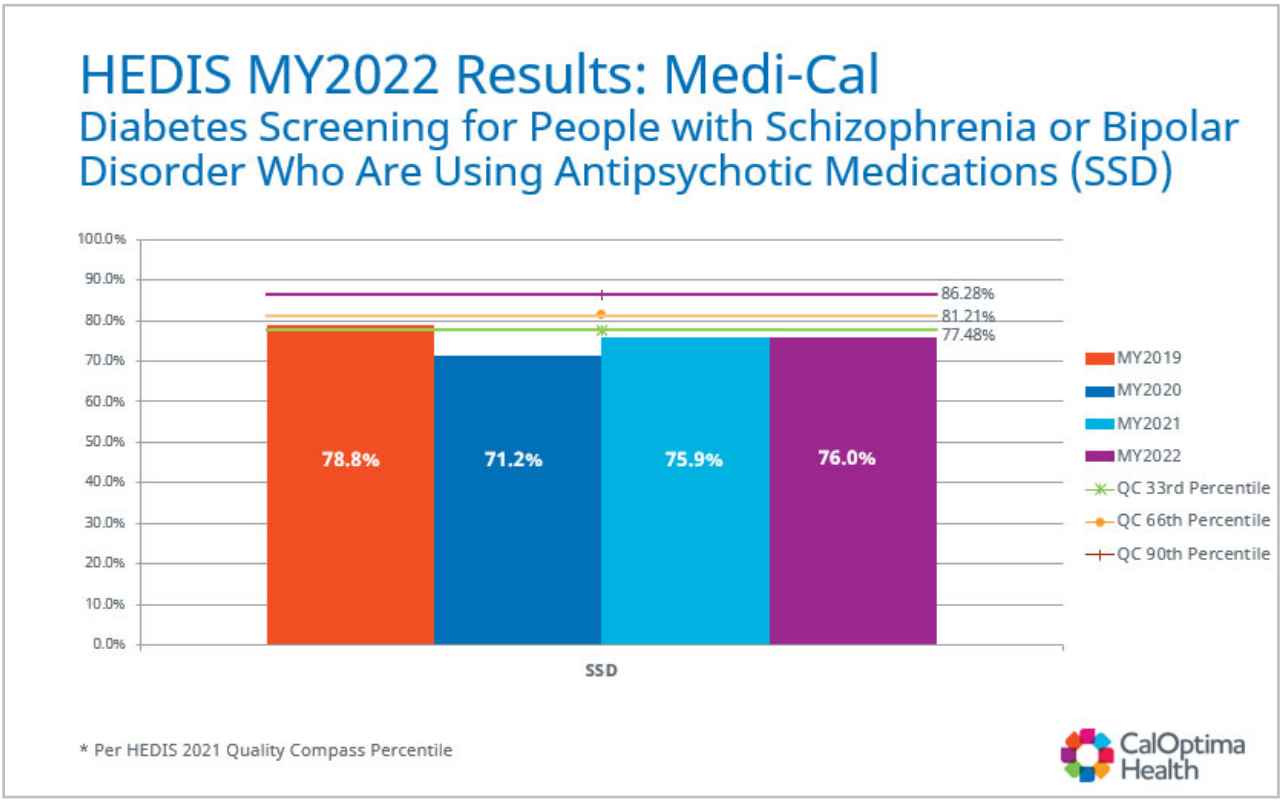
Goals: To increase chances to meet or exceed HEDIS goals though effective interventions that are aligned with current practice and technological options.

Measure	2023 Medi-Cal Goal	MY2022 Medi-Cal Rate	MY2022 Goal Met/Not Met
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	MC 77.48%	MC 76.0%	Medi-Cal: Not Met

Actions/Interventions:

Planned Activities/Intervention	Intervention Type	Barriers	Completion Status
Identify members through internal data reports in need of diabetes screening test.	Data	• Receiving timely data, obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing.	Completed
Conduct outreach to prescribing provider and/or PCP to remind of best practice and provide list of members still in need of screening.	Provider	• Some members with this diagnosis may not see their PCP regularly. • Some members may refuse to get their lab work completed.	Completed
Remind prescribing providers to contact members' PCP with lab results by providing name and contact information to promote coordination of care.	Provider	• Some members with this diagnosis may not see their PCP regularly. • Some members may refuse to get their lab work completed.	Completed
Text Messaging Campaign	Members	Lengthy process approval from DHCS	Completed

Results:



Quantitative Analysis: CalOptima Health's 2022 SSD Measurement of Effectiveness of Opportunity HEDIS final rate was 76.0%, which did not meet the intended goal of 86.28%. The final rate has demonstrated a slight increase.

Qualitative Analysis/Barriers:

A. Receiving timely data
B. Obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing.
C. Some members with this diagnosis may not see their PCP regularly.
D. Some members with this diagnosis may refuse to get their lab work completed.

Conclusion and Next Steps:

A. Continue to track members in need of diabetes screening test.
B. Continue to outreach to prescribing providers.
C. Future state in 2024 we are working closely with ITS to deliver this member information electronically via the CalOptima Health Provider Portal. The use of modern technology will allow CalOptima Health to deliver this important information best practices to providers in a timely matter, while streamlining workflows and processes in the BHI Quality Department.

5.3.2 Chronic Conditions

5.3.2.1 Diabetes Care (HBD, EED)

Background: According to the CDC, diabetes raises the risk for high blood pressure, which increases a person's chances of heart disease, stroke, vision loss and kidney disease. Tests and screenings for diabetes are necessary for people with diabetes to catch any changes before they turn into major health problems. They can also help providers create specific treatment plans based on their patients' needs.

The following are diabetes performance measures for HEDIS.

The Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control > 9% (HBD) is a hybrid HEDIS measure, and part of the Medi-Cal Managed Care Accountability Set (MCAS), which is required to meet the minimum performance level (MPL) of 50th percentile as defined by the National Committee for Quality Assurance (NCQA) National Quality Compass Benchmarks. For this measure, DHCS requires annual reporting by Medi-Cal managed care health plans. HBD is defined as members 18–75 years of age with diabetes (type 1 and type 2) who had a recent HbA1c level of >9.0% or is missing a result, or if a HbA1c test was not done during the measurement year (lower is better).

Eye Exam for Patients with Diabetes (EED) a hybrid HEDIS measure, is defined as members 18–75 years of age with diabetes (type 1 and type 2) who had a recent retinal eye exam during the measurement year.

In addition, both HBD and EED measures are also part of the CMS 5-Star quality rating system.

Goals:

MY2023 Work Plan Goals

Acronym	Measure	MY2022 Medi-Cal Rate	MY2022 OneCare Rate	MY2022 Goal Met/Not Met	2023 Medi-Cal Goal	2023 OneCare Goal
HBD*	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control > 9%	30.41%	21.67%	Medi-Cal: Met (34.06%)- (WP 2022) OneCare: Not Met (19%)- (WP 2022)	30.9% (WP 2023)	17% (WP 2023)
EED	Eye Exam for Patients with Diabetes	62.63%	73.33%	Medi-Cal: Not Met (63.2%)- (WP 2022) OneCare: Met (71%%)- (WP 2022)	63.75% (WP 2023)	79% (WP 2023)

For HBD lower rate is better.

The table above reviews the goals for MY2022 and MY2023 and the Medi-Cal and OneCare final rates for HEDIS MY2022.

Goal methodology for 2023 is set based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2021 reported

performance results compared to the national percentile from NCQA Quality Compass. If current reported reached NCQA Quality Compass percentile, then the goal was set to the next percentile. The OneCare goal setting for MY2023 is based on the MY2021 reported performance results compared to the Star Rating cutoff. If current reported reached Star cutoff, then the goal was set to the next Star cutoff.

CalOptima Health's HEDIS MY2022 HBD rate for Medi-Cal was 30.41% and met the MPL of 43.19% and met the internal goal of 34.06% (lower rate is better). CalOptima Health's HEDIS MY2022 EED rate for Medi-Cal was 62.63% and met the MPL of 51.36% but did not meet the internal goal of 63.2%.

CalOptima Health's HEDIS MY2022 HBD rate for OneCare was 21.67% and met the projected 4 Star of 25.00% but did not meet the internal goal of 19.00%. CalOptima Health's HEDIS MY2022 EED rate for OneCare was 73.33% and met the project 3-Star of 79.00% and met the internal goal of 71.00%.

Actions/Interventions:

List of MY2023 Medi-Cal and OneCare HBD and EED Initiatives

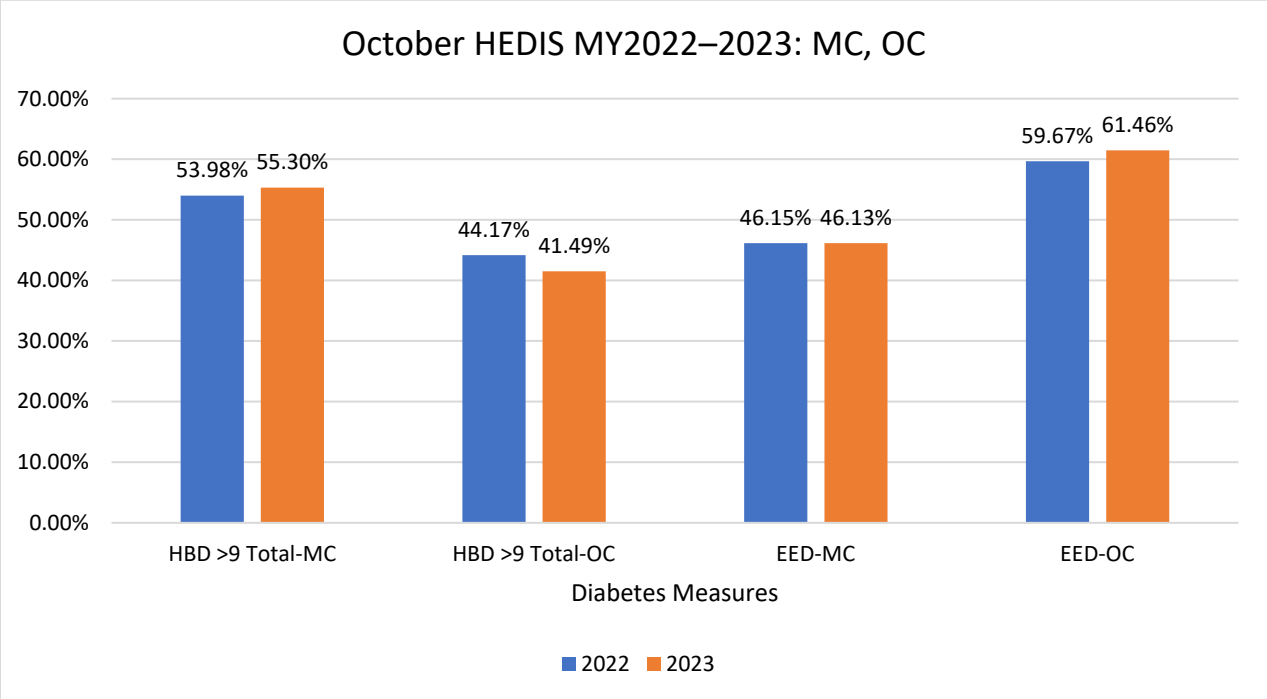
Planned Activities / Intervention	Intervention Type	Barriers	Completion Status	Measure
Member Health Reward (Member Incentive) (ongoing throughout the year)	Member	• Requires a signed/stamped attestation by the PCP or imaging center, which may prevent some members from participating in the health rewards. • Late finalization of forms resulted in late promotion in the year perhaps impacting lower participation rates.	In Progress	HBD, EED
Member Mailing (ad hoc)	Member	• Incorrect or incomplete addresses • Members do not update their address with SSA. • It is unknown what percentage of mail is returned due to wrong addresses	Completed	HBD, EED
Text Messaging (ad hoc)	Member	• Member has a do-not-contact notice • Incorrect cell phone number • Missing or member does not have cell phone number • Do not have verbal or written TCPA consent for text messaging • Member has opted out of receiving text messages	Completed	HBD, EED

Planned Activities / Intervention	Intervention Type	Barriers	Completion Status	Measure
Telephonic Outreach (Live Call, CareNet, CSR, etc.) (ad hoc)	Member	• Incorrect land line or cell phone number • No answer • Limited staff members conducting outreach • Calls were initiated for yearend push may not give enough time to complete screening	Completed	HBD, EED
Member Newsletter (Spring/Fall)	Member	• Incorrect or incomplete addresses • Members do not update address with SSA. • It is unknown which percentage of mail is returned due to wrong addresses • Unable to measure member engagement	Completed	HBD, EED
Paid Print Ad (ad hoc)	Community	• Advertisement only in three threshold languages, English, Spanish and Vietnamese	Completed	HBD, EED
Paid Digital Ad (ad hoc)	Community	• Advertisement only in three threshold languages, English, Spanish and Vietnamese • Inadequate duration and intensity/exposure to potential opportunity to see the campaign • Limited by budget allotment	Completed	HBD, EED
Radio Ad (ad hoc)	Community	• Advertisement only in three threshold languages, English, Spanish and Vietnamese • Inadequate duration and intensity/exposure to potential opportunity to see the campaign • Limited by budget allotment	Completed	HBD, EED
Paid Social Media (ad hoc)	Community	• Advertisement only in three threshold languages, English, Spanish and Vietnamese • Inadequate duration and intensity/exposure to potential opportunity to see the campaign • Limited by budget allotment	Completed	HBD, EED
Electronic Newsletter (Community Connections) (ad hoc)	Community	• Unable to measure community engagement	Completed	HBD, EED

Planned Activities / Intervention	Intervention Type	Barriers	Completion Status	Measure
VSP Data Share	HN	• No requirement for sharing of eye exam results from VSP providers to CalOptima Health member PCPs for continuity of care. • No way to ensure this is executed on the side of VSP due to VSP providers often lacking electronic medical records or PCP information. • Lack of medical release forms requesting the sharing of exam results directly to PCPs. • Lack of data sharing between VSP specialist and PCP due to contract restrictions between CalOptima Health and VSP provider network, prohibiting data share to any health network and only permitting sharing data with the health plan.	In Progress	EED

Results:

Diabetes Measures Figure 1: October HEDIS Rates MY2022–MY2023: Medi-Cal (MC) and OneCare (OC)



Claims/Encounters processed through October 2023

Quantitative Analysis:

A. Medi-Cal Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control > 9% (HBD): Figure 1 above compares CalOptima Health Medi-Cal HBD prospective rates for

October HEDIS MY2022–MY2023. The rates are based on the administrative data and represent the claims/encounters process through the month of October for each respective year. As of October 2023, the HBD prospective rate was 55.30%, which is higher than the October 2022 prospective rate of 53.98% by 1.32 percentage points.

B. Medi-Cal Eye Exam for Patients with Diabetes (EED): Figure 1 above compares CalOptima Health Medi-Cal EED prospective rates for October HEDIS MY2022–MY2023. The rates are based on the administrative data and represent the claims/encounters process through the month of October for each respective year. As of October 2023, the EED prospective rate was 46.13%, which is lower than the October 2022 prospective rate of 46.15% by 0.02 percentage points.
C. OneCare Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control > 9% (HBD): Figure 1 above compares CalOptima Health OneCare HBD prospective rates for October HEDIS MY2022-MY2023. The rates are based on the administrative data and represent the claims/encounters process through the month of October for each respective year. As of October 2023, the HBD prospective rate was 41.49%, which is lower than the October 2022 prospective rate of 44.17% by 2.68 percentage points.
D. OneCare Eye Exam for Patients with Diabetes (EED): Figure 1 above compares CalOptima Health OneCare HBD prospective rates for October HEDIS MY2022–MY2023. The rates are based on the administrative data and represent the claims/encounters process through the month of October for each respective year. As of October 2023, the EED prospective rate was 61.46%, which is higher than the October 2022 prospective rate of 59.67% by 1.79 percentage points.

Qualitative Analysis/Barriers:

A. HBD and EED:
    1. Member Health Reward (Member Incentive)
        a. Requires a signed/stamped attestation by the PCP or imaging center, which may prevent some members from participating in the health rewards.
        b. Promotion was limited to members or providers resulting in lower than expected member health reward participation.
        c. Limitations of Provider Attestation
            i. Incomplete Forms: A1C test reward forms regularly came back with the A1C value field empty, or it was clear members had filled out the form themselves with a blood sugar value reading instead of an A1C test value.
            ii. Incorrect Information: Many members received the forms in the mail and simply filled out their information and submitted without having the service done. Some of those submitted forms used old dates of service which do not qualify.
            iii. Members give the form to their doctor assuming the provider will submit the form to CalOptima Health. CalOptima Health often does not get those submissions.
        d. Members submit the form, but the date of service is not within the incentive timeframe.

e. A1C testing is usually done quarterly or as directed by a provider, this consistency may lead to member lab visit fatigue due to frequent lab visits for testing.

2. Text Messaging
    a. Member has a do-not-contact designation to not receive test messages.
    b. Incorrect cell phone number
    c. Missing or member does not have cell phone number
    d. Do not have verbal or written TCPA consent for text messaging
    e. Member has opted out of receiving text messages
3. Member Mailing
    a. Incorrect or incomplete addresses
    b. The member does not update address with SSA
    c. It is unknown which percentage of mail is returned due to wrong addresses
4. Telephonic Outreach
    a. Incorrect land line or cell phone number
    b. No answer
    c. Limited staff members conducting outreach
    d. Calls were initiated for year-end push may not give enough time to complete screening
5. VSP Eye Exam letter (EED only): In initial analysis, CalOptima Health found the following to be main barriers for the sharing of diabetic retinal eye exam results between specialist and PCP:
    a. No requirement for sharing of eye exam results from VSP providers to CalOptima Health member PCPs for continuity of care. Although VSP said that best practices of sharing exam results, especially when retinopathy is positive, are emphasized to VSP providers, there is no way to ensure this is executed on the side of VSP due to VSP providers often lacking electronic medical records or PCP information. Lack of medical release forms requesting the sharing of exam results directly to PCPs is one of the biggest barriers as to why providers do not exchange information.
    b. Lack of data sharing between VSP specialist and PCP due to contract restrictions between CalOptima Health and VSP provider network, prohibiting direct data share to any health network and only permitting sharing data via the health plan. A workaround was created for sharing files from VSP to Health Networks, but not all networks participated in the setup requirements for the data exchange.

Disparity Analysis:

A. Analysis Methodology: Disparity analysis was conducted for HBD and EED measures based on the HEDIS MY2022 top 10 race/ethnicity administrative data by denominator. This was then compared with HEDIS MY2021 top 10 race/ethnicity administrative data by denominator to observe any changes from the previous year.
B. Quantitative Analysis
    1. Medi-Cal HBD: When looking at the top three race/ethnicity groups by denominator count, the Hispanic group was first with a rate of 38.07%, increased by 8.36 percentage points from the previous year (29.71%), in second, the Vietnamese

group had a rate at 15.52%, decreased by 7.56 percentage points from the previous year (23.08%) and in third, the White group had a rate at 15.38% decreased by 17.38 percentage points from the previous year (32.76%).

2. OneCare HBD: When looking at the top three race/ethnicity groups by denominator count, the Hispanic group was first with a rate of 40.54%, increased by 4.48 percentage points from the previous year (36.06%), in second, the White group had a rate at 44.25%, increased by 17.89 percentage points from the previous year (26.36%) and in third, the Vietnamese group had a rate at 21.43% increased by 2.13 percentage points from the previous year (19.30%).
3. Medi-Cal EDD: When looking at the top three race/ethnicity groups by denominator count, the Hispanic group was first with a rate of 65.91%, decreased by 3.23 percentage points from the previous year (69.14%), in second, the Vietnamese group had a rate at 72.41%, increased by 7.79 percentage points from the previous year (64.62%) and in third, the White group had a rate at 55.77 increased by 7.49 percentage points from the previous year (48.28%).
4. OneCare EDD: When looking at the top three race/ethnicity groups by denominator count, the Hispanic group was first with a rate of 74.65%, decreased by 7.99 percentage points from the previous year (82.64%), in second, the White group had a rate at 61.96%, decreased by 11.16 percentage points from the previous year (73.12%) and in third, the group identified as Other had a rate at 76.92 increased by 2.73 percentage points from the previous year (74.19%).

Conclusion and Next Steps:

A. Health Rewards Program will continue for eligible CalOptima members for HBD and EED measures. We continue to focus on initiatives to increase participation in the program and motivate members to schedule and complete their screenings.
B. Creation of member initiatives that identifies members that have multiple gaps in care that can be closed in one visit to minimize member abrasion will continue to be an area of focus. Staff will also look into disparity analysis to target race/ethnicity groups that have the highest need.
C. Since HBD and EED perform well historically, CalOptima Health will continue and monitor both HBD and EED measures closely. HBD will be retiring as a MCAS measure. We will continue with having our members get their tests/labs done by conducting multicomponent interventions (mailers, live call outreach, automated calls and text messaging).
D. Will use disparity analysis to develop interventions to target higher risk members with health inequities caused by race/ethnicity.

5.3.2.2 Disease Management Program

Background: CalOptima Health Disease Management (DM) Program promotes self-management for members with low- and high-risk chronic conditions through comprehensive assessments, individualized telephonic health and nutritional coaching, and providing resources as needed. The DM Program meets the Basic PHM requirement as defined by the DHCS CalAIM PHM Program, and NCQA standards for Health Plan Accreditation.

Program Goal: The goal of the program is to increase effective self-management of chronic conditions through behavioral change. Through increasing positive disease management behaviors

such as medication compliance, self-monitoring, and trigger avoidance, the expected outcomes include reduced emergency visits and inpatient hospitalizations due to disease exacerbations, member empowerment to manage one's own health, and increased quality of life. In 2023, the DM Program focused on evaluating the member experience with services provided and planning a new program for chronic kidney disease.

Actions/Interventions:

Planned Activities	Description	Date of Completion
Member Satisfaction Survey	Annual survey to elicit feedback from DM members on program satisfaction.	• Survey completed November 2022 • Data analyzed January–March 2023
Develop Chronic Kidney Disease (CKD) Program	Develop CKD data dashboard to establish priorities for CKD Pilot Program	• Dashboard completed August 2023 • Pilot initiated November 2023

Results:

A. Member Satisfaction Survey
    1. Chronic Conditions team developed a nine-question mail satisfaction survey to obtain member experience with the DM program.
    2. Surveys sent to English and Spanish speaking members enrolled in DM program between January 1, 2022–October 1, 2022.
    3. A total of 1,100 surveys were mailed in November 2022 with 114 returned, resulting in a response rate of 10.36%.
    4. Each response was evaluated individually with a goal of 85% satisfaction indicated through member responses of Strongly Agree and Agree.

B. Develop Chronic Kidney Disease (CKD) Pilot Program
    1. Developed Tableau dashboard with data on CKD to identify health disparities and identify priority populations and potential strategies for interventions.
    2. Pilot launched in November 2023, and included Health Education coaching paired with nutritional support by assigned Registered Dietitian.
    3. Program target: Members 18+ with Stage or Stage 4 CKD, with two co-mobilities, not connected to nephrologist, and eGFR = 15-29
    4. The goal of the program is to connect member to nephrologist, coordinate healthcare needs, provide necessary referrals to resources, and identify health care gaps.

Quantitative Analysis:

A. Member Satisfaction Survey
    1. The 2022 response rate increased by 1.08% over the 2021 survey responses. All eight questions exceeded the threshold goal of 85% satisfaction. These survey results suggest that positive member interactions with their health coach may have contributed to overall satisfaction with CalOptima Health's DM programs. In addition, members have provided comments expressing how their health coach has enabled them to improve their chronic conditions.

Survey Question	2021 Satisfaction Rate	2022 Satisfaction Rate	Met Goal (Yes/No)
1. The information I received from my health coach while participating in the program helped me to better manage my health.	93.60% (N= 89)	96.50% (N=111)	Yes
2. My health coach helped me follow my doctor's recommendations.	93.50% (N=87)	99.10% (N=113)	Yes
3. I was included when making decisions about my care plan.	90.40% (N=85)	97.30% (N=110)	Yes
4. The information and resources I have received from my health coach have been useful.	93.40% (N=86)	95.60% (N=108)	Yes
5. My health coach helped me improve my relationship with my doctor.	74.50% (N=70)	85.80% (N=95)	Yes
6. My health coach helped me manage my health needs and concerns.	90.50% (N=86)	98.20% (N=101)	Yes
7. My health coach helped me meet my care plan goals.	89.50% (N=85)	87.6% (N=99)	Yes
8. I am satisfied with CalOptima's Health Management program.	94.70% (N=90)	91.20% (N=103)	Yes

B. Chronic Conditions Chronic Kidney Disease (CKD) Pilot Program
   1. The initial goals developed for the CKD pilot program included: development of CKD dashboard for data analysis to prioritize program focus, and an initial enrollment goal of 30 members to participate in the pilot program by February 2024.
   2. The CKD Dashboard development was completed in August 2023, and the CalOptima Health member population was analyzed by CKD stage, race, ethnicity, language, and engagement of health care provider (by PCP, nephrologist). Preliminary analysis revealed many CKD stage 3 and stage 4 members were not connected with nephrologist as recommended by the National Kidney Disease Kidney Disease Outcomes Quality Initiative (KDOQI) clinical practice guidelines. The pilot program will prioritize health and nutrition coaching interventions for members with stage 3 and stage 4 CKD and seek to address and understand barriers to provider engagement.
   3. The pilot program is currently in the enrollment stage. In 2024, the pilot program data will be evaluated, and results reported to medical management leadership.

Qualitative Analysis/Barriers:

A. Member Satisfaction Survey
   1. The rate for question #5, "My health coach helped me improve my relationship with my doctor" increased from 74.5% (2021) to 85.80% (2022), demonstrating the health coaches' efforts and effectiveness in assisting members to enhance their relationships with their provider at the point of care. To improve this measure, health coaches intentionally coached members on the importance of asking relevant questions to their providers. Health coaches also served as member advocates by communicating important information to the providers to improve member well-being.

2. In addition, the rate for question #6, “My health coach helped me manage my health needs and concerns” showed noticeable improvement, with the rate increasing from 90.5% to 98.20%. These results are supported by all the positive comments received from members. Another measure that improved is question #5, “I was included when making decisions about my care plan.” This rate increased from 90.4% to 97.30%, reflecting member satisfaction in being actively involved in decisions made related to their care.
3. Overall, improvements are likely a result of health coaches taking a more proactive approach in member care. Another reason for outcome improvements is likely due to intentional enhancements to member care management efforts by health coaches. This includes process standardization, following best practices, ongoing training to improve skills and team adaptation. Health coaches have also refined member care management methods, which has enabled them to better serve and meet the needs of our members.

B. Chronic Kidney Disease Program
    1. As the CKD pilot program is in the beginning launch stage, barriers and qualitative evaluation will happen in 2024.

Conclusion and Next Steps:

A. Member Satisfaction Survey
    1. While goals were met, Chronic Conditions leadership will focus on the following areas:
        a. Offer surveys through a variety of channels to increase response rate
        b. Enhance health coach skills and engagement techniques through continual training opportunities
        c. Enhance health coach communication with members regarding their care plan, self-advocacy and progress toward meeting goals
B. Chronic Kidney Disease Program
    1. The Chronic Conditions team will refine the pilot program as data is captured during the initial phase. Data and program evaluation will occur in 2024 at the end of the initial pilot stage. Program evaluation will be evaluated on the effectiveness of behavior change evidenced through provider engagement and behavior change. At the end of the pilot program, the results will be evaluated to determine expansion, additional refinement, or program termination.

5.3.2.3 CalOptima Health Community Network Latino Members Pilot

Background and Goals: Diabetes is a complex disease that involves multi-organ systems that requires a comprehensive effort by a member’s care team. The CalOptima Health Diabetes Care Program was initially planned as a 12-month pilot program to support PCP offices with managing eligible members of the Medi-Cal CCN adult Latino members (≥ 21 years old) with uncontrolled diabetes (i.e., A1c level ≥8). The goals were to implement a multidisciplinary approach to improving diabetes care by lowering HbA1c levels to avoid complications and improving member and provider satisfaction. The final pilot program design consisted of strategies such as:

A. CalOptima Health Pharmacist interventions
B. Support from CalOptima Health Population Health Management Health Educators, Health Coaches and Registered Dietitians

C. PCP engagement

The project initiatives included finalizing the member stratification list to identify eligible members and their PCPs, then making outreach attempts to high-volume PCPs through various marketing and communication strategies, and finally launching the pilot program in Q3 2023.

Barriers/Conclusions and Next Steps: Although the pilot program received interest from one provider, due to the overall lack of provider engagement, CalOptima Health's senior leadership decided that it was in our best interest to sunset this pilot project and re-strategize future efforts. To ensure the continued support of the interested CCN provider, we provided additional suggestions and resources to their team via email but have not heard back since.

5.4 Population Health Management

5.4.1 Population Overview

As different populations may have different needs, challenges and opportunities, CalOptima Health's population is also unique and has needs that must be considered when developing a PHM Strategy to improve the health of the entire population. CalOptima Health's member population is comprised of members with a range of demographic characteristics. The tables below summarize key demographic factors that are used, along with other member needs data, to develop a PHM Strategy with an approach aimed at improving the health of the entire population.

MEMBERSHIP DATA* (AS OF NOVEMBER 30, 2023)

Total CalOptima Health Membership	Program	Members
963,968	Medi-Cal	945,874
	OneCare (HMO D-SNP)	17,648
	Program of All -Inclusive Care for the Elderly (PACE)	446

**Based on unaudited financial report and includes prior period adjustment*

Membership Demographics (as of NOVEMBER 30, 2023)

Member Age

0 to 5	8%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65+	13%

Language Preference

English	58%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category

Temporary Assistance for Needy Families	39%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

5.4.2 Population Health Management (PHM) Strategy with Population Need Assessment (PNA)

Background: The DHCS launched the PHM Program, which is a cornerstone of CalAIM. Participation in the PHM Program requires MCPs to submit a PHM Strategy deliverable on an annual basis starting in 2023. The purpose of this yearly deliverable is for MCPs to show that they are meaningfully responding to the needs of the community as well as providing other updates on the PHM Program to inform DHCS' monitoring efforts.

For 2023, the PHM Strategy deliverable is intended to ensure that PHM Standards outlined in the NCQA Health Plan accreditation are being met. Additionally, MCPs should collaborate with their Local Health Department(s) (LHD) to identify mutual priorities within the LHD's community health assessments (CHA) and community health improvement plans (CHIP) process and develop shared goals and specific, measurable, attainable, realistic, and time-bound (SMART) objectives that will promote further alignment. The 2023 PHM Strategy deliverable will also serve as a precursor to future annual PHM Strategy Deliverable submissions (2024 and beyond).

Goals and Objectives:

A. Conduct an annual Population Needs Assessment (PNA) to review of the characteristics and needs of our organization's member population and relevant focus populations to support data-driven planning and decision-making as well as to meet regulatory and accreditation requirements.
B. Outline CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care.
C. Timely submission of PHM Strategy Deliverables to DHCS.
D. Adopt DHCS' new KPI as baselines for measuring the CalAIM PHM Program, and timely report these KPIs to DHCS Actions/Interventions

Planned Activities	Description	Date of Completion
Population Needs Assessment (PNA)	• Update and submit the PNA to DHCS in October 2023 • Participate in the Orange County Health Care Agency's Community Health Assessment sessions	July–October 2023
Develop PHM Strategy in accordance with NCQA and DHCS standards	Modify the PHM Strategy to include a workplan and submit to DHCS as part of the CalAIM PHM Program	October 2023
Submit PHM KPIs to DHCS	Track, validate and submit PHM KPI data to DHCS to comply with regulatory requirements for the PHM Program and to establish a baseline for measuring the CalAIM PHM Program.	August–November 2023

Results:

Planned Activities	Description	Date of Completion
Population Needs Assessment (PNA)	• The 2023 PNA reporting format was revised to include member data on culture and linguistic services, quality improvement efforts according to member race and ethnicity and health education programs/services. • PNA content was validated by stakeholders. • PHM leadership reviewed and approved PNA. • NCQA-HP consultant reviewed PNA. • The PNA was updated and submitted to DHCS in October 2023.	Q1-Q3, 2023
PHM Workplan	• CalOptima Health PHM department met with stakeholders to determine programs/services for each focus area. • CalOptima Health PHM department co-developed program/service SMART objectives with stakeholders. • PHM Workplan was approved QIHEC • CalOptima Health PHM department met with stakeholders to document progress on goals and member activities to support programs/services.	Q3-Q4, 2023
PHM Strategy Deliverables	• Pulled data on the five new PHM KPIs and submitted to DHCS in August and November 2023. • CalOptima Health established collaborative workgroup with Orange County Health Care Agency (OCHCA). • CalOptima Health submitted 2023 MCP PHM Strategy DHCS Deliverable in October 2023. • CalOptima Health and OCHCA approved focus areas for collaboration and began to co-design goals and SMART objectives focused on children and pregnant/postpartum members.	Q3-Q4, 2023

The table below describes the PHM KPIs, the CalOptima Health rate, and how CalOptima Health ranked in a cohort of 25 MCPs. DHCS provided plans with this information based on the first submission on August 15, 2023.

KPI	PHM Monitoring Categories	Measure	CalOptima Health Rate	Statewide Average Rate	CalOptima Health Rank Among MCPs
1	Basic PHM: Emergency Department Care	% of members who had more ED visits than primary care visits within 12-month period	6%	10%	6th out of 25
2	Basic PHM: Primary Care	% of members who had a primary care visit with their assigned PCP within the past 12 months	56%	47%	8th out of 25
3	Basic PHM: Ambulatory Care	% of members with no ambulatory visit claims within the past 12 months	38%	40%	12th out of 25
4	Complex Care Management	% of members eligible for CCM who are successfully enrolled in the CCM program	70%	26%	4th out of 25

KPI	PHM Monitoring Categories	Measure	CalOptima Health Rate	Statewide Average Rate	CalOptima Health Rank Among MCPs
5	Transitional Care Services	% of transitions for high-risk members that had at least one interaction with their assigned care manager within 7-days post discharge	25%	12%	3rd out of 25

Quantitative Analysis:

A. While the data is only based on the first submission, CalOptima Health is ranked in the top 10 for five of the six measures.
B. Basic PHM for Ambulatory Care is ranked 12th out of 25 health plans and only outperforms a little more than half of the health plans.
C. Complex Care Management and Transitional Care Services are performing well, as they are ranked fourth and third, respectively.

Qualitative Analysis:

CalOptima Health successfully met all goals and objectives to develop PNA, PHM Work Plan, PHM Strategy Deliverables and PHM KPIs.

A. Factors that drove improvement:
    1. Increased commitment in support of PHM efforts from CalOptima Health internal and external stakeholders.
    2. Enhancements to workflows and reporting process.
    3. Staying up to date and sharing regulatory guidance with stakeholders.
B. Challenges:
    1. Keeping abreast of the frequent changes to regulatory guidance.
    2. Data limitations to explore impact and address health disparities.

Conclusion and Next Steps:

In 2023, we met all DHCS and regulatory deliverables. In 2024, the PHM program will continue to focus on addressing health inequities and meeting member's social needs. PHM identified the following opportunities to enhance PNA, PHM Work Plan, PHM Strategy Deliverables and PHM KPIs efforts:

A. Improving screening for member social needs and connections to resources through an integrated closed-loop referral platform.
B. Enhancing and/or developing interventions and programs in response to needs identified in the PNA.
C. Develop a KPI dashboard for easier tracking and regulatory reporting of PHM Program.
D. Develop workplan and collaborative approach with the Health Care Agency to work on DHCS's Bold Goals.

5.4.3 Initial Health Appointment (IHA)

Background: In July 2022, the DHCS released the PHM Strategy and Roadmap, which mandates MCPs to ensure that network providers are held responsible for routine screening and assessment

during a member's initial meeting with an assigned PCP. This is to be carried out through a distinct process known as the Initial Health Appointment (IHA). The IHA is specifically defined as appointment(s) that must be completed within 120 days of MCP enrollment for new members. It encompasses gathering the member's physical and behavioral health history, identifying risks, assessing the need for preventive screenings or services and health education, as well as establishing a diagnosis and treatment plan for any identified diseases. Additionally, DHCS monitors quality measures as part of PHM Program to include basic PHM monitoring (emergency department care, primary care, and ambulatory care visits).

Program Goal: The goal of the program is to strengthen primary care and promote prevention and wellness for new CalOptima Health members. DHCS will be measuring primary care visits as a proxy for the IHA as of January 2023. Therefore, primary efforts were made to increase overall IHA completion rates. To reach this goal the following initiatives were arranged:

A. Increased HN and provider communications, trainings and resources
B. Developing procedures and oversight of the IHA process
C. Increase member outreach efforts

Actions/Interventions:

Planned Activities	Description	Date of Completion
HN and Provider Communications, Trainings, and Resources	1. Joint Operation Meetings (JOM) Presentations: JOM ongoing monthly presentations are provided to all 12 health networks in efforts to offer IHA updates, performance, and reminders.	1. 01/2023-12/2023 (Qtr. 1-4, 2023)
	2. CCN Virtual Learn: Ongoing quarterly presentations provided to CCN to offer IHA updates, performance, and reminders.	2. 06/2023-12/2023 (Qtr. 2-4, 2023)
	3. Provider Newsletter	3. 01/2023 (Qtr. 1, 2023), 02/2023 (Qtr. 1, 2023), 06/2023 (Qtr. 2, 2023), 12/2023 (Qtr. 4, 2023)
	4. Health Network Newsletter	4. 01/2023 (Qtr. 1, 2023), 02/2023 (Qtr. 1, 2023), 06/2023 (Qtr. 2, 2023), 12/2023 (Qtr. 4, 2023)
	5. Provider Onboarding: Training provided to all new CCN contracted providers.	5. 09/2023 (Qtr. 3, 2023)
	6. Provider Annual Training: Yearly training for CCN contracted providers to discuss updates and ongoing education.	6. 09/2023 (Qtr. 3, 2023)
	7. IHA Reference Guide for PCPs: A guide for PCPs to complete the IHA within the first 120 days from the member's enrollment date with CalOptima Health.	7. 04/2023 (Qtr. 2, 2023), 11/202 (Qtr. 4, 2023)

Planned Activities	Description	Date of Completion
CME/CE IHA Training	This course discusses IHA updates, pediatric and adult requirements, and current preventive services and screening requirements.	07/12/2023 (Qtr. 3, 2023)
IHA Chart Review Audit (CCN only)	1. Research and gathered collaborative feedback from internal departments for the development of the IHA chart review process. 2. Develop Chart Review Timeline and retrieve sample population for Chart Review preparation. 3. Develop IHA Chart Review Audit Tool, Closure Letters and Email Templates. 4. Launched and carryout pilot phase of chart review.	1. 06/2023- 8/2023 (Qtr. 2-3, 2023) 2. 07/2023 (Qtr. 3, 2023) 3. 08/2023-12/2023 (Qtr. 3-4, 2023) 4. 08/2023- 12/2023 (Qtr. 3-4, 2023)
IHA Report Methodology Updates	1. Update reports CC0163 and CC0163B to remove the Staying Healthy Assessment (SHA) requirement. 2. Update reports CC0163 and CC0163B with CPT Codes that have been validated by the coding department and remove specialists from being able to receive credit for IHA completion. 3. Add CODMEDA members to reports CC0163 and CC0163B. 4. Update Provider Taxonomy to only include approved PCP provider types on reports CC0163 and CC0163B (Internal medicine, Pediatrics, Obstetrics/gynecology, Family practice, Perinatal care providers, Nurse practitioners, physician assistants and PCPs in training). 5. Update report CC0163B to include additional information that is found on the data universe to merge alignment. 6. Add retro members and date to report CC00163B. 7. Add IHA completed status to report CC00163 per request by Health Networks. 8. Update Procedure Codes that give IHA completion credit to only primary office visit type codes.	1. 02/2023 (Qtr. 1, 2023) 2. 03/2023 (Qtr. 1, 2023) 3. 07/2023 (Qtr. 3, 2023) 4. 07/2023 (Qtr. 3, 2023) 5. 10/2023 (Qtr. 4, 2023) 6. 10/2023 (Qtr. 4, 2023) 7. 11/2023 (Qtr. 4, 2023) 8. 11/2023 (Qtr. 4, 2023)

Planned Activities	Description	Date of Completion
Member Outreach Efforts	1. New Member Packet/IHA Flyer: As a new CalOptima member, you will get a "Welcome to CalOptima" package in the mail which includes the IHA Flyer. 2. Spring Medi-Cal Newsletter 3. Fall Medi-Cal Newsletter 4. IHA Member Outreach Script: Talking point for member facing staff regarding the importance of IHA completion within a member's 120 days of enrollment. 5. IVR Campaign: Campaign efforts are ongoing monthly to reach all CalOptima Health members of the importance of their IHA visit.	1. 05/2023 (Qtr. 2, 2023) 2. 04/2023 (Qtr. 2, 2023) 3. 09/2023 (Qtr. 3, 2023) 4. 09/2023 (Qtr. 3, 2023) 5. 05/2023-12/2023 (Qtr. 2-4, 2023)

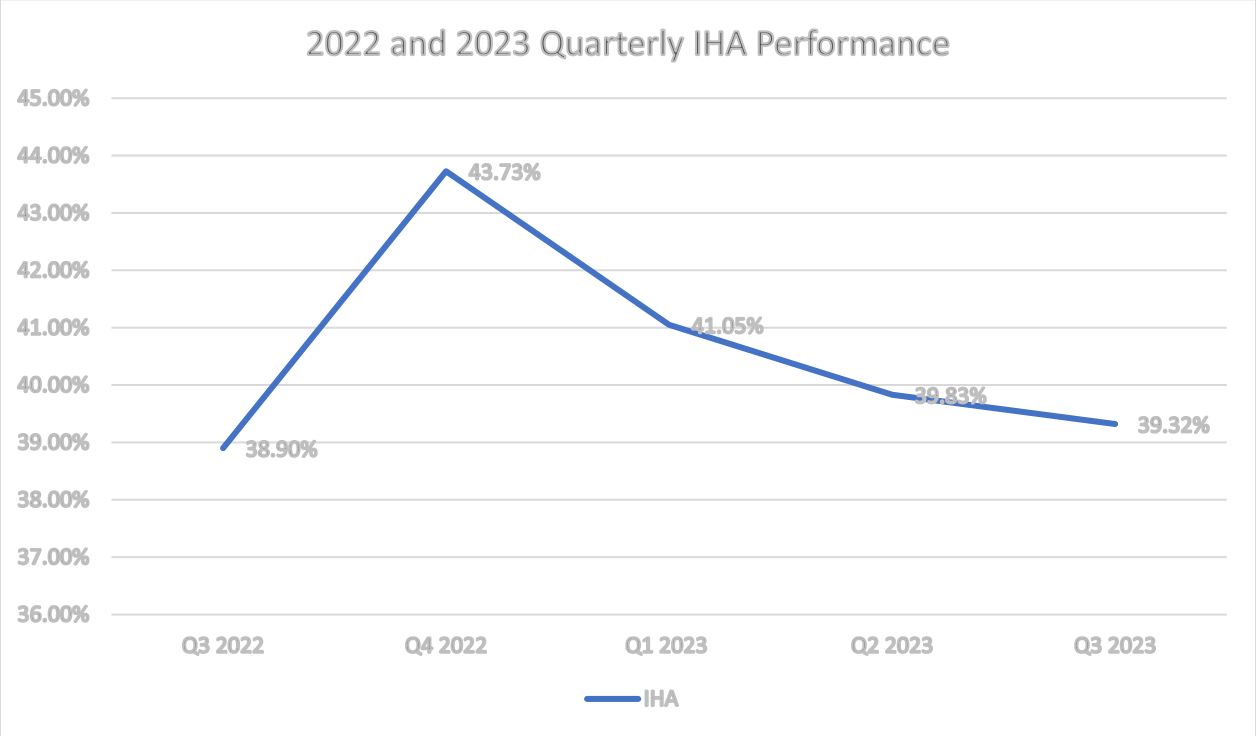
Results:

The following charts provide insight into IHA accomplishments by intervention and activity.

Planned Activities	Description	Date of Completion
Assessment and Interventions	• Staff presented at IHA provider and delegate trainings; JOM quarterly per HN, CCN Virtual Meeting quarterly, HN Forum semi-annually, QIHEC quarterly, CME/CE on IHA annually.	Q1, 2023
IHA Report Methodology Updates	• Multiple tickets were created throughout the year to update IHA reports CC00163 and CC00163B to ensure data and reporting accuracy. • Initial updates were made based on the new APL 22-030 which superseded all previous plan letters regarding IHA and no longer required the SHA to be completed as a requirement. Furthermore, after meeting with Coding and Claims additional codes were added to the report for IHA completion and specialists were removed from being able to receive credit for IHA completion. Provider taxonomy type was later further updated to align with DHCS definition of PCP type. In preparation for the upcoming year's audit, additional columns were added to align with the data universe on report CC00163B. Based on feedback from Health Networks, a change was made to report CC00163 to add member information regarding completed IHAs. After further discussion, another update was made to add retrospective members and date to report CC00163B. Lastly, after staff validation of report logic, further updates were made to ensure that credit for completed IHA visit is only captured when a valid office visit code is submitted.	Q1-Q4, 2023

Planned Activities	Description	Date of Completion
IHA IVR Campaign	• IVR for enhanced patient outreach and access to IHA information. • IVR campaigns are for all new members. This campaign fulfills both IHA outreach as well as HIF/MET outreach. • Initial IVR released on May 30, 2023. Staff scheduled to send an IVR message for June 2023. Beginning July 2023 IVRs are scheduled for the 3rd and 24th of each month.	Q1-Q2, 2023
IHA Chart Review Pilot	• Chart audits are conducted to ensure that the IHA is being properly documented in the members' medical records and for report validation. • Research conducted by reaching out to other managed care plans. • Collaborative discussions with Quality Initiatives to plan chart review audit process and Provider Relations to plan provider communication. • Established data sample for IHA Chart Review Audit by utilizing IHA reports CC0163B and conducted random sample of adult and pediatric populations identified as fully met and not met. • Outreach to provider to request for patient records.	Q3-Q4, 2023

Results:



Quantitative Analysis:

Quarter 1, 2023: Figure 1 demonstrates a 2.68% decrease from Q4 2022 (43.73%) to Q1 2023 (41.05%) in IHA completion due to the first cycle of methodology updates to IHA reports CC0163 and CC0163B. This time period marks methodological updates of the removal of SHA for IHA completion per APL 22-030.

Quarter 2, 2023: Q1 2023 (41.05%) to Q2 2023 (39.83%) in Figure 1 demonstrates a 1.22% decrease in IHA completion as the result of the second cycle of IHA report methodology updates to CC0163 and CC0163B to guarantee only primary CPT codes, including qualifying telehealth visits were being given credit for IHA completion.

Quarter 3, 2023: Q2 2023 (39.83%) to Q3 2023 (39.32%) in Figure 1 shows a .51% decrease in IHA completion due to the third cycle of methodology updates to IHA reports CC0163 and CC0163B. The report methodology updates ensured only PCP including (Internal medicine, pediatrics, obstetrics/gynecology, family practice, perinatal care providers, nurse practitioners, physician assistants and PCPs in training) were being credited for IHA completion.

Qualitative Analysis/Barriers:

A. When All Plan Letter (APL) 22-030 was issued, it superseded all previous APLs regarding the IHA process and changed the IHA requirements. This change created a need to train delegates and providers on new IHA requirements and processes.
B. A change in leadership resulted in the lack of historical knowledge regarding IHA processes that were already implemented.
C. There was a lack of oversight of the IHA process by designated staff.

Conclusion and Next Steps:

CalOptima Health's 2023 IHA efforts encompassed building out internal processes, IHA oversight, enhancing data report methodologies and the development of provider and health network resources. The overall IHA performance and individual health network performance rates have exceeded the previously established benchmark of 17%. In December 2023 staff established a new IHA performance benchmark of 50%, representing a stretch goal of at least double the current standard. CalOptima staff anticipates that IHA completion rates will continue to increase with regular provider training and updates.

In 2024 staff will continue to focus on member, provider education and IHA monitoring as follows:

A. Implement quarterly IHA chart review process to ensure member care and IHA requirements are being met.
B. Increase member outreach by IVRs and include member text reminders to ensure CalOptima Health is providing outreach support to all new members regarding the importance of completing the IHA in a timely manner.
C. Leverage MCAS/HEDIS measures specific to infant and child/adolescent well-being visits as well as adult preventive visits as a proxy for IHA completion.

5.4.4 Health Equity

Background: In 2022, the CalOptima Health Board of Directors approved five strategic priorities to guide and support planning and development of programs and interventions to ensure members are served with excellence and dignity, respecting the values and needs of each person. Among these strategic priorities is the Overcoming Health Disparities priority that focuses on members and communities impacted by inequities. Additionally, CalOptima Health is committed to annually assessing members' social determinants of health. This commitment aligns with the DHCS PHM Program which emphasizes the importance of coupling quality and health equity efforts with prevention.

Program Goal(s): The Health Equity intervention within the PHM department is focused on increasing member screening and access to resources that support the social determinants of health. The activities described in Section 3. Actions and Interventions were intended to support ongoing efforts to:

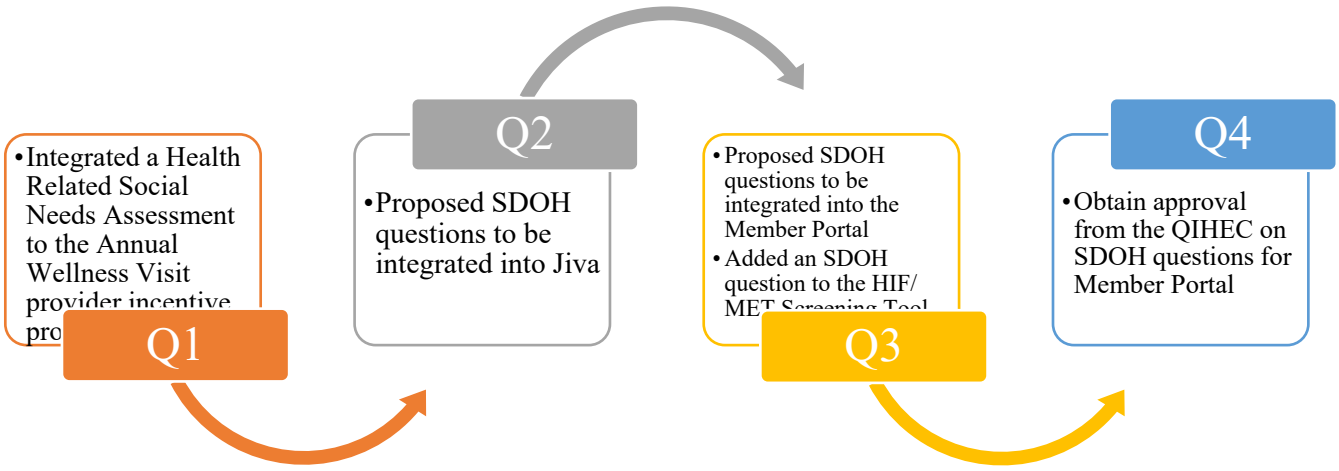
A. Increase members screened for social needs.
B. Implement a closed-loop referral system with resources to meet members' social needs.
C. Implement an organizational health literacy (Health Literacy for Equity (HL4E)) program.

Actions/Interventions:

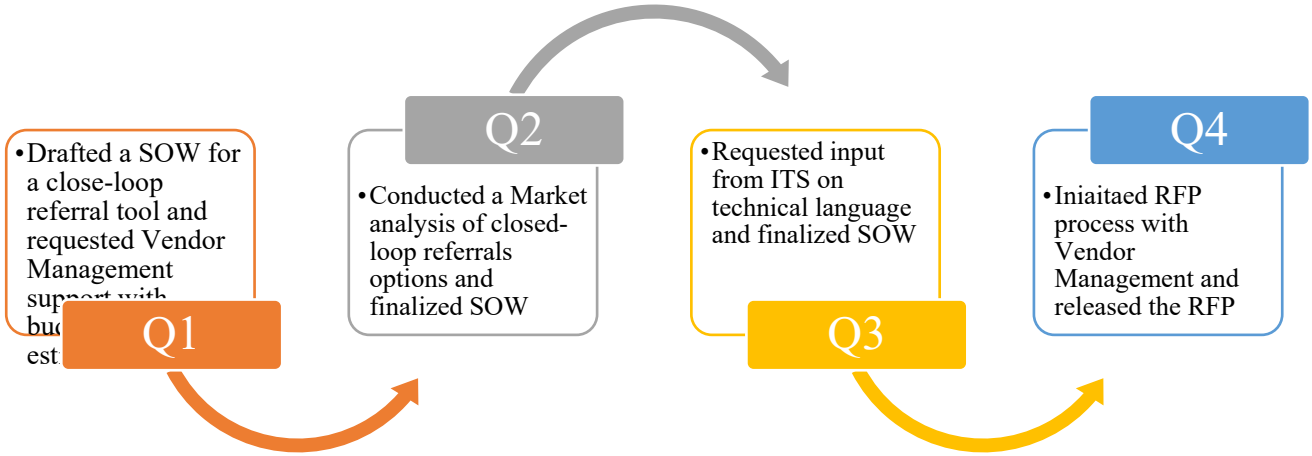
Planned Activities	Description	Date of Completion
Social Determinants of Health (SDOH) Screening	• Add a health-related social needs (HRSN) question to the Annual Wellness Visit (AWV) Provider Incentive • Propose SDOH Screening questions for integration into the HIF/MET, Jiva and Member Portal	Q1 2023 In Progress
Closed-Loop Referral	• Support process for the adoption of a Close-Loop Referral platform to assist members in navigation, provider referrals, and coordination of health and services across health care delivery systems and community-based organizations	RFP released Q4 2023 In progress
Health Literacy for Equity (HL4E) Program	• Launch the Health Literacy for Equity (HL4E) program in collaboration with the Orange County Health Care Agency, Social Services Agency, St. Jude's Neighborhood Clinic and the Institute for Healthcare Advancement (IHA)	Program Launched Q1 2023 In Progress

Accomplishments/Results:

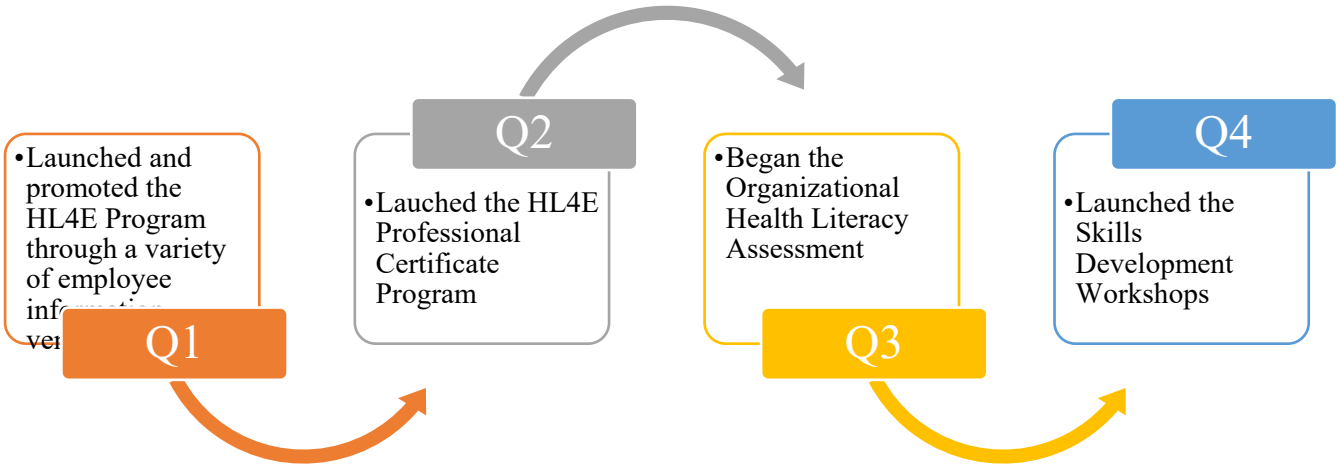
SDOC Screening



Closed-Loop Referral



HL4E Program



Quantitative Analysis:

A. SDOH Screening

1. The goal for the SDOH Screening intervention was to increase members screened for social needs. At the provider level, the primary focus of the intervention was to encourage provider utilization of SDOH Z-codes. At the member level, the focus was to develop a screening tool to streamline assessment of members across the organization. The provider incentive intervention was implemented and is currently being assessed for impact. The SDOH Screening for Jiva and the Member portal is being developed and expected to be fully implemented in 2024.
2. SDOH Screening Question for AWV Provider Incentive: This objective was met through the Medi-Cal AWV program which added and incentive for qualified providers effective April 1, 2023, for providing a comprehensive annual wellness visit, reporting confirmed condition diagnosis codes, capturing SDOH factors and properly documenting such information in Medical Records.
3. Staff are currently analyzing the impact of the AWV incentive program to determine if utilization rates increased as well as to assess if screening of members increased.
4. Propose SDOH Questions for Jiva: This objective was met. Staff researched industry standard SDOH questions and tools used across health plans and made

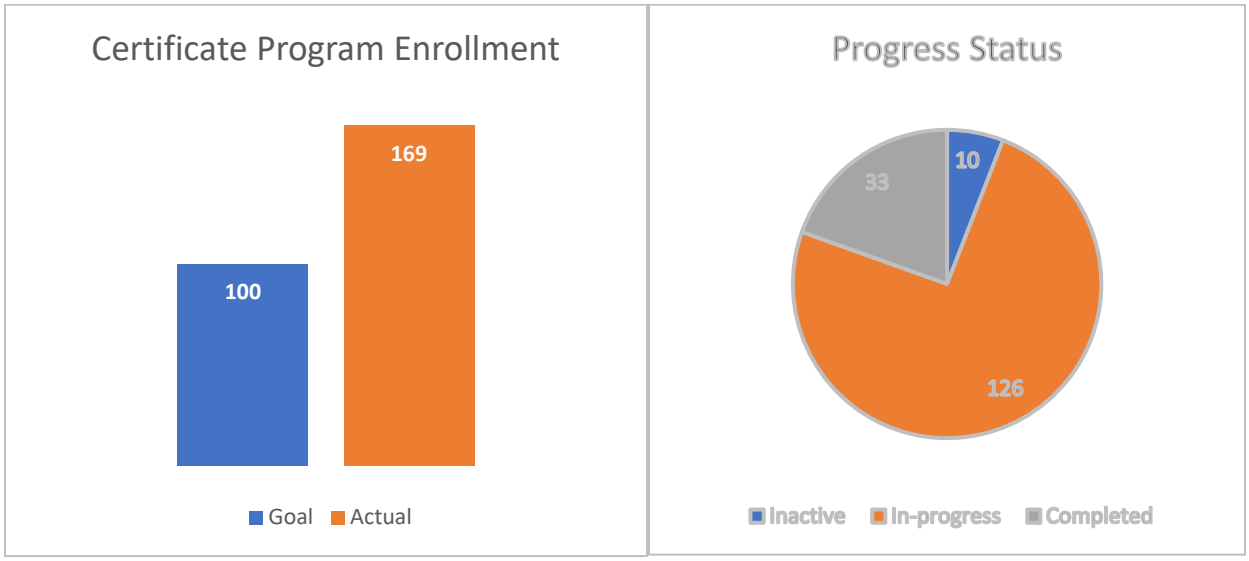
recommendations for these questions to be built as part of the PHM Population Characteristics Report in Jiva. No quantitative data resulted from this intervention. Upon implementation in 2024, analysis will be conducted to best align screening questions across member touch points.

5. Propose SDOH Questions for Member Portal: This objective was met. A literature review was conducted to identify SDOH screening questions/tools being used across health plans. Upon review by medical management and the chief health equity officer, a list of eight questions representative of four different SDOH domains was presented to the QIHEC approval. The approved questions are currently under Member Material Review and translation to then be built into the member portal as an instrument for members to self-screened. No quantitative data resulted from this intervention.

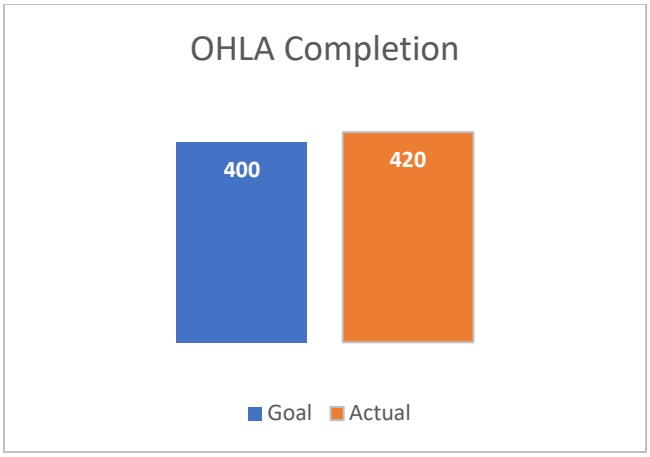
B. Closed-Loop Referral
    1. The goal of the Closed-Loop Referral is to be able to assist members in navigation, provider referrals, and coordination of health and services across health care delivery systems and community-based organizations. Efforts to accomplish this goal are underway.
    2. Market analysis was conducted, a collaborative workgroup was formed to draft a scope of work and Vendor Management department was engaged to initiate process for releasing an RFP. CalOptima Health is on target for meeting this regulatory requirement ahead of the January 2025 implementation due date. No quantitative data resulted from this intervention. Upon implementation in 2024, analysis will be conducted to determine the impact of this intervention.

C. HL4E Program
    1. The goal of the program is to partner with other systems in Orange County to increase organizational health literacy through a variety of activities including the following:
        a. Awareness and Education. IHA created two awareness-raising videos about the importance of health literacy. The introductory video was a short 5 minutes and the "Health Literacy 101" video had two different versions—an initial 47-minute video was later replaced with a refined 33-minute video. An email from CMO Dr. Richard Pitts included links to these videos, as well as multiple e-newsletter announcements about the HL4E program. These videos were intended to be viewed by as broad of an audience as possible. As of November 27, 2023, the introductory video has 530 views and the Health Literacy 101 video has 254 views.
            i. Another key piece of raising awareness was promotion and support from CEO Michael Hunn, who recorded a "Better. Together. Moment" video that was sent out to all staff. In this video, he spoke to the importance of improving organizational health literacy for improved communication and health outcomes.
        b. Health Literacy Specialist Certificate. The Certificate Program is a rigorous program that provides deep learning for enrollees on health literacy principles. It is comprised of seven "micro-credentials": Organizational Systems and Policies; Communications; Education; Public Health; Ethics; and Language Culture and Diversity. The program was estimated to take 55–80 hours to complete. The original goal was to have a total of 100

enrollees, which we surpassed with 169 total enrollees. As of November 27, 2023, 11 students never registered, bringing the active number of enrollees to 158. Of these, 22% have completed the entire program. The completion goal is 100% by the end of April 2024.

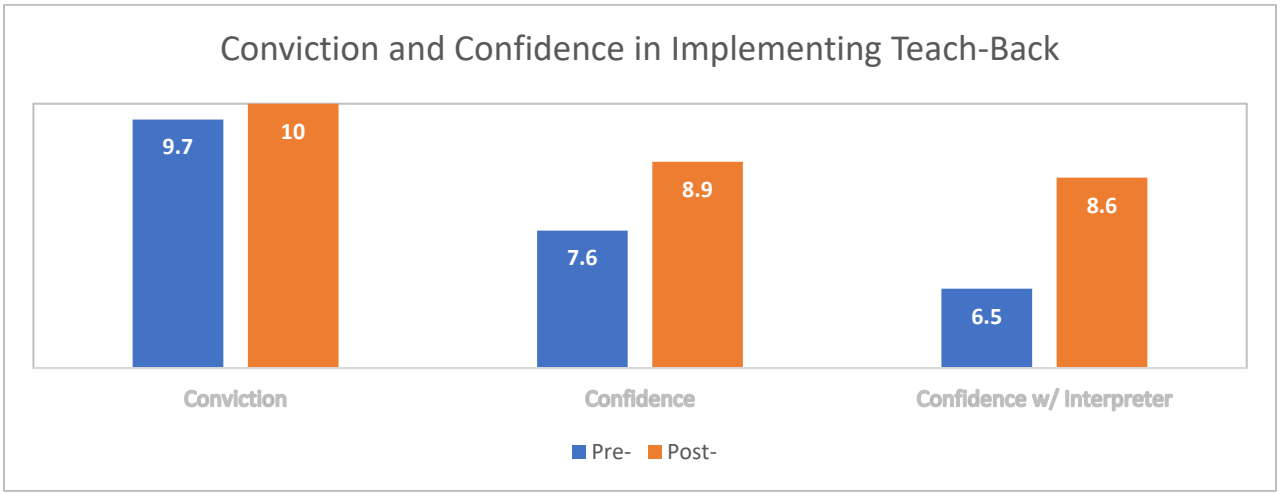


c. Organizational Health Literacy Assessment (OHLA). This assessment is part of a comprehensive review of CalOptima Health's organizational health literacy, conducted by IHA's Chief Policy and Research Officer, Marian Ryan, Ph.D. The assessment includes a scan of CalOptima Health's external communications for members including website and publicly accessible information as well as a comprehensive survey administered by IHA to CalOptima Health staff. The original goal for survey completion was 400, and we exceeded this with 420 completed assessments. Final results of the assessment will be provided to CalOptima Health once analysis is complete.



d. Skills Workshops. As part of deepening the organizational health literacy and creating sustainable knowledge base, IHA is offering skills workshops to Health Literacy Specialist Certificate enrollees. The first in a series of workshops was held on November 16, 2023, and was focused on the Teach-Back Method of member education. The goal for this workshop was to have

12 attendees, which we exceeded by seven attendees. IHA conducted a pre- and post-test to evaluate three measures: confidence implementing Teach-Back, confidence implementing Teach-Back with an interpreter, and conviction of implementing Teach-Back. In the table below, there are improvements in each measure. The goal set forth was to increase each measure by 10%. This was exceeded on each measure except Conviction, as the baseline score was already high enough that the greatest improvement possible was less than 10%.



Qualitative Analysis and Barriers:

A. SDOH Screening
   1. SDOH Screening Question for AWV Provider Incentive
      a. The AWV Incentive program was newly implemented in April 2023 and the ending data is not yet available to determine the impact of the intervention.
      b. SDOH Z-code utilizations is not reflective of the number of members being screened as not every screening will result in an SDOH Z-code.
   2. Propose SDOH Questions for Jiva
      a. Staffing constraints due to workload impact and other competing priorities.
      b. Streamlining screening questions and assessments across the organization and collaboration with other departments created dependencies and delays to move at a faster pace.
      c. Not having appropriate resources to address identified needs that may result from the assessment created limits on the type of questions SDOH domains that could be asked.
      d. Not having a closed-loop referral in place to ensure members receive the appropriate referrals to needed services outside of CalOptima Health's scope, created limits on the questions that could be asked.
   3. Propose SDOH Questions for Member Portal
      a. Same barriers as the SDOH question for Jiva
      b. Limiting the questions based on existing interventions
      c. Adopting validated questions intended for in-person or telephonic modality to self-reporting questions and ensuring fidelity of validated questions.
B. Closed-Loop Referral

1. Not sufficient knowledge of industry standards for closed-loop referrals systems. This was mitigated through a market analysis conducted to understand Closed-Loop Referral systems' capabilities
2. Not sufficient technical language within PHM department staff to draft an adequate scope of work. This was quickly mitigated with ITS support to ensure technical language requirements were included in the Scope of Work

C. HL4E Program
    1. In implementation of the HL4E program, there were many successes. Staff were very dedicated to the work, as they see the need for improving the organizational health literacy at CalOptima Health to meet the needs of members with a diverse set of health literacy needs. Our largest barrier arose with enrollees in the Health Literacy Specialist Certificate program given the rigor of the program which required about 40–60 dedicated hours for coursework and exams. Despite this, many participants were still eager to complete the program. There was inconsistency in direction as to whether staff were able to work on the coursework while on the clock, which meant staff often had to participate in their personal time or disenroll altogether. Following are staff testimonials to the importance of this program:
        a. *Knowledge is power, and the Health Literacy Program is a beautiful opportunity for health equity promotion. I deeply appreciate this opportunity for myself as well as my team.*
        b. *My eyes were really opened to the difficulty that so many people have with the health care system. I always knew this, but I think the certificate program did a good job at framing how detrimental it can be when a person does not understand things such as a procedure or medication.*
        c. *When I started the program, I was not sure of the impact to my job since I do Compliance and Policies and Procedures, but it had a great impact on me to realign the reason I do what I do. Our P&P documents are for health networks, providers and members so they need to be looked at with health literacy lens, so these trainings have been helpful in that regard. I brought back some of my takeaways to my team to give them some insight into the program as well.*

Conclusion and Next Steps:

A. SDOH Screening
    1. With the implementation of the AWV incentive program, the integration of the SDOH Assessment in Jiva and the self-reported SDOH assessment in the member portal, we expect to see an increase in members being screened for social needs. The following steps are needed to determine impact:
        a. Analyze SDOH Z-codes utilization data post implementation of the AWV Provider Incentive Program
        b. Finalize the integration of SDOH screening to Jiva
        c. Train staff on SDOH Assessment Intake
        d. Build out the SDOH assessment into the member portal
        e. Ensure the interventions are in place to support members based on need identified through the assessment

B. Closed-Loop Referral
    1. With the adoption of a Closed-Loop Referral, we anticipate seeing an increase in connecting members to a broader range of social services base on needs and

preferences identified through the SDOH screening and self-identified by members. Additionally, we anticipate an increase in collaborative partnerships among community-based organizations that assist members with social risks factors and community supports. The following steps are needed for successful integration of a Closed Loop Referral system.

a. Complete the RFP process
b. Bring proposal to Board of Directors for approval of vendor
c. Integrate the CLR into CalOptima Health's Care Management systems and member portal
d. Onboarding training for staff and community partners
e. Full implementation by January 2025

C. HL4E Program

1. While the program is still in progress, there is promising evidence of the positive impact the program is having on staff ability to implement and sustain health literacy principles throughout the organization. One of the best achievements in sustainability and accountability in this work comes from our PACE Clinic staff. Staff created an internal Health Literacy Super Heros team, which will lead efforts to sustain their work to improve organizational health literacy over time. They have had a dedicated core group going through the certificate program and a strong presence in the workshop. They are also incorporating health literacy into their internal training. This is an ideal state for sustainability, and our partners at the IHA have shared this as a model practice among other partners.
2. While we are on track to meet our December goals, there will be a continued push to get staff complete the certificate program before the end of the grant funding period in April 2024. There will be additional workshop opportunities, especially a Train-the-Trainer on Teach-Back Method and a Communications workshop held jointly with IHA's other partners will ensure continued opportunities to deepen knowledge and build internal capacity to meet the diverse health literacy needs of our members and potential members.
3. In the coming months, we expect to successfully reach our goals. The following steps are needed to ensure successful completion of the program in 2024.
    a. Complete CME webinar on Teach-Back for providers
    b. Plan Train-the-Trainer workshop for Teach-Back to ensure sustainability
    c. Communications staff participation in IHA workshop with SSA, HCA, and St. Jude.
    d. Identify improvement projects
    e. Complete project by end of April 2024.

5.4 Improvement Projects (QIPs, PIPs, PDSAs and CCIP)

5.5.1 Performance Improvement Project (PIP)

Background: For the 2023–2026 clinical performance improvement projects (PIPs), the California DHCS is requiring all MCPs to focus on improving Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure rates for their Black/African American populations.

The California 2020 Health Disparities Report identified disparities for most of the indicators of the Children's Health domain. Per this report, Black/African American group fared lower than other groups across all 6 key indicators.

The PIP aims to reduce the racial/ethnic disparities in W30-6+ visits in support of the statewide goals. In alignment with the recommendations in the Health Equity Framework, this PIP will involve the African American population, the group most affected by health care disparities, through a survey call campaign to understand firsthand the experiences with well child visits, the barriers, and facilitators to attending well-child visits.

Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate has the potential to improve member health status among these key indicators. Insight on the barriers to attending well-child visits has the potential to identify key areas that may improve member satisfaction across health care services.

PIP AIM Statement: Do targeted interventions increase the percentage of African American children 15 months of age that had size or more well-child visits during the measurement year.

Action/Interventions: Improving Well Child Visits in the First 30 Months of Life (W30 – 6+) for African American Medical Members.

A. Per the HEDIS technical specifications, the (W30 – 6+) measure assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life.
B. CalOptima Health baseline data indicates that in MY2022, the baseline data shows that 34.64% of African American children completed W30 visits in the first 30 months of life.
C. Target population: African American child members who are turning 15 months old during the measurement year, between January 1 and December 31.

Results: This is a three-year PIP from 2023–2026. Results are pending as the intervention will be implemented during the 2024 calendar year.

Quantitative Analysis: Quantitative analysis is pending following the results of the intervention.

Conclusion and Next Steps:

A. CalOptima Health is currently in the process of identifying an appropriate intervention.
B. Once the intervention is implemented and analyzed, we will choose to either adapt, adopt or abandon the intervention.

5.5.2 Chronic Care Improvement Program (CCIP)

Background: CMS requires all Medicare Advantage (MA) and Special Needs Plans (SNP) to conduct a CCIP as part of their required QI Program over a three-year period. The purpose of the CCIP is to promote effective chronic disease management and the improvement of care and health outcomes for members with chronic conditions. For this three-year CCIP program beginning 2023 and ending in December 2025, CalOptima Health has chosen to focus on diabetes as the target condition with a focus to increase diabetes management. The target population for the CCIP interventions will be OneCare members identified with diabetes (type 1 and 2). One of the most important ways patients with chronic disease can manage their health is by taking their prescribed medication as directed. Medication nonadherence can lead to unnecessary hospitalization and

emergency department visits, increase costs, and potential harm to the patient. A patient is nonadherent when they take less than 80% of prescribed medications. Nonadherence is common among diabetes patients, with about 50% of patients not taking their medications as prescribed. Therefore, a PDSA for the performance measure Medication Adherence for Diabetes (MAD) was initiated with a global aim to increase the percentage of members ages >18 with a PDC calculation of ≥ 80% for their medications (non-insulin) for diabetes during the measurement year.

SMART Goal: By 12/31/2023, complete a minimum of 1 outreach attempt to 90% (n=315) of members on the target list (N=350) of CalOptima OneCare members ages >18 with a PDC calculation <85% for their medications (non-insulin) for diabetes.

Actions/Interventions:

Planned Activities	Barriers	Intervention Period Start Date	Intervention Period End Date
Telephonic Outreach by Health Educators or Case Managers	• To be determined after completion of first cycle	10/19/2023	12/31/2023

Conclusion and Next Steps:

A. Identify barriers at the end of the intervention period for telephonic outreach by health educators and case managers.
B. Choose to either adapt, adopt or abandon the intervention.

5.5.3 Plan-Do-Study-Act (PDSA)

Background: In alignment with DHCS Comprehensive Quality Strategy (CQS), which outlines specific quality and health equity strategies, CalOptima Health aims to meet the CQS goals by analyzing our membership population to better identify ethnic group priorities. After a barrier survey and telephonic outreach campaign to the W30-2+ population the most common thread found was that, typically a child's guardian lacks awareness about the timeliness to schedule and attend well-child visits. As such, the priority barrier to address is improved awareness and education among key populations. The focus will be on members who identify as American Indian or Alaska Native, Black, and Native Hawaiian or Other Pacific Islander ethnic groups. Members identifying as one of these ethnicities was chosen since historically these groups have a lower well-child visit rate and the small population size allows for a pilot intervention and multiple PDSA cycles.

SMART Goal(s):

Goals	Goal Met / Not Met
Cycle 1: 11/4/22–3/17/23 By 02/28/2023, complete a minimum of two outreach call attempts, which includes both unsuccessful-unanswered calls and successful-answered calls by parent or guardian, to at least 90% of members (n=319) on the target list who meet the following criteria: age: 12-30 months old, eligible CalOptima Health Medi-Cal member, identify their ethnicity as: Guamanian, Laotian, Alaskan Native or American Indian, Samoan, Japanese, Black, Native Hawaiian, Asian or Pacific Islander, or Asian Indian.	Not Met
Cycle 2: 3/27/23–7/28/23 By June 30, 2023, successfully outreach to 50% of members on outreach list (n=462) who are: ages: 12–30 months old, eligible CalOptima Health Medi-Cal member, identify their ethnicity as: Guamanian, Laotian, Alaskan Native or American Indian, Samoan, Japanese, Black, Native Hawaiian, Asian or Pacific Islander, Asian Indian, or Amerasian.	Not Met
Cycle 3: 7/31/23–11/30/23 By October 31, 2023, successfully outreach to 45% of members who completed PDSA Cycle 2 (n=104) and who meet the following criteria: successfully outreached in Cycle 2: received live call campaign and completed call script, ages: 12–30 months old, eligible CalOptima Health Medi-Cal member, and identify their ethnicity as: Guamanian, Laotian, Alaskan Native or American Indian, Samoan, Japanese, Black, Native Hawaiian, Asian or Pacific Islander, Asian Indian, or Amerasian.	Met Goal

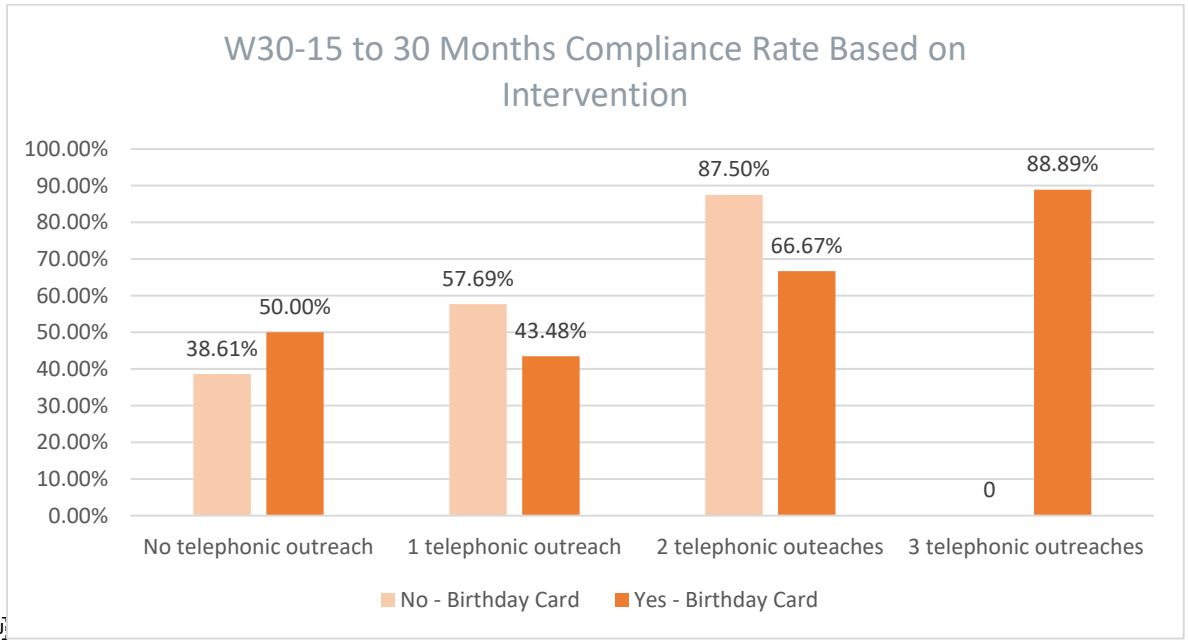
Action/Interventions:

Planned Activities	Barriers	Intervention Period Start Date	Intervention Period End Date
In-house telephonic call campaign	• Obtaining data on members who need to attend well-child visits as align with HEDIS technical specifications • Members under foster care did not have a PHI Form of File for staff to conduct call • Staffing availability to conduct call campaign • Wrong phone number, disconnected phone numbers, or voice mailbox is full • Member's health care coverage was not updated in system (e.g., member had dual coverage)	02/01/2023	02/10/2023
In-house telephonic call campaign and birthday card mailer.	• Members under foster care did not have a PHI Form of File for staff to conduct call • Staffing availability to conduct call campaign • Wrong phone number, disconnected phone numbers, or voice mailbox is full • Member's health care coverage was not updated in system (e.g., member had dual coverage) • Incorrect or incomplete addresses • Member did not update address with Social Security Administration office	05/22/2023	06/30/2023

Planned Activities	Barriers	Intervention Period Start Date	Intervention Period End Date
In-house telephonic call campaign and birthday card mailer.	• Members under foster care did not have a PHI Form of File for staff to conduct call • Staffing availability to conduct call campaign • Wrong phone number, disconnected phone numbers, or voice mailbox is full • Member's health care coverage was not updated in system (e.g., member had dual coverage) • Incorrect or incomplete addresses • Member did not update address with Social Security Administration office	09/25/2023	10/26/2023

Results:

Well-Child Visits Compliance Rate Based on Intervention Type



Data only reflects members who were included in the PDSA for Cycle 1-3 and fell into the W30-15 to 30 Months denominator based on October 2023 Prospective Rate. Birthday Card Mailing included members who had a first or second birthday between April 2023–November 2023. Telephonic outreach is defined as successful outreach where a live person was reached.

Quantitative Analysis:

A. Graph 1 evaluates the impact of the number of successful telephonic outreaches and birthday card mailer intervention has on the W30-2+ rate. Members who received no successful telephonic outreach, but received a birthday card (1-touchpoint) had a higher compliance rate (50.00%) then those who received no intervention at all (0-touchpoint).
B. Members who received three successful telephonic outreaches and a birthday card, which is max touchpoints for this intervention (4-touchpoints), had the highest compliance rate of 88.89%. However, members with two successful telephonic outreaches and no birthday card mailing (2-touchpoints) yielded 87.50% compliant for the measure, which is comparable to members who received 4-touchpoints.

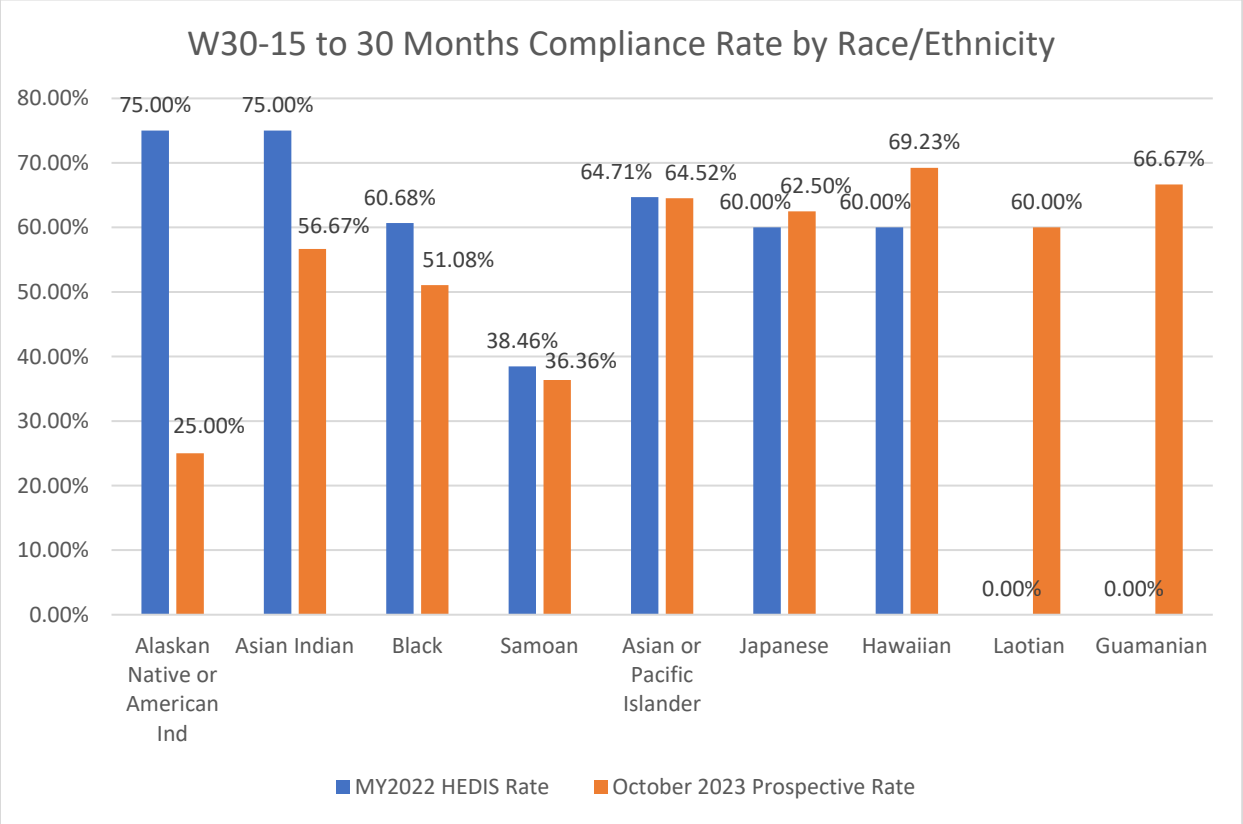
Qualitative Analysis/Barriers:

A. Members who had two successful telephonic outreaches (87.50%) had a comparable W30-2+ compliance rate to those who had three successful telephonic outreaches and a birthday card mailing (88.89%). In terms of resources, since the margin of W30-15 to 30 months rate impact is small (-1.39%), aiming for successful telephonic outreaches would be sufficient.
B. Parents/guardians requesting for a text message to remind them of visits instead of live call, but CalOptima Health doesn't have the capability at this time.
C. Parent/guardians lack understanding of health care coverage and benefits. Did not know they were able to take their child to well-child visits at no-cost.
D. Parents/guardians did not accept scheduling assistance. The majority of parents/guardians opted to call their child's PCP on their own time.
E. If the first call attempt was unsuccessful due to wrong phone number or disconnected phone number, it is highly likely the second call attempt to alternative phone number was also unsuccessful.
F. Father's phone number was listed as the member's primary phone number. Father doesn't have detailed information on child's health care since it's usually their mother who takes the child to the doctor appointments. CalOptima Health call staff documents member's alternative phone number in GuidingCare if it's provided during outreach call.
G. Timeliness of updating member's health care coverage. This includes parents/guardians stating they want to change member's primary care provider, moving out of county/state, or member having dual coverage (e.g., PPO coverage under Father's insurance).
H. Lack of parents/guardians accepting the scheduling assistance. Out of all the calls, staff only assisted with scheduling a well-child visit for two members.
I. Lack of understanding of health care coverage. Call staff educated parents/guardians about well-child visits and vaccinations being a part of the preventative health screening which is a covered benefit. Moreover, some parents/guardians shared their concern of losing coverage because they did not take their child to their recent visits. Staff was able to address their concerns.
J. Parents/guardians did not receive the birthday card mailing even though the address on file is correct.

Disparity Analysis:

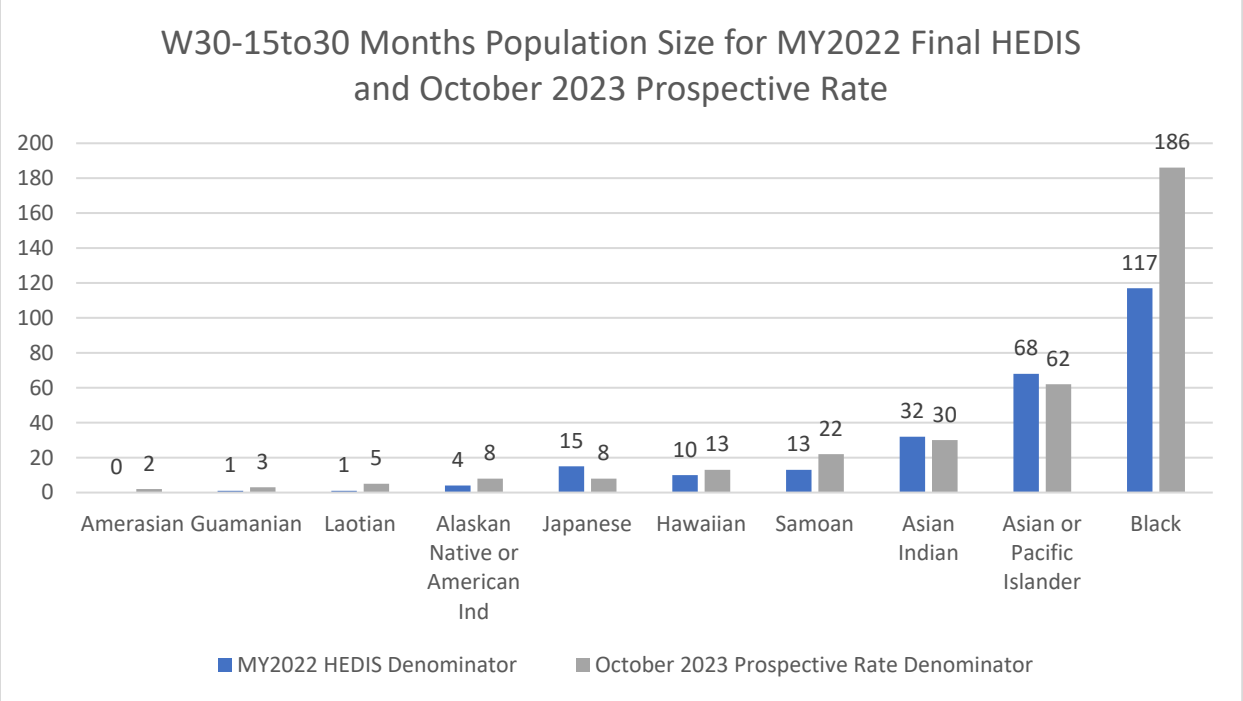
A. Analysis Methodology: (1) American Indian or Alaska Native, (2) Black, and (3) Native Hawaiian or Other Pacific Islander members continue to trend lower than other subpopulations based on August 2022 Prospective Rates Report pulled at the initiation of this improvement project. CalOptima Health implemented the W30-15 to 30 Months intervention to members who identify as Guamanian, Laotian, Alaskan Native or American Indian, Samoan, Japanese, Black, Native Hawaiian, Asian or Pacific Islander, or Asian Indian. October 2022 Prospective Rates Report is used to analyze if there has been an improvement in well-child utilization rate compared to MY2022 Final Rates since interventions did not begin until February 2023.
B. Results

Well-Child Visits Compliance Rate by Race/Ethnicity



Amerasian race/ethnicity group is not displayed because it cannot be trended. No members identified as Amerasian in 2022. Data is based on MY2022 Final HEDIS Rate and October 2023 Prospective Rate, using no continuous enrollment methodology. Denominators for each race/ethnicity group differs year to year.

Well-Child Visits Population by Race/Ethnicity



Denominator is defined as the population. The data displayed is the count of members identified as the respective race/ethnicity.

C. Quantitative Analysis
    1. Graph 2 displays the W30-15 to 30 Months rate increase for Japanese (+2.50%), Hawaiian (9.23%), Laotian (+60.00%), and Guamanian (+66.67%) populations. However, it is important to note the small denominator sizes for each group in Graph 3.
    2. Despite the Black population not having an increased utilization rate (-9.61%) compared with last year. In looking at the count of members who completed the visits, for October 2023 Prospective Rates, there were 95 Black members, compared to 71 Black members for MY2022 who completed their well-child visits.
D. Barriers/Qualitative Analysis
    1. The population size for members who identify as Guamanian, Laotian, Alaskan Native or American Indian, Samoan, Japanese, Black, Native Hawaiian, Asian or Pacific Islander, or Asian Indian is small, which makes it difficult to evaluate true effectiveness. The addition of one member completing their visits drastically impacts the W30-15 to 30 Months rate for the evaluated populations.

Conclusion and Next Steps:

A. When Final HEDIS MY2023 data becomes available, to conduct a thorough analysis of the Well-Child Visits in the First 30 Months of Life-15 to 30 Months measure to evaluate if the rate increased to the ethnicities outreached in this PDSA.
B. Recommend having regular telephonic call campaigns to remind parents about well-child visits and their benefits. Outreach calls also increase member satisfaction and help remediate other inquiries they may have (e.g., redeterminations, changing PCP, updating address). If members are unreachable via telephonic outreach, leverage birthday card mailer.
C. Collaborate with offices and health networks to understand who has the capability to send appointment reminders via text, email or phone call, and to urge them to make it a best practice to send out reminders.
D. In conclusion, the more touchpoints a member receives, the more likely they are to complete the needed preventative well-child visits. Suggest using a multipronged approach to outreach to members who are due for visits to allow the intervention to be opened to the larger W30 population. This may include telephonic calls, birthday card mailer, text message campaign and/or robocall.

5.5.4. BH Performance Improvement Project (PIP)

Background: In May 2023, DHCS requested all managed care plans to select 1 of 3 Performance Improvement Projects. CalOptima Health selected the option to improve the percentage of members enrolled into care management (CM), complex care management (CCM) or ECM, within 14 days of a provider visit where the member was diagnosed with Specialty Mental Health (SMH)/ Substance Use Disorder (SUD).

CalOptima Health chose to narrow the scope of the PIP to improve the percentage of members (age >21 years) enrolled into CM, CCM or ECM, within 14 days of an Emergency Dept (ED) visit where the member was diagnosed with SMH/SUD.

SMART Goal(s): SMART goals were identified in November 2023

Goal(s)	Goal Met / Not Met
Develop internal report to identify baseline data for members who enroll in Case Management, CCM or ECM after being diagnosed with SMH/SUD at ED Visit.	Goal Met

Actions/Interventions:

Planned Activities	Barriers	Intervention Period Start Date	Intervention Period End Date
Realtime ED data received from vendor on a daily basis for CCN and COD members.	Lack of resources to conduct member outreach.	October 2023	Ongoing
Collaboration meetings with internal business units to identify process and reporting specifications.	N/A	August 2023	Ongoing

Qualitative Analysis/Barriers:

A. Lack of data. Reports had to be developed to identify baseline information.
B. Lack of resources to conduct member outreach.

Conclusion and Next Steps:

A. Increased enrollment into these programs will assist in achieving member wellness and autonomy through advocacy, assessment, planning, communication, education, resource management, and service facilitation.
B. Development of internal process to refer identified members from real time ED data, to provide linkages and coordination of care by referring members to ECM, CM and CCM.

Section 6: Quality of Service

6.1 Member Experience

6.1.1 Member Experience Survey (CAHPS)

Background: CalOptima Health is committed to annually monitoring member satisfaction and identifying areas for improvement for all lines of business. By actively seeking feedback from the affected population CalOptima Health assesses the current state of member satisfaction and experience and identifies specific areas for improvement. Collecting valid data ensures that the insights gained are reliable which allows for formulation and implementation of evidence-based interventions. CalOptima Health's goal is to improve the overall member experience by better meeting our members' needs.

CalOptima Health utilizes the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to measure member experience. The CAHPS program is overseen by the U.S. Department of Health and Human Services and the CAHPS surveys are a nationally recognized

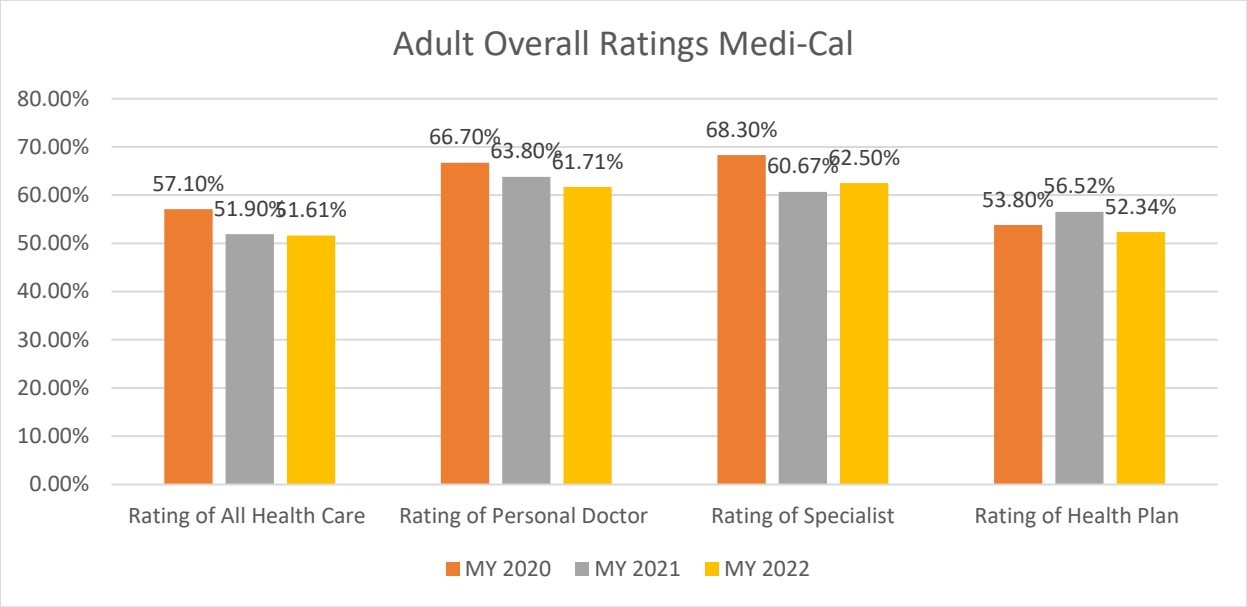
tool developed by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS process has standardized tools, questionnaires and data collection protocols. CalOptima Health submits CAHPS rates to NCQA for NCQA accreditation and to CMS as part of the Stars Ratings for Health Plans.

Goal(s) and Results:

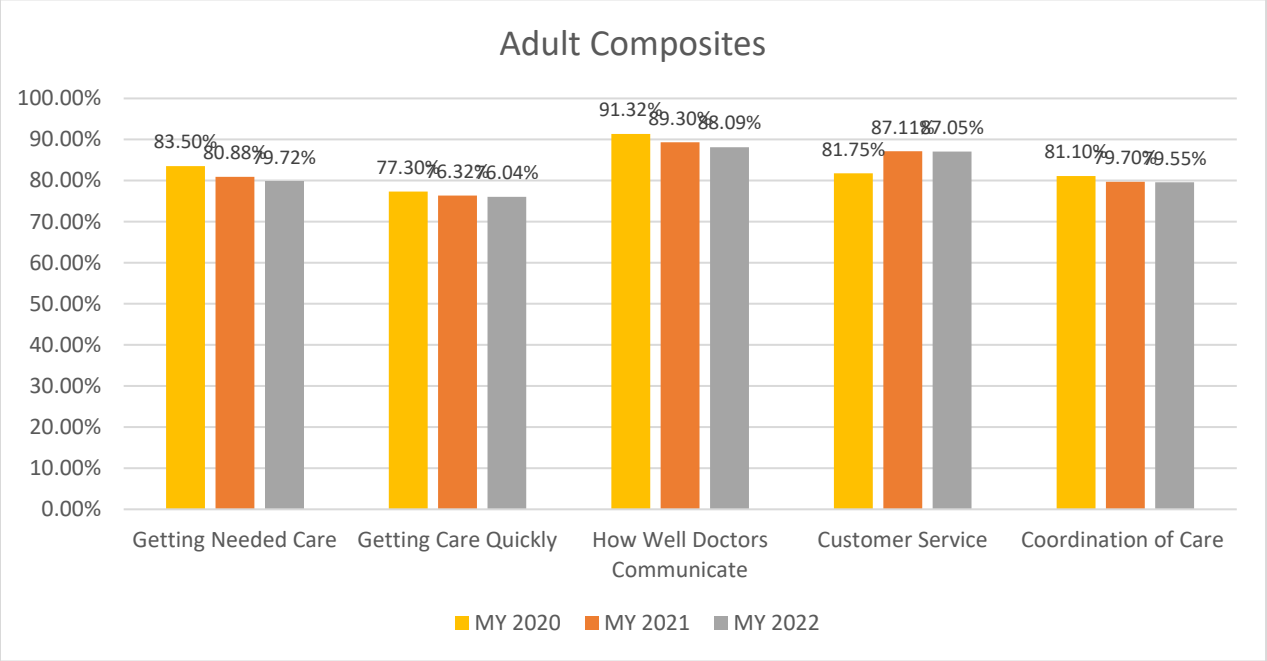
The following graphs display CAHPS survey results for MY2022.

Medi-Cal Adult CAHPS Survey Results

Goal: To meet the 66th percentile when compared with National Medicaid Benchmarks.



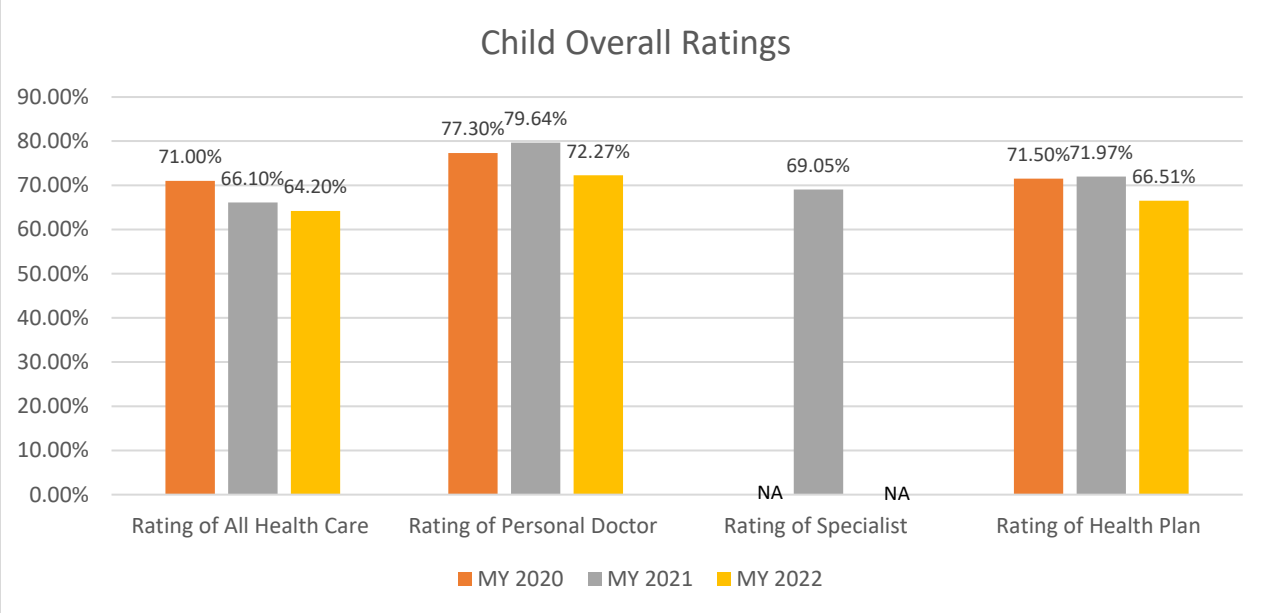
Measure	2023 Medi-Cal Goal	MY2022 Medi-Cal Rate	MY2022 Goal Met/Not Met
Rating of All Health Care	58.27	51.61	Not Met
Rating of Personal Doctor	70.59	61.71	Not Met
Rating of Specialist Seen Most Often	68.31	62.50	Not Met
Rating of Health Plan	64.02	52.34	Not Met



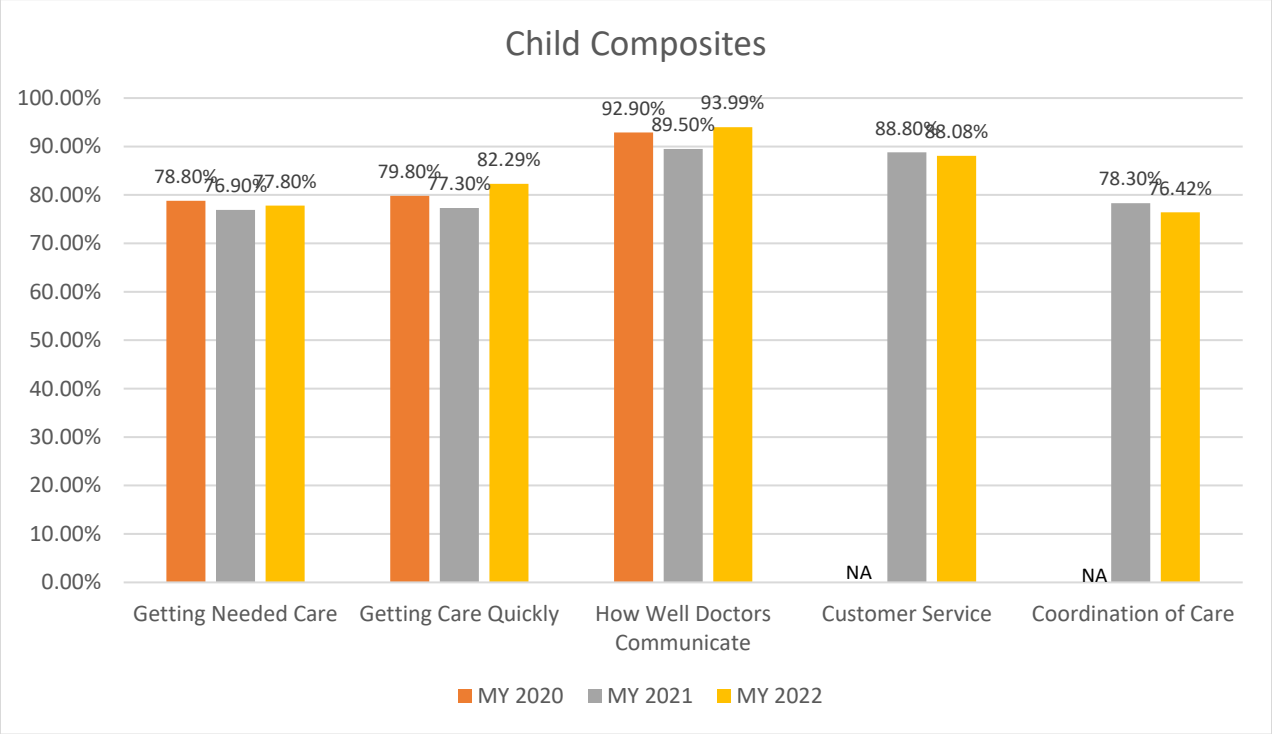
Measure	2023 Medi-Cal Goal	MY2022 Medi-Cal Rate	MY2022 Goal Met/Not Met
Getting Needed Care	83.11	79.72	Not Met
Getting Care Quickly	83.78	76.04	Not Met
How Well Doctors Communicate	93.55	88.09	Not Met
Customer Service	90.38	87.05	Not Met
Coordination of Care	86.73	79.55	Not Met

Medi-Cal Child CAHPS Survey Results

Goal: To meet the 66th percentile when compared with National Medicaid Benchmarks.



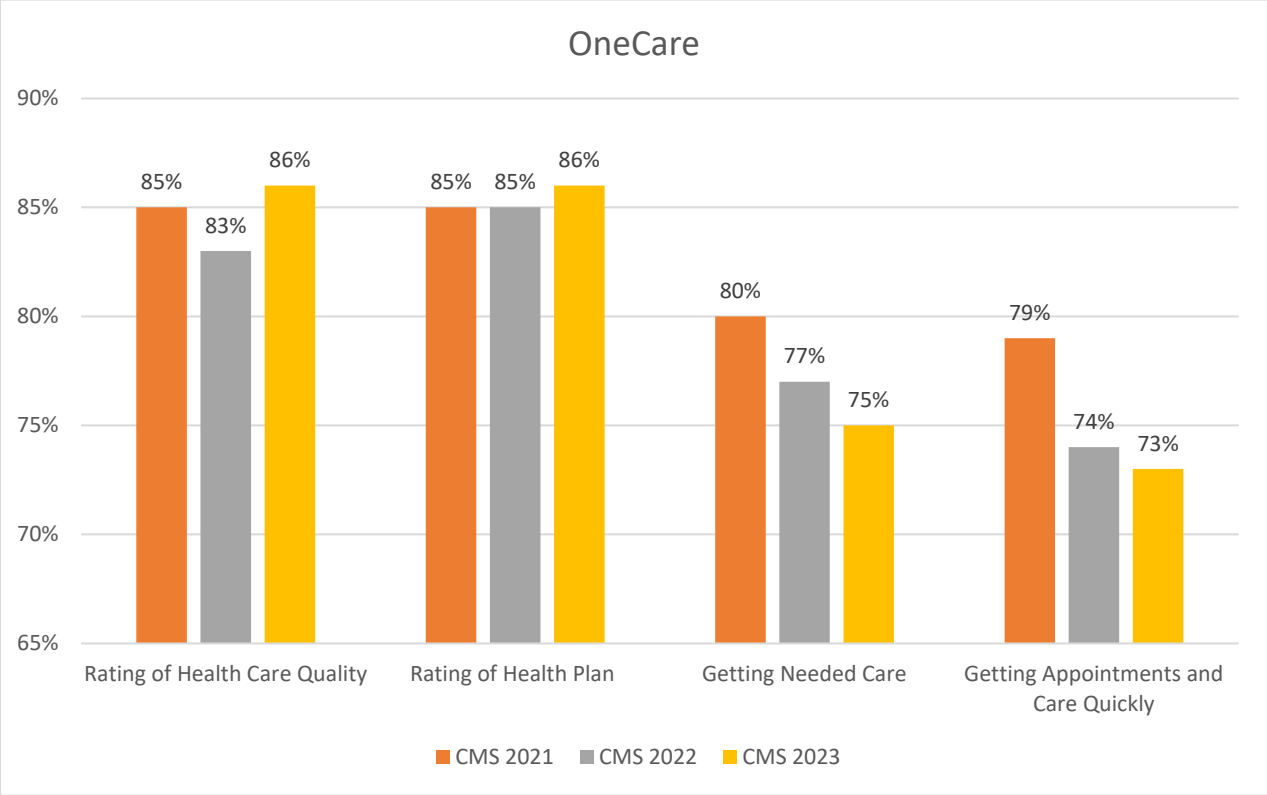
Measure	2023 Medi-Cal Goal	MY2022 Medi-Cal Rate	MY2022 Goal Met/Not Met
Rating of All Health Care	70.69	64.02	Not Met
Rating of Personal Doctor	77.84	72.27	Not Met
Rating of Specialist Seen Most Often	73.58	NA	NA
Rating of Health Plan	73.82	66.51	Not Met



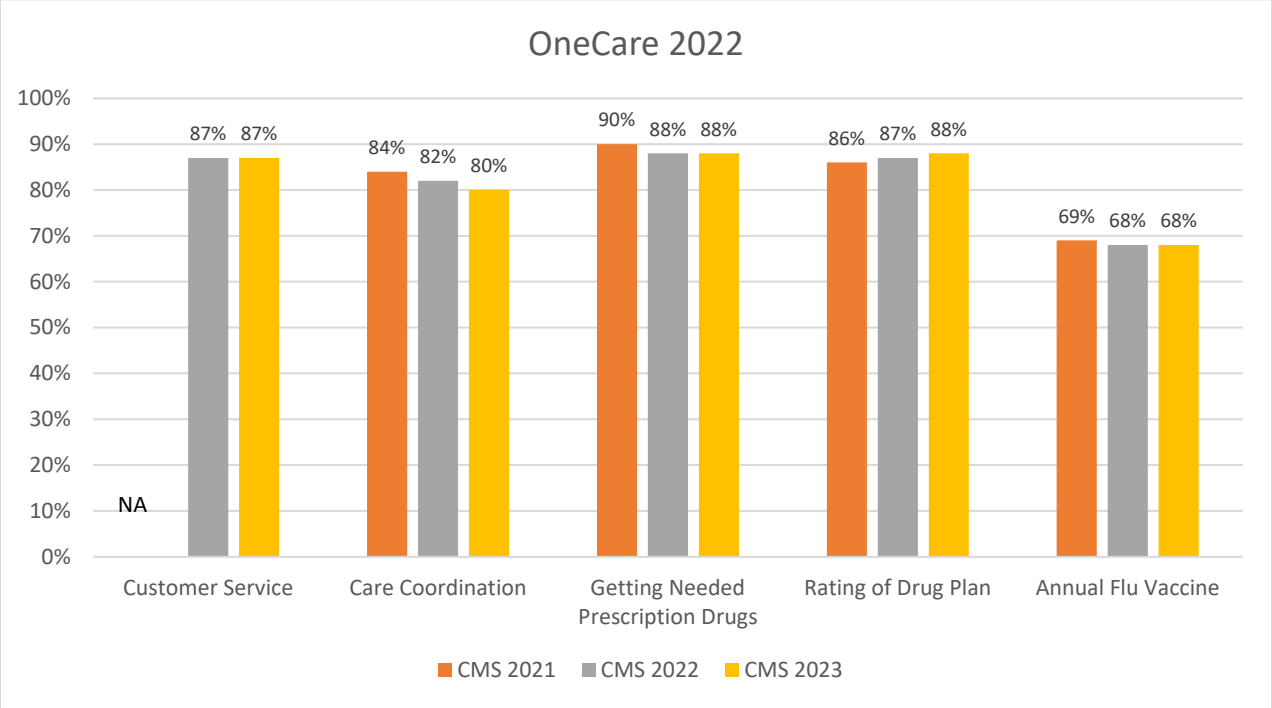
Measure	2023 Medi-Cal Goal	MY2022 Medi-Cal Rate	MY2022 Goal Met/Not Met
Getting Needed Care	85.61	77.8	Not Met
Getting Care Quickly	88.51	82.29	Not Met
How Well Doctors Communicate	94.75	93.99	Not Met
Customer Service	89.0	88.08	Not Met
Coordination of Care	86.51	76.42	Not Met

OneCare Adult CAHPS Survey Results

Goal: To meet the CMS 4-Star Rating.



CAHPS Measure MY2022 CAHPS	Mean Score	Statistical Significance	Star Rating Goal	Star Rating Score	MY2022 Goal Met/Not Met
Rating of Health Care Quality	86	No Difference	4	3	Not Met
Rating of Health Plan	86	Below Average	4	2	Not Met
Getting Needed Care	75	Below Average	4	1	Not Met
Getting Appointment and Care Quickly	73	Below Average	4	1	Not Met



CAHPS Measure	Mean Score	Statistical Significance	Star Rating Goal for MY2022 CAHPS Score	Star Rating for MY2022 CAHPS Score	MY2022 Goal Met/Not Met
Customer Service	87	Below Average	4	1	Not Met
Care Coordination	80	Below Average	4	1	Not Met
Getting Needed Prescription Drugs	88	Below Average	4	2	Not Met
Rating of Drug Plan	88	No Difference	4	4	Met
Annual Flu Vaccine	68	Below Average	4	2	Not Met

Action/Interventions:

Planned Activities / Intervention	Intervention Type	Barriers	Completion Status
Issue an RFP to obtain information on CAHPS improvement vendors and strategies, contract and launch program	Member	• The RFP process is lengthy, which created a slowdown in start-up of the project. • Vendor data process is different than CalOptima Health's for provider IDS. For the first year there may be an impact on members who are being outreached to.	In Progress: RFP was completed and contract signed. Initiated working relationship with Rex Wallace Consulting and Decision Point to improve CAHPS performance. Currently creating content and planning interventions/campaigns to be implemented in Q4 2023 and in Q1 2024.
Member outreach to all OneCare members	Member	• The incentive programs are a manual process so utilization may be affected. • Access to quality phone and address information is limited.	In Progress: live call campaign to remind and assist members with PCP visits, provide education and member incentives underway. Developing IVR/text outreach for remainder of year for high-priority members.

Quantitative Analysis:

A. CalOptima Health reviewed all MY2022 CAHPS rates in detail and compared them with the benchmarks. All Medi-Cal measures were below the 66th percentile. For the OneCare program, one measure, Rating of Drug Plan, received a CMS 4.0-Star rating with the remainder of the Star measures below a CMS 4-Star Rating.
B. CalOptima Health did not meet any goals set for CAHPS for Medi-Cal. For adult Medi-Cal the Rating of Personal Doctor, How Well Doctors Communicate and Rating of Health Plan were below the 10th percentile. Rating of All Health Care, Rating of Specialist, Getting Needed Care, Getting Care Quickly, Customer Service and Coordination of Care performed at the 10th percentile. For child Medi-Cal Coordination of Care was below the 10th percentile and Rating of All Health Care, Rating of Personal Doctor, Rating of Health Plan, Getting Needed Care, Getting Care Quickly and Customer Service performed at the 10th percentile. Customer Service and How Well Doctors Communicate performed at the 33rd percentile.
C. CalOptima met the goal for the Rating of Drug Plan for OneCare with a CMS 4-Star Rating, but all other OneCare goals set for CAHPS were not met. OneCare CAHPS performed "Below Average" for seven measures. The "Below Average" for OneCare measures are Rating of Health Plan, Getting Needed Care, Getting Appointments and Care Quickly, Customer Service, Care Coordination, Getting Prescription Drugs and Annual Flu Vaccine.
D. CalOptima Health maintained performance from the previous year with a .0 CMS 4-Star rating for Rating of Drug Plan for OneCare.

E. Member response rates for CAHPS continue to be a challenge even as CalOptima Health has increased oversamples. The child CAHPS survey experienced a significant decline in the response rate of 6.4%. The adult Medi-Cal and OneCare CAHPS response rates each saw nominal improvements of .49% and .8% respectively.
F. Member grievances for CY 2022 related to member experience from the prior year showed a decrease in grievances of 2% for Access, a decrease of 5% for Attitude and Quality Service and an increase of 3% for Quality of Care.

Qualitative Analysis:

A. Response rates continue to decline, or remain stagnant, for CAHPS surveys.
B. Appointment Timeliness and Availability: Members were unable to obtain timely appointments for routine and urgent care. Some PCPs have too many members in their panel, making it challenging to get an appointment or their panel is closed to new members. There is a lack of providers who offer extended office hours for urgent appointments and overcapacity of members for PCPs contributed to appointment access issues.
C. Members experienced challenges with reaching providers for a variety of reasons, including, provider not seeing new patients, provider cancelled appointment, phone calls not being answered, and unable to reach the provider due to outdated contact information.
D. Referrals expired because patients could not get an appointment or provider canceled/changed appointment.
E. Some PCPs have too many members in their panel, making it challenging to get an appointment. This may limit the amount of time they can spend with a member during a visit, may cause delays in appointment availability and/or increase appointment cancellations or rescheduling by the provider.
F. Lack of providers who offer extended office hours for urgent appointments.
G. There are not enough specialists in the CalOptima Health network for cardiology/interventional cardiology, endocrinology, gastroenterology, general surgery neurology, ophthalmology, psychiatry, and pulmonology.
H. Members are not receiving referrals to specialty care requested due to the limited number of specialists and/or access in certain geographic areas.

Disparity Analysis:

A. Analysis Methodology: CalOptima Health's survey vendor uses collected data and conducts analysis of selected demographic categories for the CAHPS overall ratings and composites to better understand differences in the member experience. The categories are gender, age (18–44 and 45+), education (low education: through high school graduate or GED), ethnicity (Hispanic or Latino and not Hispanic or Latino), survey language was fielded in (English or Spanish), and race (white, black, or African American, Asian, American Indian or Alaska native, native Hawaiian or other Pacific Islander and other). The variables are coded into the following colors for performance: green (score is equal to or higher than 85%), yellow (score is less than 85% but equal to or higher than 75%), and red (score is less than 75%) for performance.
B. Results: Analysis of the Medi-Cal adult survey results showed that by race members of Asian descent scored lower than all other members of different race. For members of Asian descent the composite How Well Doctors Communicate performed > 75% but < 85% and all other ratings and composites performed <75%.

Adult CAHPS Survey Overall Ratings and Composites by Race

CAHPS Elements	*White*	*Black or African American*	*Asian*	*Hawaiian*	*American Indian*	*Other*
Ratings						
Rating of All Health Care	77.1%	100%*	63.3%^	100%*	100%*	80.5%
Rating of Personal Doctor	77.2%	100%*	71.8%^	66.7%*	100%*	91.3%
Rating of Specialist Talked To Most Often	85.5%	-	72.1%^	100%*	100%*	85.2%
Rating of Health Plan	70.8%^	80%*	64.1%^	66.7%*^	100%*	84.3%
Composites						
Getting Needed Care	82%	100%*	72.1%^	100%*	75%*	78.3%
Getting Care Quickly	82.1%	-	62.1%^	100%*	100%*	72.6%^
How Well Doctors Communicate	89%	-	81.4%	100%*	100%*	95.1%
Customer Service	91.8%	-	73.5%^	100%*	-	91.1%
Coordination of Care	85.7%	-	62.4%^	66.7%*^	50%*^	77.8%

^ <75%; **Score based on < 11 cases; -no respondents met the criteria.*

HN CAHPS Aggregate HN Reporting by Asian Languages

CAHPS Elements	*Vietnamese*	*Korean*	*Chinese*
Ratings			
Rating of All Health Care	77.9%	60%^	68%^
Rating of Personal Doctor	81.9%	75.5%	50%^
Rating of Specialist Talked To Most Often	82.4%	76.5%	45.5%^
Rating of Health Plan	73.8%	51.9%^	50%^
Composites			
Getting Needed Care	71.2%^	62.2%^	52.1%^
Getting Care Quickly	78.2%	72.1%^	56.3%^
How Well Doctors Communicate	88.6%	84.4%	83.3%
Customer Service	76.5%	71.1%^	72.2%^
Coordination of Care	78%	60%^	80%

^ <75%

C. Quantitative Analysis
   1. For overall ratings members of Asian descent were below the 75th percentile for all four measures and for composites below the 75th percentile for four of the five measures.
   2. For Asian languages in which CalOptima fielded the CAHPS survey: members speaking Vietnamese two measures performed below the 75th percentile, Korean members had six measures performed below the 75th percentile and seven measures performed below the 75th percentile for Chinese speaking members.

D. Barriers/Qualitative Analysis

1. Both Korean and Chinese speaking members are experiencing access issues with Getting Needed Care and Getting Care quickly. This may lead to lower performance of Rating of all health care and Rating of health plan. Chinese speaking members may have access issues which lead to lower Rating of personal doctor and Rating of specialist talked to most often

Conclusion and Next Steps:

A. CalOptima Health will continue to collect data for disparity reporting, analysis, and trending.
B. CalOptima Health has contracted with a predictive analytics vendor that will provide CalOptima Health with a defined path and process to improve CAHPs scores.
C. To improve member experience CalOptima Health will continue to deploy a continuous, data-driven approach for stars and quality improvement by using machine learning and artificial intelligence to identify members at various levels of satisfaction and engagement and utilize member engagement tools to educate, outreach, and improve member health outcomes.
    1. CalOptima Health will be soliciting stars analytics companies in late 2023 and early 2024.
    2. CalOptima Health will issue an RFP for a new HEDIS software vendor to increase analytics for HEDIS measures.
D. To improve response rates CalOptima Health will maintain the survey oversample for those populations affected.
E. CalOptima Health is in discussions with our contracted survey vendor to expand the use of QR codes that will allow members to access their survey electronically for ease of use to improve response rates.
F. CalOptima Health issued Corrective Action Plans (CAPs) to six contracted Health Networks in 2023 to HNs with a CAHPS member experience score below a 2.5. HNs were required to submit a member experience performance improvement plan and provide quarterly updates regarding progress.
    1. CalOptima Health continues to meet quarterly with contracted health network staff to educate and discuss issues that affect the member experience with CalOptima Health.
G. CalOptima Health identified high impact providers that had 25–500 members per office site and CalOptima's Medical Directors visited each site with a scorecard that addressed member access and experience measures to educate providers and improve the overall member experience.
H. CalOptima Health pharmacy staff updated pharmacy information to Customer Service staff so call resolution is faster and more efficient.
I. CalOptima Health is improving the ease of members' use of the website. Updated information regarding urgent care and elevation of placement within the website for higher member visibility.
J. CalOptima Health sent out 3,876, 500 text messages from Jan. to Dec. 2023. Messages included promotion of: vaccine clinics and resource fairs, preventive screenings such as breast cancer, cervical cancer, blood pressure check-ups, well child visits, blood lead screening, immunizations, and flu campaigns. Additional outreach included informing

members of CalFresh benefits and events that support the CalOptima Health food security strategy.

K. CalOptima is launching a telehealth pilot program with its CCN Health Network to improve member access.

6.1.2 BH Member Experience

Background: CalOptima Health conducts comprehensive BH surveys and analysis annually to assess member satisfaction regarding the BH services. CalOptima Health worked with an outside vendor to field the 2023 BH Member Experience Surveys to measure member satisfaction on BH services received in 2022. Two separate surveys were administered: the BH Member Satisfaction: Applied Behavior Analysis (ABA) Services Survey and the BH Member Satisfaction: Mental Health (MH) Services Survey. The MH version of the survey assesses for both psychotherapy and medication services, whereas the ABA version is solely for ABA services. The consistent areas surveyed annually since managing BH services in house (i.e., non-delegated model) are Access to Services, and Treatment Experience. Questions related to: "As a result of my treatment," were removed from the 2023 survey as there were uncertainties about how members were interpretating that set of questions. The survey questions focused on four main areas: telehealth services, access to services, treatment experience, and overall experience.

Goal(s):

Acronym	Measure	2023 Medi-Cal Goal	MY2022 Medi-Cal Rate	MY2022 Goal Met/Not Met
BH ME	BH Member Experience Survey	Mental Health 85% ABA 85%	Mental Health 75% ABA 81%	Medi-Cal: Not Met

Action/Interventions:

Planned Activities/Intervention	Intervention Type	Barriers	Completion Status
One wave- 4-week mailout survey Methodology	Member	Protracted approval from DHCS	Completed
Removal of "As a result of my treatment" section from survey tool.	Member	Protracted approval from DHCS	Completed
Cover Letters and Survey Tools Translated in Threshold Languages	Member	Protracted approval from DHCS	Completed

Results:



A. A one-wave mailout survey methodology using random sampling for a sample size of 4,739 members was used to carry out the survey. Members of all ages and genders were surveyed. The survey was available to all members in their preferred language. Questions were scored on a five-point Likert scale with options of: Strongly Disagree, Disagree, Neutral, Agree, and Strongly Agree. A Not Applicable (NA) optional response was also included apart from the 5-point scale.
B. CalOptima Health has established an overall satisfaction goal of 85%. The Overall Member Experience Survey rates for areas surveyed consistently year-to-year (i.e., Access to Services, and Treatment Experience) did not meet the intended goal of 85%. The MH survey fell short at 75% with a 10% gap to goal in 2022. ABA received an 81% satisfaction rate but missed the goal by 4%.

Quantitative Analysis:

A. Analysis of 2021 compared with 2022 did not show a significant change in the MH survey overall satisfaction rates. The rate dropped slightly by 2%. The ABA overall satisfaction rates decreased 5% from 2021 to 2022.
B. Overall satisfaction rates decreased from 2021 and the goal of 85% satisfaction rate for both MH and ABA was not met.

Qualitative Analysis/Barriers:

A. Process Perspective: Reviewed survey questions, length of survey, methodology (e.g., mail verses other mediums, best time to administer, etc.), and survey burnout/fatigue and member abrasion.
B. Quality Perspective: Access to services was an area that resulted in lower satisfaction rates. During 2022, many provider offices were still transitioning back to in-office visits.

Appointments were hard to obtain, and members preferred to go in person versus a telehealth visit.

C. Time Constraints: Due to recommended updates from the CalOptima Health BHQI Workgroup, the Survey Tool and cover letters had to be reviewed and approved by DHCS, which caused the fielding of the survey to be delayed and only allowed a 4-week period for members to respond.

Conclusion and Next Steps:

A. To improve the response rate and avoid survey fatigue, it might be worth considering alternative survey methods such as phone calls, text messages or QR codes. This could enable a wider range of CalOptima Health members to participate and share their experiences with behavioral health services.

B. Increase Network:
   1. DHCS Children and Youth Behavioral Health Initiative (CYHBI) investments focused on increasing access through offering additional opportunities for mental health. For instance, the Student Behavioral Health Incentive Program (SBHIP) will allow youth to receive mental health services on or near a school campus. In addition, a new fee schedule will allow CalOptima Health to reimburse for such services in 2024.
   2. Addition of New Telehealth Vendor.

6.1.3 Grievances and Appeals

Background: CalOptima Health has a grievance and appeals process for all lines of business and a peer review process for cases that need to be escalated. Grievances are monitored by staff from our Grievance and Appeals Resolution Services (GARS) department, and they are tracked and trended in order to identify member and provider pain points when accessing care. The analysis is used to identify opportunities to develop interventions and improve member care as well as satisfaction.

Goals: Quarterly tracking and trending of grievance and appeals to be reported to GARS Committee. Trends are reported by line of business, provider type, general category and subcategories.

Results:

2023 Medi-Cal Member Grievances

	Billing & Financial			Quality-Practitioner Office Site			Quality of Care			Attitude/Quality of Service			Access				
Health Network	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q3 Total	Q3 Rate per 1000 / MM
AltaMed	11	11	6	0	0	0	26	30	38	64	77	98	27	30	33	**175**	**0.84**
AMVI	3	4	4	0	0	0	4	10	11	6	15	16	7	3	5	**36**	**0.40**
Arta	9	12	8	0	0	0	20	16	16	68	86	64	25	39	41	**129**	**0.66**
CHA	18	20	17	0	0	0	29	31	28	58	72	58	28	30	40	**143**	**0.29**
Family Choice	5	5	4	0	0	0	10	13	16	30	30	32	7	12	13	**65**	**0.45**
Heritage	2	1	7	0	0	0	5	6	4	24	20	21	6	9	8	**40**	**1.52**
Kaiser^^^	114	114	77	0	0	0	21	30	16	341	390	355	67	98	56	**504**	**2.77**

Monarch	71	64	59	0	0	0	70	71	103	283	292	282	134	152	122	**566**	**1.75**
Noble	1	1	3	0	0	0	4	5	9	20	21	24	8	8	8	**44**	**0.66**
Prospect	10	7	7	0	0	0	17	17	20	44	52	90	27	23	33	**150**	**1.12**
Talbert	15	8	4	0	0	0	15	18	17	47	45	77	18	26	33	**131**	**1.32**
UCMG	8	11	2	0	0	0	6	8	6	34	33	44	17	17	35	**87**	**0.63**
CCN	69	56	82	0	0	0	141	150	152	470	562	613	196	271	302	**1149**	**2.78**
COD	33	47	49	0	0	0	15	25	17	109	135	144	30	25	19	**229**	**0.58**
CalOptima Pharmacy	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**	**0.00**
VSP	0	4	2	0	0	0	0	3	1	0	17	13	0	4	5	**21**	**0.01**
Behavioral Health	9	16	9	0	0	0	17	24	21	46	45	43	38	33	30	**103**	**0.04**
NMT Transportation	0	0	1	0	0	0	3	6	28	217	316	522	1	0	2	**553**	**0.19**
Grand Total	**378**	**384**	**341**	**0**	**0**	**0**	**403**	**463**	**503**	**1861**	**2290**	**2497**	**636**	**786**	**785**	**4127**	**1.42**

Medi-Cal Trends in Q3 2023:

A. Quantitative Analysis: Medi-Cal Grievances increased from 1.57 (Q2) to 1.77 (Q3) average rate per 1,000/member months
B. Qualitative Analysis:
    1. Non-Medical Transportation (NMT) Q2 302 to Q3 612
    2. MTM changed the Veyo members to align with the MTM system/platform on August 1, 2023 — significant hold times in the month of August
    3. Calls answered by a national call center vs. a dedicated call center for CalOptima Health — this led to incorrect benefits being quoted/services denied
C. Actions/Interventions:
    1. Benefits training by MTM for their staff on the rich CalOptima Health transportation benefits
    2. Additional staff hired by MTM to answer calls
    3. Frequent meetings as needed but no less than weekly
    4. Effective April 2024, ModivCare will be the new vendor for CalOptima Health transportation

2023 OneCare Member Grievances

	Billing & Financial			**Quality-Practitioner Office Site**			**Quality of Care**			**Attitude/Quality of Service**			**Access**				
Medical Group	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**Q3 Total**	**Q3 Rate per 1000 / MM**
Alta Med Health	3	0	0	0	0	0	3	3	1	6	8	16	11	6	6	**23**	**7.9**
AMVI Care	1	3	0	0	0	0	0	0	1	3	1	2	3	1	1	**4**	**3.3**
Arta Western	2	1	1	0	0	0	2	2	2	7	4	7	6	5	3	**13**	**4.9**
CCN OC	23	36	9	0	0	0	7	13	11	45	58	58	42	32	16	**94**	**11.7**
Family Choice	4	5	1	0	0	0	0	1	0	8	3	11	16	9	2	**14**	**2.4**
Monarch	20	34	5	0	0	0	14	14	20	85	73	87	86	59	19	**131**	**7.7**
Noble	3	2	0	0	0	0	1	0	3	1	1	1	5	1	0	**4**	**3.7**
Prospect	5	14	4	0	0	0	5	4	4	35	15	29	38	26	7	**44**	**6.2**

Regal	0	5	0	0	0	0	0	2	0	1	5	1	1	2	2	**3**	**4.3**
Talbert	1	7	1	0	0	0	3	5	2	20	14	16	27	12	6	**25**	**5.9**
UCMG	0	2	1	0	0	0	1	1	1	2	3	5	7	2	0	**7**	**3.0**
OneCare Pharmacy	0	0	0	0	0	0	0	0	0	6	6	6	5	4	0	**6**	**0.1**
Behavioral Health	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	**1**	**0.0**
Convey Health	1	0	0	0	0	0	0	0	0	16	17	12	34	9	2	**14**	**0.3**
Silver and Fit	0	0	0	0	0	0	0	0	0	1	1	1	14	12	0	**1**	**0.0**
VSP	0	1	0	0	0	0	1	0	0	3	8	1	1	2	1	**2**	**0.0**
Veyo	0	0	0	0	0	0	1	1	1	122	146	158	11	4	0	**159**	**3.0**
Grand Total	**63**	**112**	**22**	**0**	**0**	**0**	**38**	**46**	**46**	**361**	**407**	**412**	**307**	**201**	**65**	**545**	

OneCare Trends in Q3 2023:

A. Quantitative Analysis:
    1. OneCare Grievances decreased from 19.06 (Q2) to 14.66 (Q3) average rate per 1,000/member months
    2. Decrease in Member Billing complaints Q2 112 to Q3 22
    3. Decrease in Member Access complaints Q2 201 to Q3 65
B. Qualitative Analysis:
    1. Increase in grievances related to NMT Transportation and Provider Attitude
C. Actions/Interventions:
    1. Benefits training on MTM for their staff on the rich CalOptima Health transportation benefits
    2. Frequent meetings as needed but no less than weekly
    3. Effective April 2024, ModivCare will be the new vendor for CalOptima Health transportation
    4. Provider and Health Network education and reminders on access standards
    5. Provider and Health Network notification and/or request for training on any issues identified or perceived by our members

General trends identified in CY2023 included:

A. Appointment availability
B. Members being billed directly for care
C. Delays in referrals/treatment
D. Transportation barriers (NMT)

Action/Interventions:

A. Partnering with Provider Relations in identifying trending specialties and geographic locations
    1. Urology and Neurology were priority subspecialties as a result
B. Education provided to members, Health Networks and providers on the importance of insurance verification to properly bill the responsible parties
C. Engaged UM department to identify perceived barriers to referrals. Additional provider education was provided.

D. CalOptima Health created a dedicated team for all transportation complaints, which was led by a former EMT. This team works closely with the members and vendor to improve the driver no-show rate.

Conclusion and Next Steps: CalOptima Health to continue to monitor and report as appropriate.

6.1.4 STARs Measures Improvement

Background: Each year, all Medicare Advantage plans are given a Star Rating by CMS based on the performance of the plan in a number of metrics, including HEDIS, CAHPS, HOS, Part D, and Administrative measures. For the 2023 Star Rating, OneCare received a 2.5 rating for Part C which resulted in a Corrective Action Plan (CAP) from CMS.

Goals: The short-term goal was to realize improvements in the Part C measures to satisfy the CAP received from CMS. In addition, increased improvements across all measures were sought to increase the overall Star Rating.

Actions/Interventions:

Planned Activities/ Intervention	Intervention Type	Barriers	Completion Status	Measure
Member Experience Improvement	Various	CAHPS surveys are only completed one time each year	In Progress	All CAHPS
Addressing the Call Center for CMS Surveillance Calls	CalOptima Health Operations	Issues with the phone system and understanding of the measure led to lower scores in 2022	Completed	C30/D01: Call Center – Foreign Language Interpreter and TTY Availability

Results:

OneCare Stars	CY 2022	CY 2023	CY 2024
Part C	3.5	2.5 ↓	3.0 ↑
Part D	4.5	3.5 ↓	3.5
Overall	4.0	3.0 ↓	3.0

OneCare Stars	CY 2022	CY 2023	CY 2024
Monitoring Physical Activity	2	3	4
Rating of Health Care Quality	3	1	3
Members Choosing to Leave the Plan	3	3	4
Plan Makes Timely Decisions About Appeals	3	4	5
Reviewing Appeals Decisions	5	3	5
Call Center – Foreign Language Interpreter and TTY Availability	5	1	3

Quantitative Analysis: Rates improved on many measures, as seen above, while others remained the same and some dropped slightly. Improvement strategies are ongoing, but the immediate short-term goal of achieving 3.0 Stars on Part C was achieved, and the CMS CAP was satisfied.

Qualitative Analysis/Barriers:

A. Access issues are consistent across all HNs and continue to be a source of member dissatisfaction.
B. Availability of some HEDIS data from the HNs and providers is limiting the improvement on HEDIS measures.

Conclusion and Next Steps:

A. Overall, the program was successful, but the efforts are ongoing. The improvement was a small step in the right direction, although there is still a lot of work to do.
B. In 2024, we are establishing a CalOptima Health Stars Steering Committee that will be tasked with the ongoing monitoring and guidance of the overall Stars Program with the goal of continual improvement each year as we work toward achieving 4-Star overall rating and the additional quality bonus payment associated with that rating.
C. We are continuing to work with HNs and providers to improve performance and access to data as well as working with third-party data aggregators to increase the availability of the data needed to succeed.

6.1.5 Customer Service

Background: Customer Service is considered the first line of contact for CalOptima Health's members and providers and is dedicated to assisting CalOptima Health members and providers with questions related to Medi-Cal for Orange County.

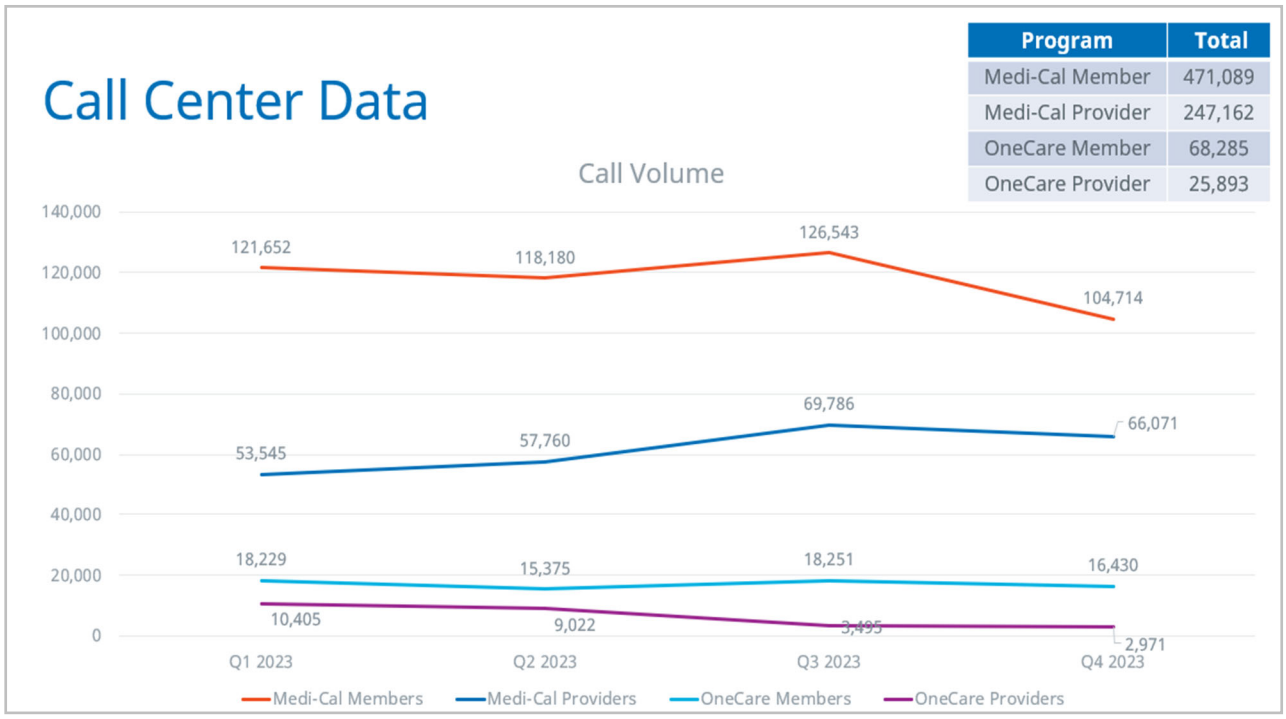
Program Goal(s): Answering inbound calls within the established regulatory requirements while providing quality and courteous service to our members and providers.

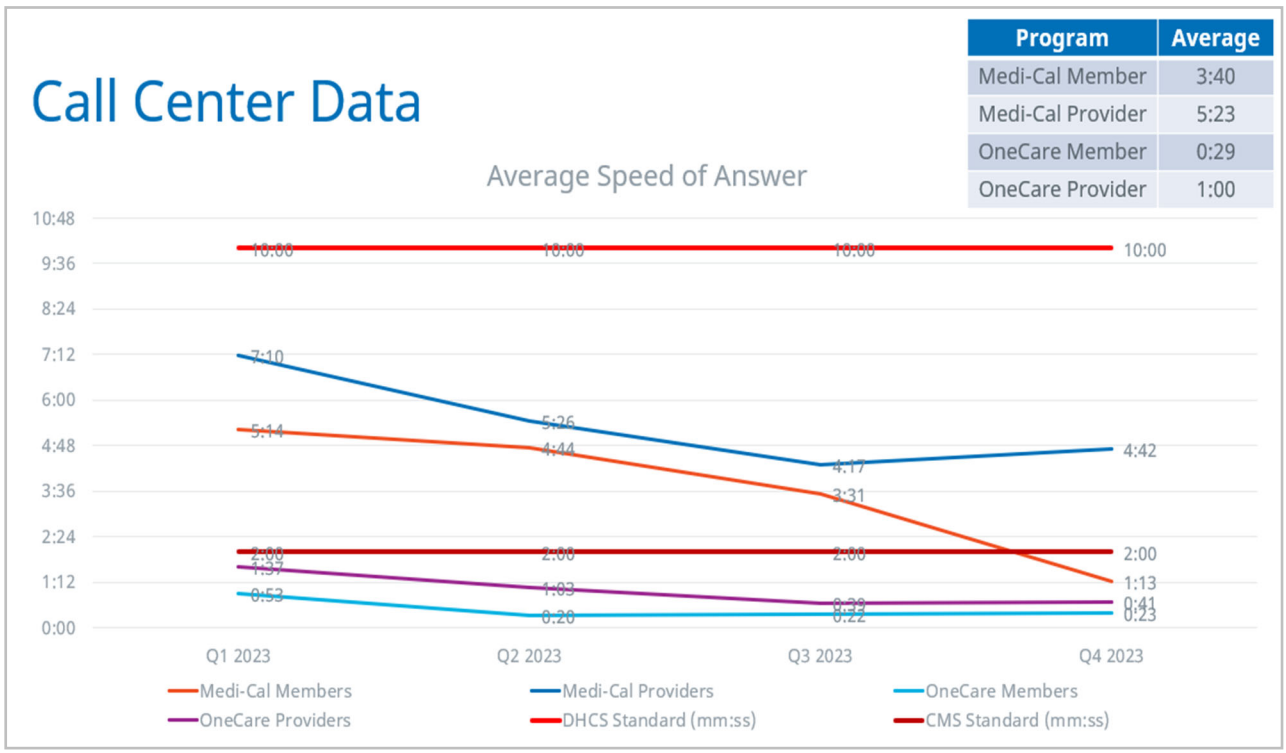
A. DHCS Requirement: Wait time for a member to speak by telephone with a customer service representative shall not exceed 10 minutes.
B. CMS Requirements:
   - The Average hold time shall not exceed two minutes.
   - Answer 80% of all incoming calls to the call center within 30 seconds.
   - The abandonment rate for all incoming calls to the call center of five percent (5%) or less.

Actions/Interventions:

A. Recruiting and onboarding temporary staff to increase the existing customer service workforce.

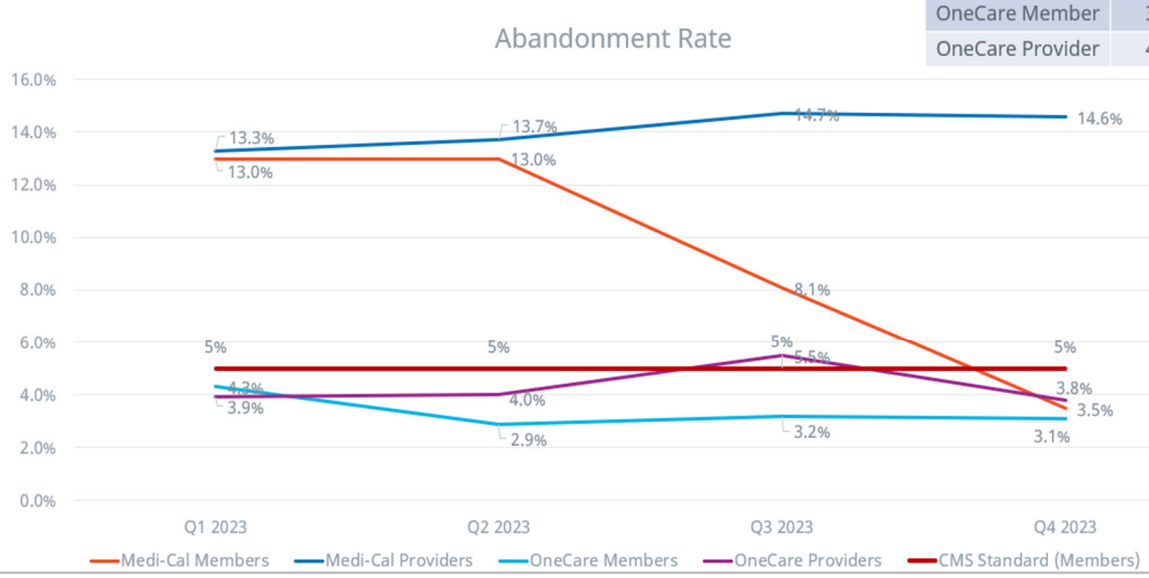
Results:


Call Center Data
Program | Total
Medi-Cal Member | 471,089
Medi-Cal Provider | 247,162
OneCare Member | 68,285
OneCare Provider | 25,893
Call Volume
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
121,652
118,180
126,543
104,714
53,545
57,760
69,786
66,071
18,229
15,375
18,251
16,430
10,405
9,022
3,495
2,971
Q1 2023
Q2 2023
Q3 2023
Q4 2023
Medi-Cal Members
Medi-Cal Providers
OneCare Members
OneCare Providers

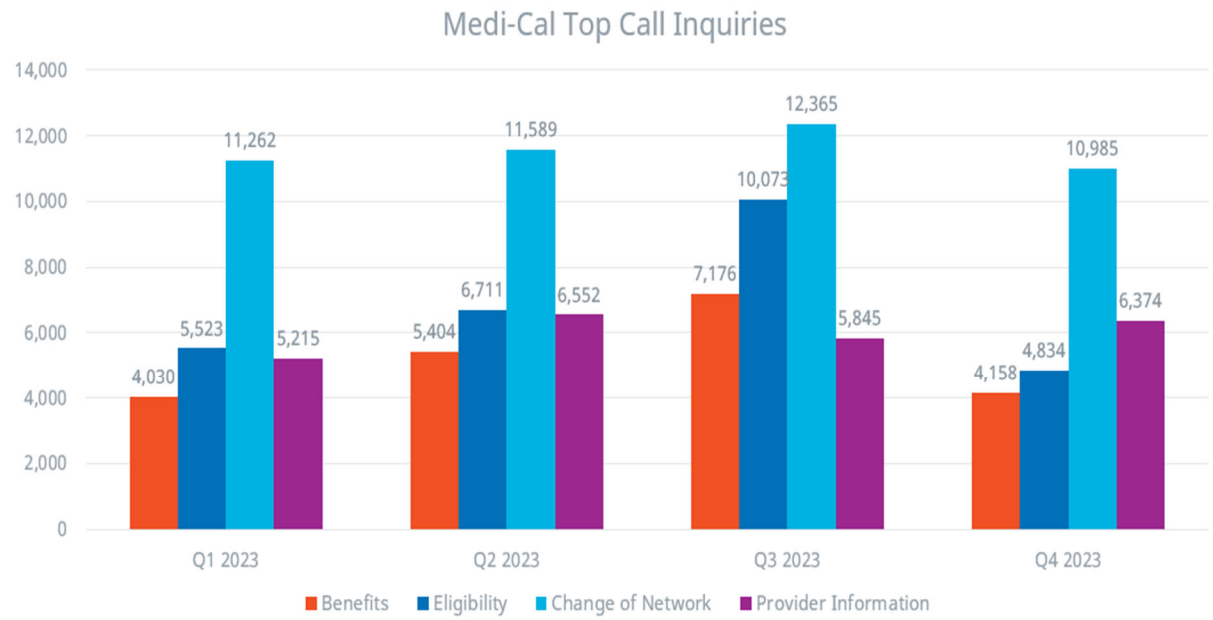

Call Center Data
Program | Average
Medi-Cal Member | 3:40
Medi-Cal Provider | 5:23
OneCare Member | 0:29
OneCare Provider | 1:00
Average Speed of Answer
10:48
9:36
8:24
7:12
6:00
4:48
3:36
2:24
1:12
0:00
10:00
10:00
10:00
10:00
7:10
5:26
4:17
4:42
5:14
4:44
3:31
1:13
2:00
2:00
2:00
2:00
1:37
1:03
0:41
0:53
0:20
0:22
0:23
Q1 2023
Q2 2023
Q3 2023
Q4 2023
Medi-Cal Members
Medi-Cal Providers
OneCare Members
OneCare Providers
DHCS Standard (mm:ss)
CMS Standard (mm:ss)

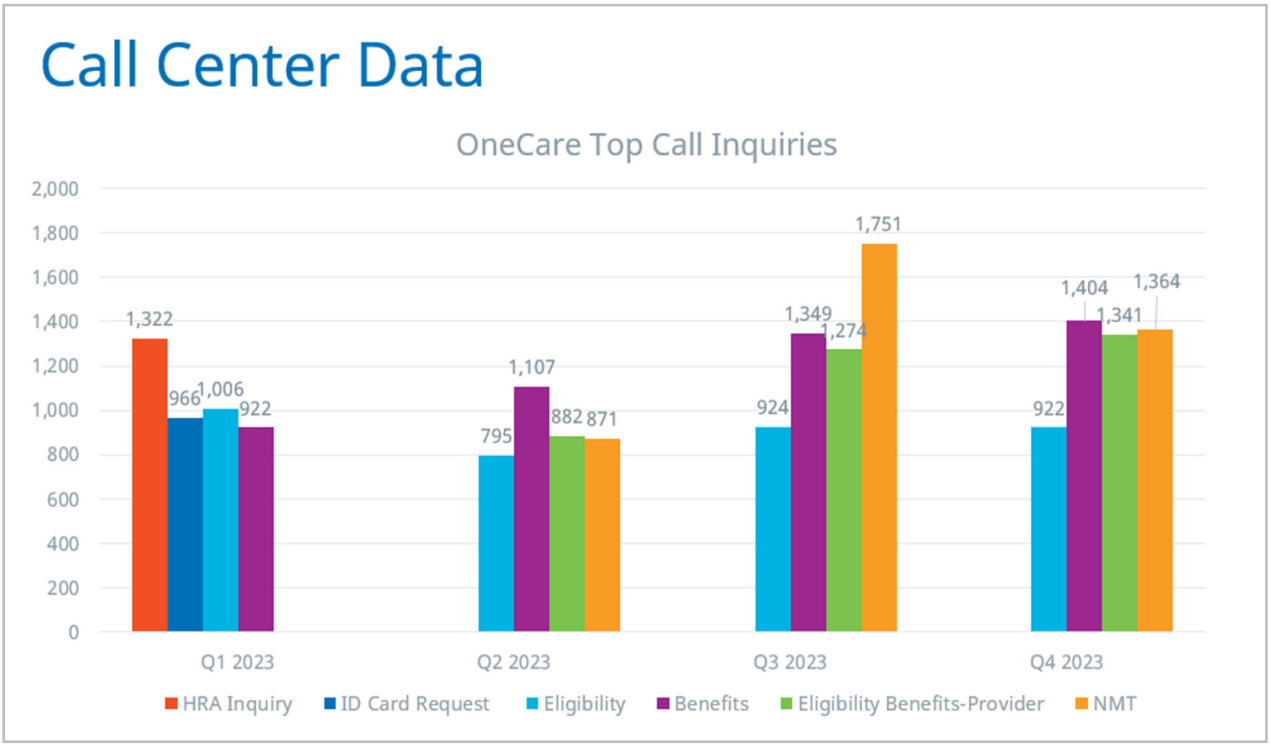
Call Center Data

Program	Average
Medi-Cal Member	9.4%
Medi-Cal Provider	14.1%
OneCare Member	3.4%
OneCare Provider	4.3%



Call Center Data





Quantitative Analysis:

A. Call Center regulatory requirements were met for 2023.
B. Member and provider call volume has some fluctuation throughout the year but remained consistent when compared with the previous year.
C. The Medi-Cal call inquiries remained consistent with eligibility and PCP/HN change requests were the highest number of calls. The cause for the high number of PCP/HN changes was the high number of new member auto assignments.
D. The OneCare call inquiries fluctuated quarter by quarter. While benefits and eligibility remained consistent, there was a high number of HRA calls in Q1 due to the annual HRA mailing and Q3 and Q4 saw an increase in NMT calls due to as system migration that was implemented by CalOptima Health's NMT vendor.

Qualitative Analysis/Barriers:

A. Variance of Customer Service workforce (i.e., staff attrition, unexpected absences, collaborating with HR to backfill vacancies)

Conclusion and Next Steps:

A. Remaining vigilant, proactive and collaborative with HR recruitment toward onboarding staff has proven beneficial.
B. In the near future and in collaboration with our ITS department, Customer Service is looking forward to utilizing better and innovative technology (i.e., Contact Center, Customer Relationship Management [CRM] solutions) that will strengthen our performance against goals.

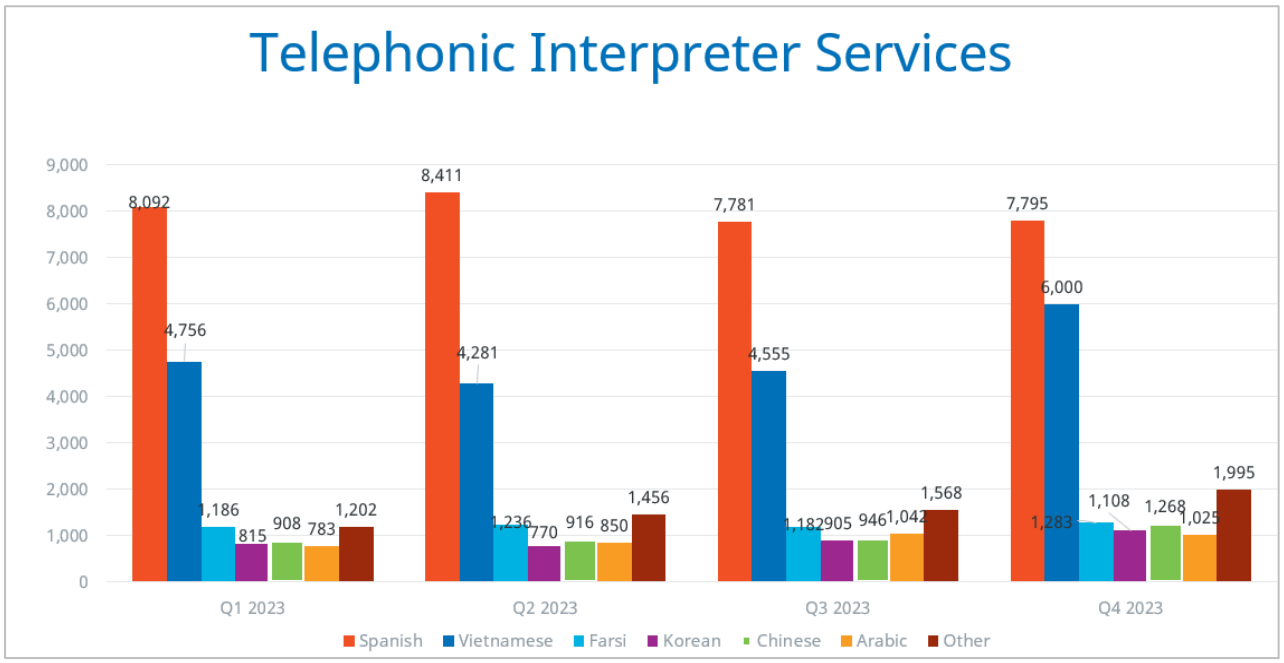
6.1.6 Cultural and Linguistics Services

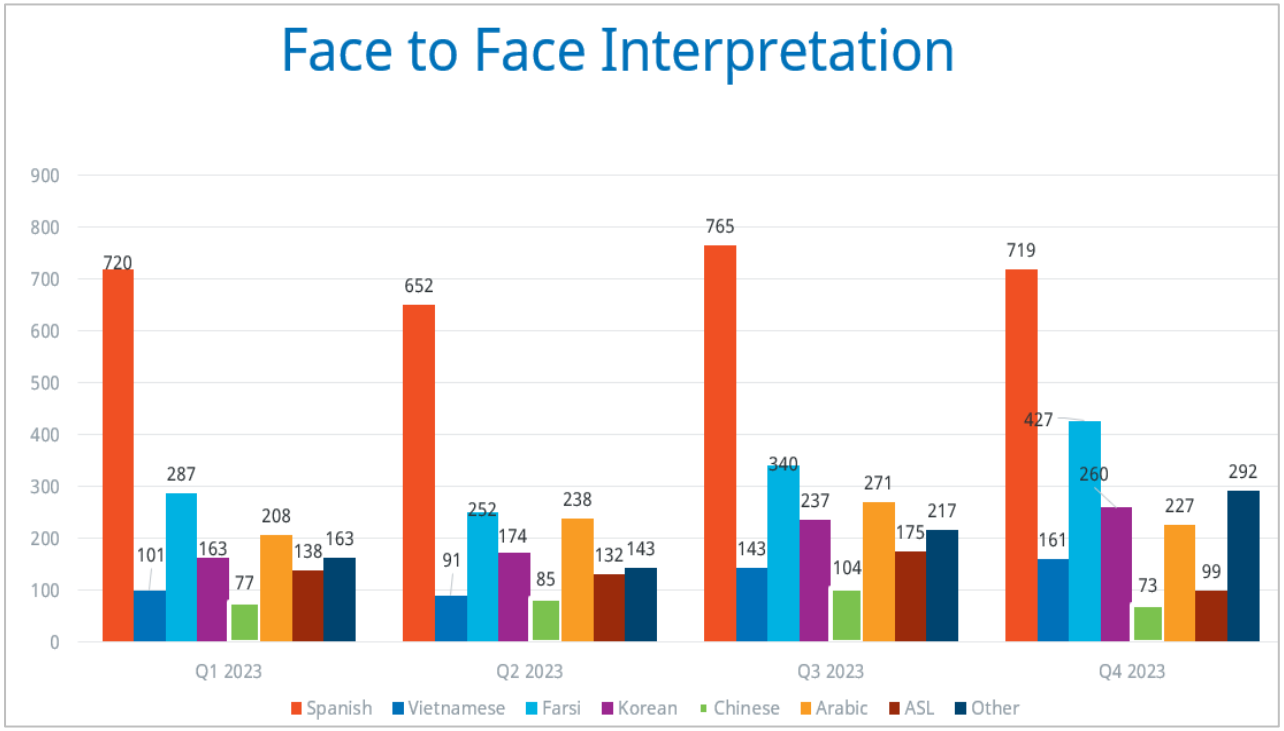
Background: As a health care organization in the diverse community of Orange County, CalOptima Health recognizes that language misunderstandings and lack of cultural awareness can sometimes negatively affect clear communication during the process of receiving care. CalOptima Health's Cultural and Linguistics (C&L) department ensures all members have access to interpretation services related to receiving health care in any language and translated member materials in CalOptima Health's threshold languages.

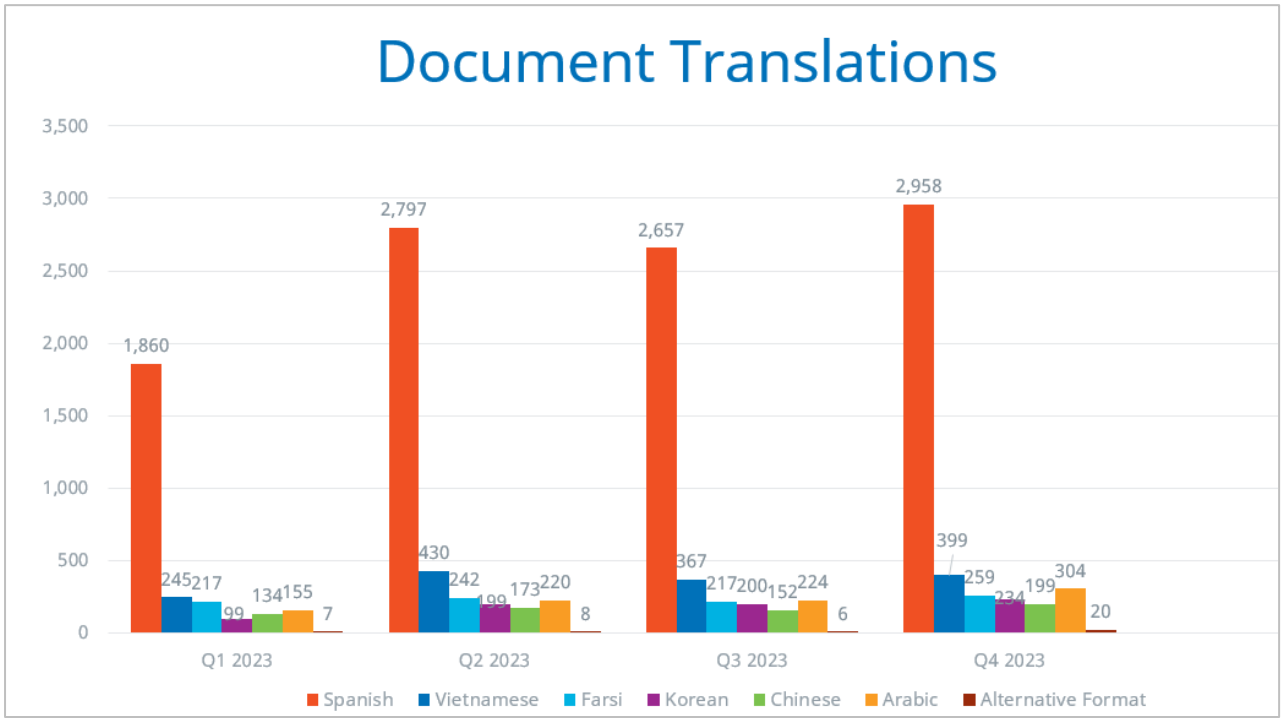
Program Goals: To provide CalOptima Health members access to quality health care and ensure that members with limited English proficiency can communicate clearly with CalOptima Health staff and health care providers in their preferred language. This includes:

A. Translated member information, including a full and immediate translation of written materials in CalOptima Health's Threshold Languages at no cost using a qualified translator to CalOptima Health's members
B. Face-to-face and telephonic interpretation services translation qualified translator, and information and materials to meet the needs of members with sensory and hearing impairments.
C. Provide member information in alternative formats, such as large print in at least 20-point size Arial font, braille, audio, or accessible electronic format, such as a data CD.

Results:







Quantitative Analysis:

A. Based on the member utilization data, CalOptima Health successfully met members needs in accessing interpretation services in any language and translated member information in CalOptima's threshold languages.

Qualitative Analysis/Barriers: No barriers or qualitative analysis were needed to achieve goals.

Conclusion and Next Steps:

A. For 2024, the focus will be to collaborate with multiple departments across the organization to ensure Health Equity accreditation requirements are met as well as continue to monitor, improve, and evaluate existing C&L services to ensure limited English proficiency members continue to receive quality health care.

6.2 Provider Satisfaction

Background: To evaluate provider experience, CalOptima Health analyzed provider grievances, provider UM appeals and provider claims disputes.

Goal: To identify and address provider complaints in a timely manner.

Results: The majority of provider UM appeals were upheld at 96% upheld.

Quantitative and Qualitative Analysis: The top reason for provider grievances are claims disputes. The top reasons for provider UM appeals were denial for no medical necessity, no prior authorization obtained prior to services, and retroactive authorization denied for non-timely submission. The top reasons for provider claims disputes were for level of payment including underpaid claims, contract rates, fee schedule, bundling, down coding, and diagnostic-related group (DRG) payments.

Actions/Interventions: Based on provider experience data, CalOptima Health continues to educate providers on prior authorization requirements and claims payment policies.

6.3 Access

6.3.1 Network Adequacy

Background: CalOptima Health routinely assesses the provider network for all programs including Medi-Cal and OneCare and to ensure our members have appropriate access to care. This includes evaluating trends, determining if any gaps exist in a particular HN or with specific practitioner specialties, identifying opportunities for improvement, prioritizing those opportunities, and taking action to improve the network.

CalOptima Health established network adequacy in accordance with state and federal law and regulations to ensure members have adequate accessibility to available services at both the plan and HN levels. Mandatory Provider Types (MPTs) standards apply only to the Medi-Cal program and Network Adequacy includes both Medi-Cal and OneCare.

A. MPTs (Medi-Cal only) standards require CalOptima Health and contracted HNs to contract with at least one of the following MPTs for each contracted service area, where available: Federally Qualified Health Center (FQHC), Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNM) and Licensed Midwife (LM).
B. Provider network data is pulled quarterly to run an analysis for MPTs and Provider-to-Member Ratio (PMR) at the plan and HN level and compared with standards used to ensure members have the appropriate types of providers and an adequate number of practitioners in the network to access care. This analysis is used to determine whether CalOptima Health is compliant with the standards identified in CalOptima Health Access and Availability Policies: GG.1600 and MA.7007.

C. CalOptima uses the Quest Analytics Suite to conduct accessibility analyses and mapping to meet Time/Distance standards identified in CalOptima Health Access and Availability Policies referenced earlier. The accessibility analyses must demonstrate coverage of the entire service area. CalOptima Health establishes network adequacy standards in accordance with state and federal regulations.

Goals:

A. Mandatory Provider Types: Required and applied to fully delegated HNs only serving the Medi-Cal population. HNs are required to contract with at least one MPT for FQHC and CNM.
B. Provider to Member Ratios: applicable to Medi-Cal population only
   A. PCP to Member Ratio is 1:2,000 or better
   B. Specialists:
      1. OB/GYN is 1:2,000 or better
      2. Nephrology, Pulmonology and Psychiatrist is 1:10,000 or better
      3. All other Specialist to Member is 1:5,000 or better
   C. Minimum Number of Providers: applicable to OneCare population only and varies per provider type according to CMS annual Health Service Delivery (HSD) table.
   D. Time or Distance Standards:
      1. Medi-Cal: Health network meet at Time/Distance standard at 100% for providers and specialists
      2. OneCare: 90% of anticipated membership must meet combination of Time/ Distance standards.

Results:

2023 Medi-Cal Mandatory Provider Type

Mandatory Provider Type	Q1		Q2		Q3		Q4	
	Count	Met / Not Met	Count	Met / Not Met	Count	Met / Not Met	Count	Met / Not Met
FQHC	37	Met	37	Met	39	Met	39	Met
CNM	5	Met	5	Met	4	Met	4	Met
LM	0	Not Met	0	Not Met	0	Not Met	0	Not Met

2023 Medi-Cal Provider to Member Ratios by Specialty Type

Provider Type	Quarters in 2023	Q1		Q2		Q3		Q4	
	Medi-Cal Specialty	Ratio	Met/Not Met	Ratio	Met/Not Met	Ratio	Met/Not Met	Ratio	Met/Not Met
PCP	Family Medicine	1:483	Met	1:471	Met	1:471	Met	1:456	Met
PCP	Pediatrics	1:188	Met	1:181	Met	1:179	Met	1:174	Met

Provider Type	Quarters in 2023	Q1		Q2		Q3		Q4	
	Medi-Cal Specialty	Ratio	Met/Not Met	Ratio	Met/Not Met	Ratio	Met/Not Met	Ratio	Met/Not Met
PCP	Internal Medicine	1:941	Met	1:903	Met	1:890	Met	1:867	Met
PCP	Total Primary Care Providers	1:243	Met	1:231	Met	1:229	Met	1:222	Met
Specialist	Cardiology/Interventional Cardiology	1:1,734	Met	1:1,670	Met	1:1,662	Met	1:1,577	Met
Specialist	Gastroenterology	1:2,108	Met	1:2,071	Met	1:2,026	Met	1:1,931	Met
Specialist	General Surgery	1:991	Met	1: 950	Met	1:942	Met	1:896	Met
Specialist	Hematology / Oncology	1:2,622	Met	1:2,502	Met	1:2,357	Met	1:2,096	Met
Specialist	Nephrology	1:1,037	Met	1:1,909	Met	1:1,891	Met	1:1,805	Met
Specialist	Neurology	1:468	Met	1:2,252	Met	1:2,269	Met	1:2,122	Met
Specialist	OB/GYN	1:219	Met	1:215	Met	1:215	Met	1:208	Met
Specialist	Ophthalmology	1:934	Met	1:1,827	Met	1:1,826	Met	1:1,786	Met
Specialist	Orthopedic Surgery	1:1,956	Met	1:1,859	Met	1:1,814	Met	1:1,741	Met
Specialist	Pulmonology	1:3,051	Met	1:2,902	Met	1:2,836	Met	1:2,744	Met

2023 OneCare Minimum Number of Providers by Specialty Type – Contracted Providers

Provider Type	Provider Specialty	Quarters	Q1		Q2		Q3		Q4	
		Minimum No. of Providers	No. of Providers	Met / Not Met	No. of Providers	Met / Not Met	No. of Providers	Met / Not Met	No. of Providers	Met / Not Met
PCP	Primary Care	72	889	Met	886	Met	1,222	Met	1,213	Met
Specialist	Allergy and Immunology	3	30	Met	31	Met	30	Met	30	Met
Specialist	Cardiology	12	166	Met	162	Met	154	Met	157	Met
Specialist	Cardiothoracic Surgery	1	35	Met	36	Met	32	Met	32	Met
Specialist	Chiropractor	5	26	Met	26	Met	25	Met	26	Met

Provider Type	Provider Specialty	Quarters	Q1		Q2		Q3		Q4	
		Minimum No. of Providers	No. of Providers	Met / Not Met	No. of Providers	Met / Not Met	No. of Providers	Met / Not Met	No. of Providers	Met / Not Met
Specialist	Dermatology	7	89	Met	89	Met	94	Met	95	Met
Specialist	Endocrinology	2	65	Met	66	Met	45	Met	46	Met
Specialist	ENT/Otolaryngology	3	61	Met	62	Met	55	Met	57	Met
Specialist	Gastroenterology	6	107	Met	107	Met	104	Met	106	Met
Specialist	General Surgery	13	127	Met	129	Met	123	Met	122	Met
Specialist	Gynecology, OB/GYN	2	205	Met	208	Met	207	Met	209	Met
Specialist	Infectious Diseases	2	55	Met	57	Met	46	Met	46	Met
Specialist	Nephrology	4	100	Met	105	Met	98	Met	94	Met
Specialist	Neurology	6	127	Met	128	Met	98	Met	103	Met
Specialist	Neurosurgery	1	44	Met	43	Met	38	Met	40	Met
Specialist	Oncology - Medical, Surgical	9	147	Met	146	Met	85	Met	88	Met
Specialist	Radiation Oncology	3	41	Met	41	Met	36	Met	36	Met
Specialist	Ophthalmology	11	179	Met	182	Met	165	Met	170	Met
Specialist	Orthopedic Surgery	9	125	Met	124	Met	118	Met	122	Met
Specialist	Physiatry, Rehabilitative Medicine	2	37	Met	36	Met	32	Met	32	Met
Specialist	Plastic Surgery	1	33	Met	33	Met	34	Met	33	Met
Specialist	Podiatry	9	84	Met	87	Met	96	Met	96	Met
Specialist	Psychiatry	7	107	Met	110	Met	93	Met	97	Met
Specialist	Pulmonology	6	80	Met	79	Met	70	Met	73	Met
Specialist	Rheumatology	4	27	Met	28	Met	29	Met	30	Met
Specialist	Urology	6	65	Met	62	Met	64	Met	67	Met

Provider Type	Provider Specialty	Quarters	Q1		Q2		Q3		Q4	
		Minimum No. of Providers	No. of Providers	Met / Not Met	No. of Providers	Met / Not Met	No. of Providers	Met / Not Met	No. of Providers	Met / Not Met
Specialist	Vascular Surgery	1	38	Met	39	Met	25	Met	24	Met

2023 Medi-Cal Time/Distance Analysis – Non-Compliance Count by ZIP Code

Provider Type	Non-Compliance ZIP Code Count for Contracted Providers							
	Q1		Q2		Q3		Q4	
	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met
PCPs	0	Met	0	Met	0	Met	0	Met
Specialists	0	Met	0	Met	0	Met	0	Met

2023 OneCare Time/Distance Analysis – Non-Compliance Count by ZIP Code

	Non-Compliance ZIP Code Count for Contracted Primary Care Providers (PCP)							
	Q1		Q2		Q3		Q4	
	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/ Not Met
OC	1	Not Met	1	Not Met	1	Not Met	1	Not Met

2023 OneCare Time/Distance Analysis – Non-Compliance Count by ZIP Code

	Non-Compliance ZIP Code Count for Contracted Providers															
	Q1 Specialties		Q1 Facilities		Q2 Specialties		Q2 Facilities		Q3 Specialties		Q3 Facilities		Q4 Specialties		Q4 Facilities	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
OC 2023	8	Not Met	31	Not Met	9	Not Met	29	Not Met	8	Not Met	30	Not Met	8	Not Met	30	Not Met
OC 2022	0	Met	0	Met	0	Met	1	Not Met	0	Met	1	Not Met	0	Met	1	Not Met

Actions/Interventions:

A. CalOptima Health actively recruited providers currently in the provider system with letters of agreements, with the end goal of getting them fully contracted.
B. CalOptima Health worked with health networks to get them certified for Subcontracted Network Certification (SNC) and submitted documentation to the State.
C. Developed a process to monitor HNs for SNC compliance, communicate results including remediation when warranted.
D. Distribute individualized network adequacy summary reports to HNs on a quarterly basis.

Quantitative Analysis:

A. MPT was monitored for the Medi-Cal population, and 2023 quarterly results show standard met for both FQHC and CNMs.
B. Member Ratio and Minimum Number of Providers
    1. Medi-Cal provider to member ratios data shows all specialty types met the standard for ratios. Provider specialists gastroenterologists, hematologists/oncologists and pulmonologists all trended downward in ratios from beginning of the year. In contrast, nephrologists, neurologists and ophthalmologists trended upward, exhibiting significant increase in ratios in Q2.
    2. The OneCare minimum number of provider plan level results show all specialty types met for in 2023.
C. Time/Distance:
    1. Medi-Cal: In 2023, the Time/Distance tables show CalOptima Health was compliant at the plan level for total PCPs and Specialists. However, in drilling down deeper into the PCP provider type, 11 ZIP Codes were identified as not met for OB/GYN PCPs.
    2. OneCare: In 2023, the Time/Distance data shows CalOptima Health was non-compliant for all four quarters for PCPs, specialists and facilities.

Qualitative Analysis:

A. Provider data is collected and housed across multiple databases at CalOptima Health and contracted networks. Counts may not be truly reflective of what is contracted within the network.
B. CalOptima Health is a Medi-Cal plan and reimburses providers utilizing the Medi-Cal reimbursement rate structure. This rate is generally lower than commercial and non-medical rates, making it less appealing for providers and specialists to contract with CalOptima Health.
C. Most OB/GYNs only want to practice as specialists and not as PCP resulting in CalOptima not meeting the Time/Distance standard for OB/GYN PCP. While members are able to select an OB/GYN as their PCP, most members do not.
D. In Q4 2023 changed methodology of monitoring Time/Distance from anticipated membership to assigned membership.

Conclusion and Next Steps:

A. CalOptima Health monitors network adequacy on a quarterly basis by running reports to evaluate whether the Plan meets the Provider Ratio and Time/Distance standards. Will continue to:
    1. Present findings to the Network Adequacy Workgroup and Member Experience Committee
    2. Educate and monitor HNs for network adequacy.
    3. Educate HNs on Alternative Access Standards (AAS) to help meet requirements for standards.

6.3.2 Timely Access

Background: CalOptima Health contracted with a health care survey vendor to field a telephone survey to our network providers to assess their compliance with CalOptima Health's Timely Access Standards to monitor telephone and appointment wait times. The survey used a combination of a "mystery shopper" methodology, in which the interviewer posed as a family member seeking the earliest appointment for a relative, and a "direct script" methodology, in which the callers identified themselves on calling on behalf of CalOptima Health in order to obtain appointment data. Callers then followed the script verbatim in order to collect the data. The direct script methodology was also used to collect administrative compliance data, for example, how long it takes to triage patients, and if providers are currently accepting new patients.

Three unique scripts were developed to collect appointments for several provider categories, including Primary Care, OB/GYN, Specialty Care, Non-Physician Behavioral Health Care, Psychiatric Care, and Ancillary Care across all programs Medi-Cal, OneCare and OneCare Connect.

The data pull methodology included both census and sampling data. With a few exceptions, census data was used for provider types with universes with less than 100 providers. Sampling was used for provider types with universes of 100 and more and included a pull of a random sample to ensure a minimum of 30 completed surveys. In 2022, 2,408 unique providers were surveyed.

The most recent survey was conducted during business hours September 29 through November 23, 2022. Providers were not called on weekends or holidays and for each contact, the surveyor made three attempts maximum to reach a live person to participate in the survey. The surveyor collected first and second appointment availability, but data included in this evaluation represents availability for first appointment only.

Goal(s): CalOptima Health established an MPL of 80% or better at the plan and health network levels.

CalOptima Plan Level

Appointment Types	*2019*	*2020*	*2021*	*2022*	*Met MPL*	*Difference 2021-2022*
Primary Routine (10 business days)	67%	76.2%	69.2%	59.1%	Not Met	-7.1
Primary Care Urgent (48 hours)	21%	68.4%	62.0%	58.9%	Not Met	-3.1
Primary Care Physical Exam (30 calendar days)	81%	84.6%	75.8%	78.0%	Not Met	+2.2
OB/GYN Prenatal (OC/OCC: 2 weeks; MC: 10 business days)	70%	80.4%	77.1%	77.8%	Not Met	+0.7
OB/GYN Routine (15 Business days)	-	85%	80.0%	82%	Met	+2
OB/GYN Urgent (48 hours)	N/A	59%	74%	68.4%	Not Met	-5.6
Specialist Routine (15 business days)	58%	67.7%	60.6%	49.1%	Not Met	-11.5
Specialist Urgent (96 hours)	16%	56.1%	63.7%	54.6%	Not Met	-9.1
Psychiatrist Routine (15 business days)	45%	78.4%	61.9%	**63.9%**	Not Met	+2.0
Psychiatrist Urgent (48 hours)	N/A	42.9%	34.4%	**69.0%**	Not Met	+34.6
Psychiatrist Follow-up (30 calendar days)	100%*	91.4%	66.7%	43.3%	Not Met	-23.4

Non-Physician Behavioral Health Routine (10 business days)	75%	76.7%	76.0%	69.1%	Not Met	-6.9
Non-Physician Behavioral Health Urgent (48 hours)	N/A	49.2%	60.0%	**69.0%**	Not Met	+9
Non-Physician Behavioral Health Follow-up (20 calendar days)	97%	85.1%	70.6%	68.3%	Not Met	-2.3
Ancillary Routine (15 business days)	75%	91.4%	88.9%	76.1%	Not Met	-12.8

*Survey methodology changed from 2019 to 2020 resulting in the data not being trendable. Therefore, 2019 data presented is for informational purposes only. – (Dash) indicates no data available * Indicates denominator is less than 10*

Actions/Interventions:

Planned Activities / Intervention	Intervention Type	Barriers	Completion Status
Targeted outreach to add providers to the network	Provider	Not enough specialists in the county to contract with. In south county, CalOptima is contracted with a low number of specialists identified as adult endocrinologist and pediatric nephrologists due to scarcity. CalOptima reimbursement rates tend to be less appealing to providers since it utilizes the Medi-Cal reimbursement rate structure, which is generally lower than commercial and non-medical rates.	In Progress
Issue corrective action plans to HNs not meeting timely access standards.	Health Networks	HNs may not have been consistent with monitoring compliance for timely access as many providers were still experiencing staff shortages after the height of the pandemic.	Completed: In Dec. 2022, CAPs were issued to 13 HNs. In addition, 12 HNs were asked to outreach and educate providers who received non-compliance notification on the same standard for two years in a row.

Planned Activities / Intervention	Intervention Type	Barriers	Completion Status
Inform and educate providers on timely access standards when non-compliant.	Providers	• Providers and staff may not be fully aware of Timely Access standards. • Providers may feel Timely Access standards are not reasonable and therefore do not feel an urgency to meet criteria. • Providers feel inundated with notices of non-compliances from plan and HNs. • Provider offices may not be staffed with non-physician practitioners to help meet appointment availability standards. • Provider offices may not have appropriate phone systems to handle large volumes of calls, triage calls, or provide required outgoing voice messages.	Letters were sent to providers in the 4th quarter-2022 notifying them of their non-compliance status and educating them of the access and availability standards. • 26 Letters - In-Office Wait Times • 1,404 Education letters – Appointment/Telephone Access • 372 Warning letters - Appointment/Telephone Access • 42 Corrective Action In Progress: In Q2 2023, a Provider/HN workgroup convened to prioritize and develop interventions to improve member experience for the OneCare population. Completed: Provider/HN developed a provider office call script to facilitate telephone patient scheduling.
Field In-office Wait Time survey to measure office wait time among providers	Providers	When provider offices are over booked, results in long wait time for patient to be seen by doctor for their scheduled appointment time.	Completed: Of the 169 wait time data collected, 165 (97.6%) were deemed compliant. Remaining four issued a CAP.

Quantitative Analysis:

A. Based on the review of timely access study results, appointment access is an area of concern. The data shows that there are opportunities for improvement for both routine and urgent appointment types, for almost all provider types.
B. Out of the 14 appointment type measures, only one “OB/GYN Routine” met the 80% minimum performance level. In comparing survey results from 2021 to 2022, six measures saw an increase in rate, with the highest for Psychiatrist urgent with a percentage increase of nearly 35 percentage points. The biggest dip in rate was with Psychiatrist Follow-Up appointments, at a little more than 23 percentage points.

Qualitative Analysis/Barriers:

In conducting analysis of the data, a list of barriers was identified that may shed light on why most appointment standards did not meet the 80% MPL for the 2022 Timely Access Survey.

A. There may be an adequate number of practitioners in CalOptima Health's network, but not all of providers have open panels or are available to see new patients.
B. Some PCPs have too many members in their panel, making it challenging to get an appointment. When a provider is over capacity, this may limit the amount of time they can spend with a member during a visit. Too many members may also cause delays in appointment availability or an increase in cancellations/rescheduling by the provider.
C. Lack of providers who offer extended office hours for urgent appointments.
D. There are not enough specialists in the network. In certain areas, CalOptima Health is currently contracted with a low number of specialists with several not meeting the 80% MPL for both routine and urgent appointments: cardiology/interventional cardiology, endocrinology, gastroenterology, general surgery neurology, ophthalmology, psychiatry, and pulmonology.
E. CalOptima Health is a Medi-Cal plan and reimburses providers utilizing the Medi-Cal reimbursement rate structure. This rate is generally lower than commercial and non-medical rates, making it less appealing for providers including PCPs and specialists to contract with CalOptima Health.
F. Members do not receive referrals to specialty care requested due to the limited number of specialists available in certain areas.

Conclusion and Next Steps:

Findings show there are significant challenges with members obtaining both routine and urgent appointments. To facilitate timely access to care, the following opportunities were identified:

A. Simplify the corrective action plan process to lessen the tracking time from three years to one or one and a half.
B. Distribute survey results to providers in a timely manner making the data more relevant and actionable.
C. Survey providers to identify provider's biggest challenges/barriers in providing timely access to care.

6.3.3 Telephone Access

Background: CalOptima Health contracted with a health care survey vendor to field a telephone survey to our network providers to assess their compliance with CalOptima Health's Timely Access Standards to monitor telephone and appointment wait times. The survey used a combination of a "mystery shopper" methodology, in which the interviewer posed as a family member seeking the earliest appointment for a relative, and a "direct script" methodology, in which the callers identified themselves on calling on behalf of CalOptima Health to obtain appointment data. Callers then followed the script verbatim to collect the data. The direct script methodology was also used to collect administrative compliance data, for example, how long it takes to triage patients, and if providers are currently accepting new patients.

Three unique scripts were developed to collect appointments for several provider categories, including Primary Care, OB/GYN, Specialty Care, Non-Physician Behavioral Health Care, Psychiatric Care, and Ancillary Care across all programs.

The data pull methodology included both census and sampling data. With a few exceptions, census data was used for provider types with universes with less than 100 providers. Sampling was used

for provider types with universes of 100 and more and included a pull of a random sample to ensure a minimum of 30 completed surveys. In 2022, 2,408 unique providers were surveyed.

The most recent survey was conducted during business hours September 29 through November 23, 2022. Providers were not called on weekends or holidays and for each contact, the surveyor made three attempts maximum to reach a live person to participate in the survey. The surveyor collected first and second appointment availability, but data included in this evaluation represents availability for first appointment only.

Goal(s): CalOptima Health established an MPL of 80% or better at the plan and health network level.

The following table represents Timely Access Survey results for Telephone availability at the plan level. Telephone access was monitored for the three years, 2020 through 2022.

CalOptima Plan Level

N/A under Met MPL indicates that this standard is not a requirement and is for informational purposes only.

Appointment Types	*2020*	*2021*	*2022*	*Met MPL*	*Difference 2021-2022*
Call back time within 24 hours (Mystery-routine)	80.0%*	50.0%*	71.4%	Not Met	+21.4
Phone triage patients within 30 minutes	93.7%	95.3%	98.0%	Met	+2.7
Flexibility in scheduling members with disabilities	95.4%	97.0%	97.8%	Met	+0.8
Instructs caller to ER/911	31.6%	20.8%	19.7%	Not Met	-1.1
Informs caller of return call time	34.3%	14.1%	10.8%	Not Met	-3.3
Call back time within 30 minutes (Direct-urgent)	28.6%	20.6%	14.6%	Not Met	-6.0
Live person answers within 30 seconds	69.6%	72.5%	67.0%	Not Met	-5.5
Currently offering telehealth	82.1%	76.3%	75.9%	N/A	-0.4
Currently accepting new patients	52.6%	84.7%	82.5%	N/A	-2.2
Currently accept CalOptima Health patients	86.1%	86.7%	88.0%	N/A	+1.3
Call hold time does not exceed 5 minutes	82.6%	86.3%	84.2%	N/A	+-2.1

**Next to rate indicates Denominator is 10 or less.*

Action/Interventions:

Planned Activities / Intervention	Intervention Type	Barriers	Completion Status
Provider Data Improvement	Health Networks	Provider data is not synced because it is collected and housed across multiple databases at CalOptima Health and at the health networks. Information on CalOptima Health website and in provider directory are not always current. Members are not able to reach their providers when calling to make an appointment because of outdated contact information.	In Progress: Develop process to utilize Lexis Nexis to correct provider data in errors in Facets and establish maintenance review process. Develop process for auditing provider directory and create a scorecard for HN directory data accuracy.
Issue corrective action plans to HNs not meeting timely access standards.	Health Networks	HNs may not have been consistent with monitoring compliance for timely access as many providers were still experiencing staff shortages after the height of the pandemic.	Completed: In Dec. 2022, CAPs were issued to 13 HNs. In addition, 12 HNs were asked to outreach and educate providers who received non-compliance notification on the same standard for two years in a row.
Inform and educate providers on timely access standards when non-compliant.	Providers	Providers and staff may not be fully aware of telephone timely Access standards. Providers may feel telephone timely Access standards are not reasonable and therefore do not feel urgency to meet criteria. Providers feel inundated with notices of non-compliance from plan and Health Networks. Provider offices may not have appropriate phone systems to handle large volumes of calls, triage calls, or provide required outgoing voice messages.	Letters were sent to providers in 4th quarter-2022 notifying them of their non-compliance status and educating them of the access and availability standards. • 26 Letters - In-Office Wait Times • 1404 Education letters – Appointment/Telephone Access • 372 Warning letters – Appointment/Telephone Access • 42 Corrective Action In Progress: In Q2 2023, a Provider/HN workgroup convened to prioritize and develop interventions to improve member experience for the OneCare population.

Quantitative Analysis:

A. A review of the 2022 timely access study results shows telephone access continues to be an area of concern. Similar to prior year, of the seven required standards, only two measures "Phone Triage within 30 Minutes" and "Offering Flexibility in Scheduling Members with Disabilities" met the 80% MPL. Both measures experienced slight increases in compliance rates from 2021 to 2022.
B. In reviewing the remaining required measures, "Call back time within 24 hours (Mystery-routine)" is the only measure that experienced an increase in rate from 2021 to 2022, at more than 21 percentage points. The remaining four experienced decreases in rates of 6 percentage points or lower.

Qualitative Analysis/Barriers:

In conducting analysis of the data, a list of barriers was identified that may shed light on why most appointment standards did not meet the 80% MPL for the 2022 Timely Access Survey.

A. Members are not always able to reach their providers when calling to make an appointment due to: incorrect phone number, long hold times, no answer, no return calls, and no answering machine to leave message.
B. Provider offices that do have answering machines may not include outgoing messages instructing members what to do in case of emergency and/or advising when they should expect a return call.
C. Provider offices may not have enough staff to effectively manage phone calls.
D. Smaller provider offices may have phone systems that are older or not equipped to handle large volumes of calls resulting in dropped calls and long wait times.
E. Provider offices may not be well informed on telephone access standards.

Conclusion and Next Steps:

Findings show there are significant challenges with informing members of return call time, instructing members to ER/911 and return phone call within 30 minutes as all three measures have a compliance rate below 20%. To improve telephone access, the following opportunities were identified:

A. Instruct provider offices identified as non-compliant for "instruct caller to ER/911" to resolve measure immediately. CalOptima Health will conduct an interim survey to validate compliance by Q2-2024.
B. Medi-Cal Timely Access standards will be included in the Provider Press newsletter, winter 2024.

6.3.4 Annual Network Certification (ANC)

Background: In April of 2021, DHCS issued All-Plan Letter (APL) 21-006, Network Certification Requirements that established network adequacy standards at the MCP level, a process to assess and certify MCPs for network adequacy at least annually through the ANC process to ensure that each MCP's provider network meets state and federal network adequacy and access requirements.

Changes to ANC:

A. Health plans are required to make good faith efforts to contract with at least one cancer center within their contracted Provider Networks and subcontracted networks.
B. Health plans must ensure processes and protections are in place for members to access services that are customarily provided by the mandatory providers either in or out of county, including the provision of transportation, if the MCP does not have a current contract with a specific MPT in its service area.
C. DHCS provided a Time or Distance Analysis Report (using Arc GIS) to determine whether the MCPs meet time or distance for anticipated members.
D. Telehealth: Health plans to cover 100% of the population points in the ZIP code in order to be considered compliant with time or distance standards with any deficiencies accounted for through AAS requests.
E. If plan covers at least 85% of the population points in the ZIP code, DHCS permits plan to use the synchronous mode of Telehealth instead of submitting an AAS request.
F. If utilizing telehealth to meet time or distance for 15% of the population in the zip code, health plan must meet the required Telehealth Provider-to-Member ratio based on the number of MCP members in the ZIP code that are not covered by in – person providers.
G. Health plans must submit Alternative Access Standards when they no longer meet time or distance standards and are not utilizing telehealth to meet requirement.
H. As part of AAS request, health plans to submit all unsuccessful contracting efforts as part of the AAS request.
I. AAS requests must be submitted to DHCS every three years.
J. Health plans that cannot demonstrate compliance with an AAS are subject to a CAP.
K. Health plans may permit subcontractors to supplement their provider networks with the plans' direct networks to ensure members who receive care through the subcontractor receive the same access to required providers.

Program Goals:

A. To meet DHCS network adequacy and access requirements as indicated in the APL
B. To submit the ANC, according to the APL

Action/Interventions:

Planned Activities	Date of Completion
Completed ANC Submission	Q2 2023
Updated CalOptima Health Policies	Q3 2023

Quantitative Analysis:

A. CalOptima Health met requirements for: Provider to Member Ratios and Time/Distance
B. CalOptima Health did not meet: Timely Access, Mandatory Provider Types

Qualitative Analysis/Barriers:

A. DHCS made significant changes to the APL and ANC submission requirements in the APL for the 2023 ANC Submission

B. For the 2023 ANC Submission, DHCS intended for plan to be held accountable to analysis that DHCS ran using the MCPs 274 file and ArcGIS rather than the MCPs analysis using the DHCS approved time/distance analysis methodology. MCPs were apprehensive of the analysis provided by DHCS since they were not provided the detailed methodology and could not replicate the analysis themselves. At the end, DHCS did not use the ArcGIS analysis and allow plans to submit their own time/distance analysis for submission.

Conclusion and Next Steps:

A. CalOptima Health staff will work with Quest Analytics software to mimic the analysis by DHCS.
B. CalOptima Health will aim to obtain a license to for ArcGIS to be able to run network adequacy analysis using DHCS' methodology.
C. The responsibility for ANC submission will transition from the Quality to Provider Network Operations.
D. CalOptima will submit the next ANC in Q1 2024, according to the APL.

6.3.5 Subcontracted Network Certification (SNC)

Background: In March 20, 2023, DHCS issued All-Plan Letter (APL) 23-006 Delegation and Subcontract Network Certification, that established network adequacy standards at the subcontractor and downstream subcontractor level, a process for MCPs to assess and certify subcontractor and downstream subcontractor for network adequacy at least annually through the SNC process to ensure that each subcontractor and downstream subcontractor provider network meets state and federal network adequacy and access requirements.

Program Goals:

A. To meet DHCS delegation requirements for network adequacy and access requirements as indicated in the APL
B. To ensure that subcontractor's provider network meets state and federal network adequacy and access requirements
C. To submit the SNC, according to the APL

Elements to SNC:

A. Health plans with subcontracted Delegates, plans are expected to assess and certify the adequacy of the plan's provider network at least annually through the SNC process.
B. Delegation and Subcontractor Network Certification (SNC) - APL 23-006 received 3/30/2023.
C. CalOptima Health SNC Submission to State – 5/30/2023
D. Monitoring of Subcontractors includes:
    1. Timely Access
    2. Time and Distance
    3. Mandatory Provider Types (MPT)
    4. Provider-to-Member Ratio
    5. Provider Directory
E. Findings show HNs are not meeting standards for MPT and Timely Access. Results vary for Time or Distance and Provider to Member Ratios as some networks met.
    1. MPT applies to fully delegated networks only.

F. In September 2023, the SNC workgroup developed a plan to share findings with HNs and requested HNs develop a plan of action for areas identified as non-compliant.
G. CalOptima Health conducted another data pull in Q4 and issued official CAPs.
H. If Health Network submits an Alternative Access Template (AAT) and is approved by Plan, CAP shall not be issued for that particular measure.
I. Plans are to submit final documents to State by 01/05/2024.

Action/Interventions:

Planned Activities	Date of Completion
Completed SNC Submission	Q3 2023
Developed a new CalOptima Health Policies for SNC	Q3 2023
Notified HNs of the areas of SNC noncompliance	Q3 2023
Issued corrective action plans to HNs with areas of SNC noncompliance	Q4 2023

Quantitative Analysis:

	Timely Access	Directory Review	Mandatory Provider Types (MPT)	Provider to Member ratios (PMR)	Time or Distance*
Health Networks	**MY-2022**	**Q2**	**Q4**	**Q4**	**Q4**
AltaMed Health Services	Not Met	Met	2/3 Not Met	1/14 Not Met	Not Met
AMVI Care Health Network	Not Met	Met	2/3 Not Met	Met	Not Met
CalOptima Health Community Network/Direct Network	Not Met	Met	1/3 Not Met	Met	Met
CHOC Physicians Network	Not Met	Met	1/3 Not Met	1/14 Not Met	Not Met
Family Choice Health Services	Not Met	Met	2/3 Not Met	Met	Not Met
Heritage Provider Network	Not Met	Met	2/3 Not Met	Met**	Not Met
Noble Mid Orange County	Not Met	Met	2/3 Not Met	Met	Not Met
OPTUM - Arta	Not Met	Met	2/3 Not Met	1/14 Not Met	Not Met
OPTUM - Monarch	Not Met	Met	2/3 Not Met	1/14/ Not Met	Not Met
OPTUM - Talbert	Not Met	Met	2/3 Not Met	Met	Not Met
Prospect Health Plan	Not Met	Met	2/3 Not Met	Met	Not Met
United Care Medical Group	Not Met	Met	2/3 Not Met	Met	Not Met

A. CCN met requirements for: Provider-to-Member Ratios, Time/Distance, and Directory Review
B. All HNs met requirements for Provider Directory.
C. All HNs did not meet standards for Timely Access and MPT.
D.

Qualitative Analysis/Barriers:

A. APL 23-006 is a newly issued APL and SNC is a new submission for CalOptima Health. Staff had many questions about the submission and DHCS provided little guidance.
B. After the submission, DHCS provided clarification to MCPs as some MCPs incorrectly defined their Delegates as being fully or partially delegated and CalOptima Health was required to submit a landscape analysis to DHCS.
C. DHCS did not follow the timeline indicated in the APL and changed the next SNC submission to early January 2024.

Conclusion and Next Steps:

A. CalOptima Health will develop an Alternate Access Standard process for HNs when they do not meet time and distance standards.
B. The responsibility for SNC submission will transition from the Quality to Provider Network Operations.
C. CalOptima will submit the next SNC in Q1 2024, according to the APL

6.3.6 Language Accessibility Analysis

Background: CalOptima Health monitors members' ability to obtain health care services by ensuring an adequate network of practitioners and by analyzing the effectiveness of the network to meet the cultural needs and preferences of its membership. To determine this, CalOptima Health collects gender, race/ethnicity, language, and member needs/preference data of CalOptima Health members and compares the data against practitioners by health network to determine if there is adequate practitioner coverage to meet the member's needs. This study collects data and utilizes ratios to compare against availability standards for:

- Gender Ratios: Male Member/Male Practitioner, Female Member/Female Practitioner
- Language Ratios: Member/Practitioner ratio for the following languages for the Medi-Cal Line of Business: Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese
- Race/Ethnicity Ratios: CalOptima Health will use language as an indication of race/ethnicity.

Additionally, CalOptima Health monitors the Cultural Competency of CalOptima Health staff, Providers, and provider's staff. In this part of the study CalOptima Health identified CalOptima Health staff and practitioner's staff who have successfully passed the annual Cultural Competency training along with identified findings and a plan of action to address the findings.

Goal(s):

A. Gender Data:

1. This gender study looks at the ratio of female members to female practitioners and male members to male practitioners to determine if there are areas that need attention.
2. CalOptima Health has applied a general standard for practitioners to member ratio, which is 1:500 for gender groups, female, and male, in order to establish a point of comparison. The standard is considered compliant if the practitioner to member ratio is less than 1:500 for each gender group. Data is presented in total, combining data from the health networks/medical groups, and by health network/medical group.

B. Assessing Language Data:
   1. This study aims to assess the linguistic needs of its members. This study collects language data of CalOptima Health members and practitioners to determine if there is adequate practitioner coverage by language. CalOptima Health uses this study to determine if there are members who do not have access to a practitioner who speaks their language.
   2. This language study looks at the ratio of members who speak the non-English language to practitioners who speak the same non-English language to determine if there are any areas where practitioner to member ratio for a threshold language is too high and needs attention.

C. Assessing Data for Members Over and Under 21 Years of Age:
   1. This study looks at the ratio of members over and under the age of 21 in comparison with the ratio of practitioners to determine if there are areas that need attention.
   2. CalOptima Health has applied a general standard for practitioners to member ratio, which is 1:500 to establish a point of comparison. The standard is considered compliant if the practitioner to member ratio is less than 1:500 for each group. Data is presented in total, combining data from the health networks/medical groups, and by health network/medical group.

D. Assessing Race/Ethnicity Data
   1. CalOptima Health captures Race/ethnicity data for its members. Members may be categorized into an ethnicity category or may not be assigned to an ethnicity category. Members may decline to share ethnicity information, or members may choose the “other” category.

Results:

A. Assessing Gender Data:

CalOptima Health met the overall male and female gender standard with ratios under 1:500

Medi-Cal Gender Data			
Male			
Year	2023		
Health Networks	Ratio	Provider	Members
Combined Medi-Cal	1 : 118	3,186	377,190
AltaMed	1 : 103	326	33,861
AMVI	1 : 58	262	15,342
CCN	1 : 25	2,088	53,645
CHOC	1 : 87	919	79,975
Family Choice	1 : 63	358	22,633
HPN - Regal	1 : 8	503	4,116
Kaiser	1 : 89	292	26,043
Noble	1 : 45	240	10,868
Optum -Arta	1 : 63	707	45,127
Optum -Monarch	1 : 58	484	28,123
Optum -Talbert	1 : 29	513	14,903
Prospect	1 : 38	546	20,749
UCMG	1 : 60	363	21,805

Medi-Cal Gender Data			
Female			
Year	2023		
Health Networks	Ratio	Provider	Members
Combined Medi-Cal	1:145	2,901	421,134
AltaMed	1 : 97	335	32,756
AMVI	1 : 49	266	13,070
CCN	1 : 36	2,154	79,344
CHOC	1 : 78	948	74,855
Family Choice	1 : 64	369	23,948
HPN - Regal	1 : 8	521	4,493
Kaiser	1:163	200	32,635
Noble	1 : 41	250	10,481
Optum -Arta	1 : 78	736	57,465
Optum -Monarch	1 : 67	497	33,388
Optum -Talbert	1 : 30	518	15,719
Prospect	1 : 37	568	21,392
UCMG	1 : 57	373	21,588

B. Assessing Language Data:

CalOptima Health met the language standard of 1:500 for Spanish, Vietnamese, Farsi, Korean, Arabic and Chinese.

Medi-Cal Language Data			
Arabic			
Year	2023		
Health Networks	Ratio	Provider	Member
Combined Medi-Cal	1:16	326	5,369
AltaMed	1:06	30	209
AMVI	1:05	13	71
Arta Western	1:15	33	505
CCN	1:16	122	1,981
CHOC	1:16	47	783
Family Choice	1:08	19	165
Kaiser	1:01	170	148
Monarch	1:17	46	801
Noble	1:03	20	60
Prospect	1:05	38	215
Regal	1:02	35	101
Talbert	1:06	28	179
UCMG	1:07	20	151

Medi-Cal Language Data			
Chinese			
Year	2023		
Health Networks	Ratio	Provider	Member
Combined Medi-Cal	1:03	438	1,431
AltaMed	1:02	29	59
AMVI	1:01	14	26
Arta Western	1:01	31	55
CCN	1:01	142	268
CHOC	1:04	49	238
Family Choice	1:03	28	100
Kaiser	1:01	255	93
Monarch	1:08	48	418
Noble	1:01	19	16
Prospect	1:01	32	37
Regal	1:01	22	16
Talbert	1:01	26	42
UCMG	1:02	23	63

Medi-Cal Language Data			
Farsi			
Year	2023		
Health Networks	Ratio	Provider	Member
Combined Medi-Cal	1:11	611	7,253
AltaMed	1:07	29	204
AMVI	1:05	20	106
Arta Western	1:08	42	368
CCN	1:05	214	1,183
CHOC	1:09	79	773
Family Choice	1:07	20	148
Kaiser	1:01	334	172
Monarch	1:38	88	3,374
Noble	1:01	22	42
Prospect	1:06	51	313
Regal	1:03	41	124
Talbert	1:03	52	177
UCMG	1:09	29	269

Medi-Cal Language Data			
Korean			
Year	2023		
Health Networks	Ratio	Provider	Member
Combined Medi-Cal	1:09	857	8,316
AltaMed	1:18	18	336
AMVI	1:08	13	108
Arta Western	1:26	31	813
CCN	1:14	152	2,228
CHOC	1:22	69	1,564
Family Choice	1:08	12	96
Kaiser	1:01	662	216
Monarch	1:31	45	1,405
Noble	1:04	25	123
Prospect	1:17	32	566
Regal	1:07	26	184
Talbert	1:15	36	574
UCMG	1:12	8	103

Medi-Cal Language Data			
Spanish			
Year	2023		
Health Networks	Ratio	Provider	Member
Combined Medi-Cal	1 : 44	5231	232,632
AltaMed	1 : 114	211	24,242
AMVI	1 : 21	159	3,457
Arta Western	1 : 68	320	21,766
CCN	1 : 32	1240	40,432
CHOC	1 : 111	612	68,510
Family Choice	1 : 46	194	9,093
Kaiser	1 : 2	3580	10,610
Monarch	1 : 44	454	20,167
Noble	1 : 50	170	8,593
Prospect	1 : 29	370	10,800
Regal	1 : 7	299	2,188
Talbert	1 : 20	310	6,477
UCMG	1 : 31	202	6,297

Medi-Cal Language Data			
Vietnamese			
Year	2023		
Health Networks	Ratio	Provider	Member
Combined Medi-Cal	1 : 78	766	60,505
AltaMed	1 : 10	71	774
AMVI	1 : 80	129	10,340
Arta Western	1 : 10	116	1,251
CCN	1 : 8	391	3,509
CHOC	1 : 22	116	2,636
Family Choice	1 : 92	189	17,549
Kaiser	1 : 2	244	678
Monarch	1 : 15	137	2,104
Noble	1 : 6	78	533
Prospect	1 : 53	136	7,253
Regal	1 : 2	186	491
Talbert	1 : 5	134	677
UCMG	1 : 77	163	12,710

C. Assessing Data for Members Over and Under 21 years of Age:

CalOptima Health met the language standard of 1:500 members over and under 21 years of age.

Medi-Cal Language Data			
Pediatric (<21 Years of Age)			
Year	2023		
Health Networks	Ratio	Provider	Member
Combined Medi-Cal	1 : 129	2,701	351,127
AltaMed	1 : 54	330	17,891
AMVI	1 : 32	264	8,519
CCN	1 : 15	2,141	32,717
CHOC	1 : 163	947	154,830
Family Choice	1 : 37	365	13,777
HPN - Regal	1 : 3	515	1,949
Kaiser	1 : 119	244	29,156
Noble	1 : 31	245	7,737
Optum -Arta	1 : 44	729	32,389
Optum -Monarch	1 : 41	492	20,482
Optum -Talbert	1 : 14	516	7,283
Prospect	1 : 16	563	9,338
UCMG	1 : 40	370	15,059

Medi-Cal Language Data			
Adult (>21 Years of Age)			
Year	2023		
Health Networks	Ratio	Provider	Member
Combined Medi-Cal	1 : 154	2,894	447,197
AltaMed	1 : 273	178	48,726
AMVI	1 : 108	183	19,893
CCN	1 : 59	1,695	100,272
Family Choice	1 : 127	258	32,804
HPN - Regal	1 : 20	318	6,660
Kaiser	1 : 67	437	29,522
Noble	1 : 77	175	13,612
Optum -Arta	1 : 120	584	70,203
Optum - Monarch	1 : 123	333	41,029
Optum - Talbert	1 : 64	364	23,339
Prospect	1 : 90	363	32,803
UCMG	1 : 116	244	28,334

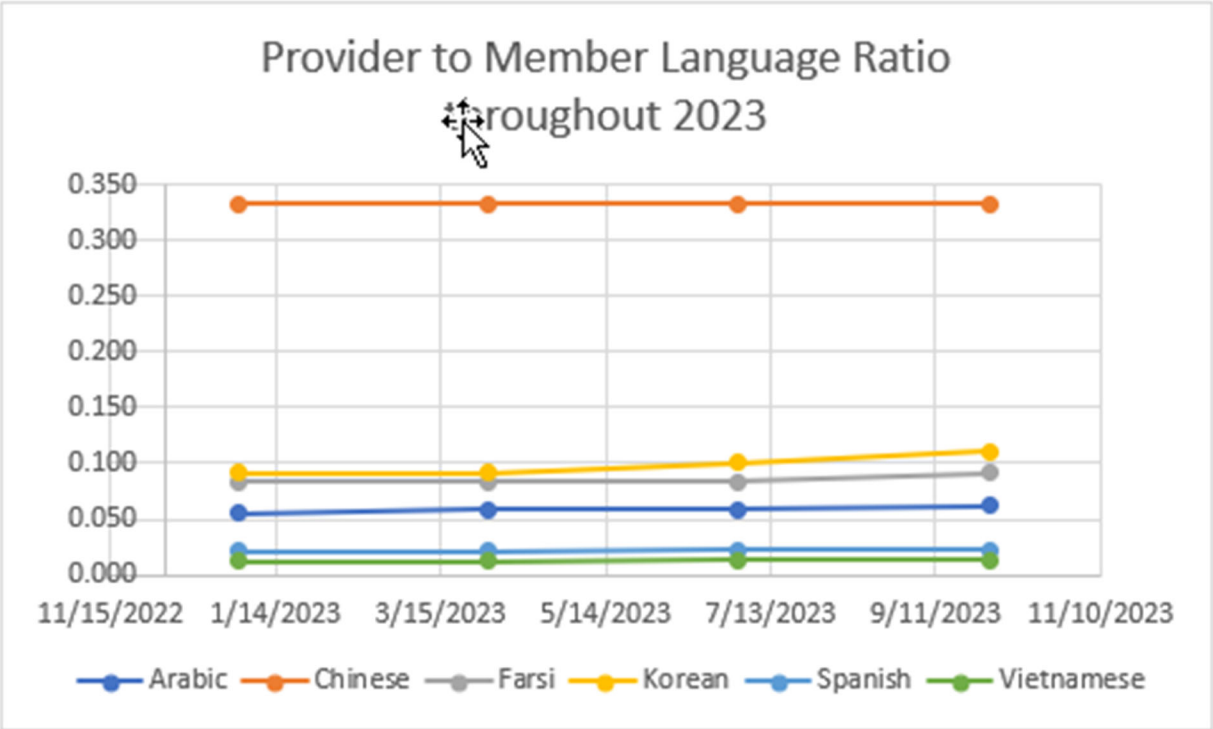
D. Assessing Race/Ethnicity Data

The table below separates members by race/ethnicity and spoken languages.

Medi-Cal Membership									
Spoken Languages									
Race/Ethnicity	Other Non-Threshold Languages	English	Arabic	Chinese	Farsi	Korean	Spanish	Vietnamese	Total
Alaskan Native or American Indian	15	647	1				18		681
Amerasian	1	27					6	17	51
Asian Indian	205	2,111	18		9	7	3	10	2,363
Asian or Pacific Islander	766	3,112	73	3	57	190	24	916	5,141
Black	114	6,851	6,849		3	34	33	3	13,887
Cambodian	324	817					13	32	1,186
Chinese	2,495	4,016		19	2	19	8	168	6,727
Filipino	585	5,493					11	5	6,094
Guamanian		61	1				22	1	85
Hawaiian	2	292					155		449
Hispanic/Latino	753	68,942			9	9	111,755	45	181,513
Japanese	52	994				5	5	5	1,061
Korean	276	6,023				4,740	15	9	11,063
Laotian	85	264				1	7	8	365
Member Declinded	10,890	347,040	4,779	1,664	7,485	77,744	136,605	42,187	628,394
Non-Hipanic/ Non-Latino	45	222	4	5	18	9	45	132	480
Not Assigned	1,665	36,794	718	1	1,526	289	6,046	1,223	48,262
Samoan	10	556			2		9	2	579
Vietnamese	651	13,830	1		3	3	20	42,724	57,232
White	2,029	58,148	595		1,456	10	1,192	48	63,478
Total	**20,963**	**556,240**	**13,039**	**1,692**	**10,570**	**83,060**	**255,992**	**87,535**	**1,029,091**

Quantitative Analysis:

Over the course of 2023, member/provider language ratios for CalOptima Health either remained the same or slightly improved.



Qualitative Analysis:

Some of the barriers we face obtaining data for language accessibility include:

- Members may decline and are not required to share race/ethnicity information
- Race/ethnicity data is not collected for practitioners at this time
- We have been unable to conduct the Member Needs and Preference Survey. Due to the COVID-19 Pandemic, in-person New Member Orientations, where this survey was issued, were halted in March 2020.
- CalOptima Health does not currently collect practitioner level data on practitioners' fluent language, race/ethnicity and religion.

Conclusion and Next Steps:

A. CalOptima Health will ensure practitioners properly assist members in their preferred language or have staff available to speak the language. We will also request the use a professional interpreter at no-cost to the member and have appropriate in-language signage communication and the different services that are available.
B. CalOptima Health continues to update its interactive web provider search tool, which allows the member to search the online practitioner directory for a gender specific provider and language of preference.
C. CalOptima Health will expand data collection from our providers on fluent language, race/ethnicity, and religion.
D. CalOptima Health's Access and Availability workgroup will continue to review on an annual basis, the provider to member ratio and adjust as needed to account for significant positive/negative changes in plan membership.
E. Additionally, CalOptima Health will continue to promote no-cost interpreter services by continuing to communicate the availability of no-cost interpreter services through a

standing article in the Medi-Cal member newsletter, on the CalOptima Health website and included a section on no-cost language services in the member handbook.

Section 7. Safety of Clinical Care

7.1 Emergency Department Diversion Pilot

Background: In 2022 to establish a 90-day collaborative pilot between CalOptima Health and Partner Hospital Emergency Department to prevent hospitalizations, decrease ED use and ensure the members needs are met. The program was structured in 2022 to embed a part-time CalOptima LVN in St. Joesph's ED Monday through Friday to ensure members with ambulatory conditions are met. Those members who are to be admitted to the hospital would not be followed as part of this program. This role would have dedicated Customer Service, Case Management, Utilization Management and LTSS support for immediate access to address the member's authorization and care coordination needs. The embedded program ended 12/30/2022. The plan for 2023 was to establish a secure Teams channel with St. Joseph's, and UCI's Emergency Departments to create a secure virtual ED support/diversion Teams channel program. That program did not launch in 2023 due to ITS technical and security barriers at CalOptima Health and the Medical Centers.

Program Goal(s):

A. Program Goals: Will submit at least 20 referrals for ECM/Community Support referrals each month.
B. Increase percentage of members with PCP follow up visits from 47.7% to 50% for those with an ED visit at St. Joseph's. Baseline of 47.7% from period 3/15/2021– 3/14/2022 from the Follow Up ED visit report.
C. Decrease in number of CalOptima Health members with five or more ED visits in 6-month period of time by 5% (with at least one ED visit at St. Joseph's). (based on existing Collective Medical Report). Will track the weekly number from Collective Medical Report to show trend.

Action/Interventions:

A. Collaborate with ED staff (MSW, RN, LVN, CM and Health Advocate) to ensure members' needs are met. Will be stationed in the same office inside/outside of the ED.
B. Direct coordination with CalOptima Health services to ensure timely services.
C. Interview member in ED with ambulatory sensitive condition to assess needs
    1. Assess SDOH (Social Determinants of Health)
    2. Assess care management medical needs, including outpatient, PCP, appointments, etc.
    3. Engage in discharge planning/care transitions to avoid hospitalization
    4. Identification of additional community supports and resources needed
        a. Recuperative care
        b. Sobering centers
        c. Housing
        d. Personal Care
        e. In-Home Support Services (IHSS)
        f. Meals
        g. Transportation

D. Ensure member has all prescriptions and follow up appointment with PCP and/or specialty care providers as needed, as well as need for:
    1. Medications/DME/Supplies
    2. Home Health
    3. Palliative care
    4. Other programs

Results: No results for 2023 were achieved due to the inability to implement the program.

Quantitative Analysis: The goals and objectives for the program were not met in 2023.

Qualitative Analysis/Barriers:

A. Inability to implement a data usage agreement with UCI and St. Joseph's.
B. Inability to establish a secure Teams channel with both entities.

Conclusion and Next Steps:

A. The secure Teams channel has been established with St. Joseph's and the data usage agreement is in process.
B. The secure Teams channel for UCI pending testing and the data usage agreement is in the process of development.
C. The goal is to go live in Q1 2024.

7.2 Plan All-Cause Readmission (PCR)

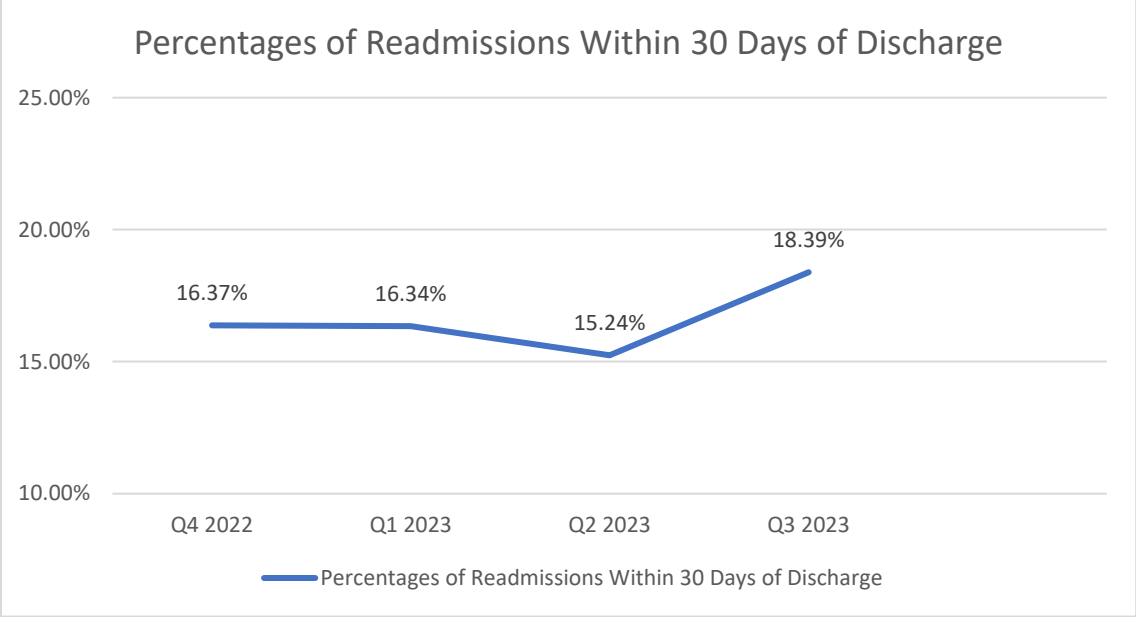
Background: A component of the Transitions of Care Services (TCS) program is monitoring of plan all-cause readmissions (PCR). CalOptima Health launched initiatives to increase the number of members who are evaluated by their PCP within 30 days after a hospital discharge, improve the quality of post-discharge PCP visit and potentially decrease all cause 30-day readmission rates. A readmission is the number of inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days of the previous discharge date.

Program Goal(s): CalOptima Health set the readmission rate at 25% for all Medi-Cal aid categories and is evaluating a new goal with the Utilization Management Committee (UMC) to better determine actions to address opportunities for care and interventions.

Actions/Interventions:

Description	Date of Implementation / Completion
Enhanced the Post Discharge Call Assessment.	October 2023
Expanded eligibility criteria to Case Management follow-up and coordination	January 2023, ongoing
Enhanced the PCP Discharge Notice to remind the PCP to file the Discharge Summary and Medication Reconciliation list in the member's medical chart and to schedule a follow up with the member	In process
Created an Inpatient Utilization Strategy Workgroup to identify members at risk for readmission and the development and implementation for focused and targeted transition support.	October 2023, ongoing
Identify members with chronic readmissions and attempt to enroll in ongoing case management for health education and ongoing chronic care coaching.	In process

Results:



Source: Membership and Utilization Trends dashboard

Quantitative Analysis: Quarter over quarter data analysis from Q4 2022–Q3 2023 shows a <1% decrease from Q4 2022 to Q1 2023, a 1% decrease from Q1 2023 to Q2 2023, and a 3% increase from Q2 2023 to Q3 2023. Although there were increases in some months, the readmit goal from Q4 2022 to Q3 2023 was met.

Qualitative Analysis/Barriers: Readmission rates are presented and discussed at the quarterly UMC meeting and/or bi-weekly UM Workgroup Meeting. Both meetings consist of but are not limited to the following staff: CalOptima Health Medical Directors, Executive Directors of Medical Management and Behavioral Health Integration. Directors of UM, Pharmacy, Quality

Improvement, Case Management, Grievances and Appeals, and Behavioral Health. Managers of Quality Improvement, Utilization Management and Long-Term Support Services. Data is reviewed at these meetings to assess barriers and identify opportunities for improvement interventions.

Through these Committee meetings CalOptima Health identified the following barriers and impacts to readmission rates. Barriers and/or impacts include but are not limited to the following:

A. Although CalOptima Health can measure member success of completing a PCP follow up appointment within 30 days of discharge, the lag in claims data can be an impact to timely interventions to improve member PCP access in the first 30 days post discharge.
B. Coordination of Care barriers between hospitals and outpatient providers continues to negatively impact readmission rates.
    1. Technology limitations exist between hospitals and PCP including the ability to communicate directly with a PCP or automate a referral or post discharge support and/or services (i.e., Case Management/Community Supports).
    2. CalOptima Health also recognized the importance of the notification rate on patient engagement. Predischarge coordinated engagement in care transition planning may also be low due to the administrative burden for the hospital team, as well as the member's willingness to coordinate care and services while the member is still in the hospital.
C. Hospitals often operate with limited administrative and case management support due to shortage of health care practitioners and staffing protocols. These capacity limitations lead to a potential delay of notification to the PCP in a timely manner, resulting in missing the opportunity for the PCP to see the patient. In addition, because of staff capacity limitations, hospital staff are frequently unable to schedule member follow up visits with their PCP prior to discharge from the hospital.
D. Additional challenges include but are not limited to:
    1. Inability to coordinate care prior to a member leaving the hospital against medical advice.
    2. Difficulty reaching the member after discharge from the hospital. If a member is not responsive to outreach for support to navigate the health care system, the member may not understand all the actions needed to prevent a readmission (health literacy).
    3. PCP availability, including after hours, does not fit all member's needs for a follow up appointment after discharge.
    4. Member symptoms and reason for hospitalization improve so there is not a perceived need to see the PCP.
    5. Lack of adoption to telehealth options.
    6. With the uptick of COVID cases there may be fear again of the member accessing care.

Conclusion and Next Steps: The readmit goal is met from Q4 2022 to Q3 2023.

A. The CalOptima Health UMC will review data and re-establish a readmit goal. Committees will monitor activities in place and continue to meet and review data, identify opportunities for improvement, develop and implement interventions and monitor the effectiveness of these interventions.

B. Work with hospital partners to gain additional EMR access for CalOptima Health staff to send timely discharge summaries and medication reconciliation to the PCP to incorporate in the member outpatient chart.
C. Enhance engagement of members through focused training and staff core competency building. The training includes the importance of motivational interviewing style to promote appropriate adherence to treatment post discharge for sustainable outcomes. Motivational interviewing will assist with member empowerment and addressing barriers related to adherence to treatment.
D. Continue to pursue increased opportunities through CalAIM Community Supports (launched in Q1 2022). Renew and expand opportunities to connect members with ECM and community supports available for SMI, SUD and the unhoused. Support is provided to appropriate members prior to discharge to boost optimal outcomes and drive improvement in the readmission rate.
E. Created a Bed Day Reduction Strategy Sub Workgroup to be led by CalOptima Health Medical Directors with the participation of UM and CM staff.
F. As part of the enhanced post discharge process the following interventions present an opportunity for improvement:
    1. Coach members on how to convene a telehealth PCP or specialty follow-up visit within 30 days post discharge.
    2. Coach members on early self-identification of risk to address signs and symptoms.
    3. Coordinate communication with all treating providers.
    4. Risk surveillance to target high risk members to proactively address transition of care needs.

Section 8: Delegation Oversight

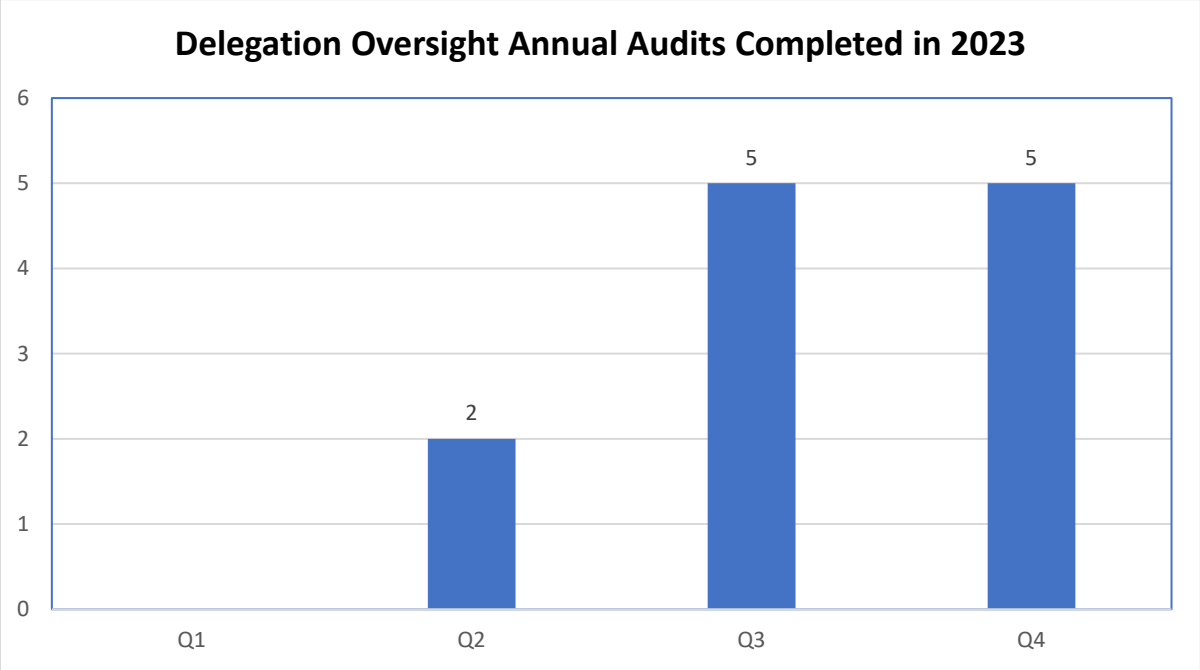
Background: CalOptima Health contracts with health care providers that are delegated to perform certain administrative services and functions as part of their agreements with CalOptima Health. CalOptima Health performs regular oversight of the Delegate's performance to ensure adherence to regulatory, contractual and operational requirements. Each year, on a regular and periodic basis, CalOptima requires Delegates to submit reports to substantiate its performance for each administrative service and function delegated. CalOptima Health, oversight activities include, but are not limited to, annual audits of the Delegate, ad hoc focused audits, as well review of monthly and quarterly reports submitted by the Delegate. The oversight is intended to assess the Delegate's performance against benchmarks and thresholds and validate regulatory and contractual compliance.

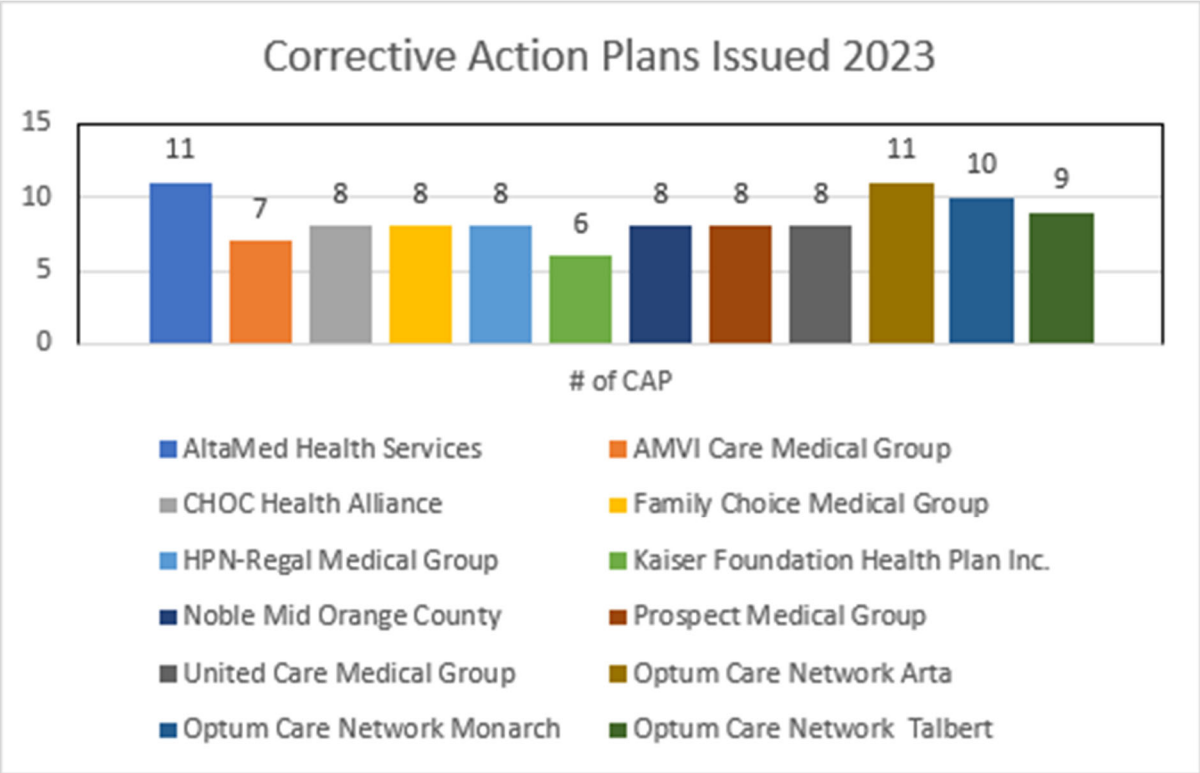
Program Goal: Complete delegation oversight audits according to the scheduled timeline agreed upon with the Delegates while identifying opportunities for improvement for the betterment of our members.

Actions/Interventions: Development of the audit preparation guide to be utilized in 2024.

Planned Activities	Description	Date of Completion
Delegation Annual Audit	All Delegates were evaluated based upon CalOptima requirements, 2023 NCQA accreditation standards, DMHC, CMS and DHCS regulatory requirements. The audit had two components: webinar and desk review.	4th Quarter 2023
DHOC Physician-Administered Drug (PAD) Audit	All Delegates were evaluated through an ad hoc audit on Physician-Administered Drug (PAD) Utilization Management authorizations in September 2023. The purpose of the audit was to monitor and assure that CalOptima Health functions are being performed satisfactorily for the Medi-Cal line of business. The audit was conducted by desk review.	4th Quarter 2023

Results:





Quantitative Analysis:

A. CalOptima Health conducted an annual audit to all 12 Delegates in 2023, where two Delegates were audited in Q2 2023, five were audited in Q3 2023 and five were audited in Q3 2023.
B. All Delegates were issued CAPs in 2023, with Kaiser Foundation Health Plan receiving the least number of CAPs at six and AltaMed Health Services and AMVI Care Medical Group receiving the most number of CAPs at 11 CAPs.
C. In 2023, a total of 102 CAPs were issued to the 12 Delegates to ensure that they are meeting their contractual obligations.

Qualitative Analysis/Barriers:

A. Extension requests from the Delegates to provide supporting documentation.
B. Technical difficulties as the delegation annual audits were performed via webinar.
C. The ad hoc audit for PADs was a new audit for the Delegates so interpretation and understanding of the requirements was a challenge for some Delegates.

Conclusion and Next Steps:

A. Continue to remain collaborative and transparent with the Delegates. Avoid transactional communication but instead develop partnerships to provide our CalOptima members with the best member experience and quality work.

2023 QI Work Plan 1Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Support Staff	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
Program Oversight	2023 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Quality Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by April 2023	Marsha Choo	Laura Guest	Approved: QIC 2/14/2023, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2022 Quality Improvement Program Evaluation	Complete Evaluation 2022 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by January 2023	Marsha Choo	Laura Guest	Approved: QIC 2/15/2022, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2023 Utilization Management Program	Obtain Board Approval of 2023 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Teresa Smith	Approved: UMC Committee via eVote on 4/7/2023, QIC 4/11/2023		
Program Oversight	2022 Utilization Management Program Evaluation	Complete Evaluation of 2022 UM Program	UM Program will be evaluated for effectiveness on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Teresa Smith	Approved: UMC Committee via eVote on 4/7/2023, QIC 4/11/2023		
Program Oversight	Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	Barbara Kidder	Updated and drafted a PHM strategy to meet NCQA requirements and currently in the process of revising and updating to meet DHCS contractual requirements. The goal is to have a single document that aligns with all regulatory requirements, NCQA accreditation and strategic priorities for the organization.	PHM Strategy will be presented to QIHEC in Q2 for feedback and continue to be refined with CalOptima Health leadership to include a comprehensive scope of services and strategies. PHM Strategy will be due to DHCS in October 2023.	
Program Oversight	CalAIM	Improve Health & Access to care for enrolled members	1) Launch ECM Academy; a pilot program to bring on new ECM providers. 2) Increase CalOptima Health's capacity to provide community supports through continued expansion of provider network. 3) Continue to increase utilization of benefits. 4) Establish oversight strategy for the CalAIM program. 5) Implement Street Medicine Program 6) Select and fund HHIP projects through Notice of Funding Opportunity. 7) Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	1) 1Q 2023 2) 4Q 2023 3) 4Q 2023 4) 3Q 2023 5) 1Q, 2Q 2023 6) 1Q 2023 7) 3Q 2023	Mia Arias	Danielle Cameron	1. The ECM Academy launched in January 2023 with 20 community health centers and community-based organizations participating. They received incentive funding to support building internal capacity for this service and will receive training through June 2023. They are anticipated to be contracted and launch services in July 2023. 2. CalAIM Team brought on 19 new providers in Q1 of 2023 and expanded the contracts of 8 current providers to expand their offering of additional services. 3. As of 3/31/2023, a total of 12,491 members had authorization for CalAIM benefits. In reviewing claims for services, 620 were receiving ECM only, 6,208 were receiving community supports, and 1,063 were receiving both ECM and community supports. 4. The CalAIM team is finalizing the community supports policy guidelines that includes requirements for documentation and quality metrics. Once this policy guide is complete, training will be conducted with providers and will be integrated into an overal quality monitoring program. 5. Healthcare in Action was fully credentialied and contracted in Q1. Services began on 4/3/2023. 6. CalOptima Health staff have executed grant agreements and award payments to selected grant recipients for each of the following funding areas, as a result of the notice of funding opportunity as follows: a. Infrastructure Projects that will increase housing navigation and organizational capacity to connect individuals to permanent supportive housing: Total of payments recommended for award: $5,832,314. b. Capital Projects to increase the current affordable and permanent housing pool: Total of payments recommended for award: $21,000,000. c. Equity Grants for Programs Serving Underrepresented Populations of people experiencing homelessness: Total of payments recommended for award: $3,021,311. 7. Planning is still under way for the HCAP 2.0 program. Focus groups are being conducted with previous providers of the HCAP program to help inform the evolution of the service.	All programs will continue to be stewarded forward.	
Program Oversight	Health Equity	Increase member screening and access to resources that support the social determinants of health	1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy project	1) 4Q 2022 2) 4Q 2022 3) 3Q 2022	Katie Balderas	Barbara Kidder	1. The Annual Wellness Visit incentive for Medi-Cal members added a requirement for providers to conduct an Health Related Social Needs Assessment 2. Worked with EPMO to draft a SOW for a close-loop referral tool. Vendor Management provided budgetay estimates from two potential vendors (FindHelp and WellSky) 3. Launched the Health Literacy for Equity (HL4E) program in collaboration with the Orange County Health Care Agency, Social Services Agency, St. Jude and he Institute for Healthcare Advancement.The goal of the program is to partner with other systems in Orange County to increase organizational health literacy through a variety of activities including leadership commitment, training courses and improvement projects.	Data evaluation of Annuall Wellness visits inentives to evaluate HRSN reporting The Close loop referral tool changed priority status since DHCS changed the timeline/requirement for the close loop referral HL4E - training, certification, organizational assessment will continue trhough April 2024.	
Program Oversight	**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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Laura Guest	Marsha Choo	I. FSR/PARS/NF/CBAS: A. FSR: Initals=8; Periodic=40; CE CAPs=39; FSR CAPs=39. Initial MRR=11, Periodic MRRs=53; MRR CAPs=42; Failed FSRs=3; Failed MRRs=3. B. PARS: PARS=133; Basic=60(45%); Limited=73 C. CBAS: No Critical Incidents reported, Non-critical declined; Fall similar to previous quarters; COVID dropped to nearly 0. Audit=13; CAPs=4; Unannouced Visits=0. D. NF: No Critical Incidents were reported in Q1. Audit=3; CAPs=0; Unannounced Visits=0. II. Credentialing: CCN initial credentialing=26, recredentials=29, BH initial credentialing=10, BH Recredentialing=13 III. PQIs There were 158 cases closed in Q1. There were 16 PQI cases presented to CPRC. Medical Care: Mismanaged Care was the greatest category/subcategory of PQIs. The number of QOC Grievances reviewed were 502, declined grievances were 91. Created report to monitor TAT of Declined Grievance PQIs with goal of MD review in 30 days and TAT of PQIs with a goal of MD review in 90 days. Requested additional staffing to accommodate additional workload.	I. FSR/PARS/NF/CBAS A. FSR: Continue to audit. B. PARS: Continue to audit C. CBAS:Continue to audit and remind centers to report critical incidents. D. NF: Re-evaluate current processes. One LVN retired, so will recruit for this position. II. Credentialing A. Continue to perform credentialing and recredentialing if CCN and BH providers. B. Review and provide feedback to the delegated CCN provider groups regarding the monthly credentialing universes they submit. III. PQI 1. Review QOC grievances, Declined grievances and PQIs. Due to backlog of PQIs, hire temp to assist with medical record requests. Meet with Quality Medical Director to evaluate method for QOS cases that don't involve a PQI.	
Program Oversight	**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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Tyronda Moses	Heather Sedillo	GARS Committee (held on 2/6/2023) was presented Q4 2022 data and reviewed the overall CY 2022 trends and remediation steps. The highest trending complaint reason remains the quality of service performed by our NMT servicer. However, the complaints remain under 1% of the total rides (they are meeting the service levels in the contract). There are additional collaboration steps that are being considered. GARS will continue to monitor and assess for remediation/reommendations for improved performance. Announced also during Committee were regulatory changes impacting DHCS reporting for Q4 and CMS/DHCS OneCare AIP impacts to appeals timeframes and grievance processing. Meeting minutes have been submitted	GARS continues bi-weekly communication with our NMT service provider for any actionable process improvements. next GARS Committee is scheduled for Q1 2023 review on May 8	

2023 QI Work Plan 1Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Support Staff	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
Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2023 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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Marsha Choo	Karen Jenkins	In Q1, MemX Committee has reviewed/discussed the following: **3/16/2023**: •Charter Review •Member Experience Workplan •OC Customer Service Member Outreach Campaign •Customer Service Interpreter Service •GARS Update •Network Adequacy Workgroup Update •Timely Access Workgroup Update & Discussion •CAHPS •Veyo Tranportation	In Q2 MEMX Committee has two meetings scheduled, April 12 and May 17.	
Program Oversight	**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.	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	Stacie Oakley	Teresa Smith	UMC met 2/23/23 and is on track to meet quarterly. Meeting minutes are available for review. Committee did the annual review of criteria used clinical decision making and Hireachy of Clinical Decision making. Reviewed and approved IRR reports. 2022 Utilization Metrics: 4th Quarter, Pharmacy, BH and LTSS update.	UMC scheduled 5/25/23	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.		Meet quarterly to provide clinical and behavioral service advice regarding Whole Child Model operations **2023 Meeting Schedules** WCM CAC Q1: February 21, 2023 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (~~4/11~~ 6/13QIC) 2Q23 update (~~7/11~~ 6/13 QIC) 3Q23 update (~~10/10~~ 9/12 QIC) 4Q23 update (~~Jan 2024~~ 12/12 QIC)	T.T. Nguyen, MD	Gloria Garcia	WCM CAC met 2/21/23 - See meeting minutes for details. A copy of those meeting minutes will be presented along with the WCM CAC report at the June 13, 2023 QIHEC.	Q2 meeting is scheduled for May 16, 2023. Continue with tranistion workgroup and follow up with HN relation to increase the number of contracted CCS paneled providers.	
Program Oversight	Health Network Quality Rating	Achieve 4 or above	Will share HN performance on all P4V HEDIS Measures via prospective rates report each month	end of 4Q 2023	Sandeep Mital		The Pay for Value (P4V) team generates a Prospective Rate (PR) report each month for all participating health networks and CalOptima Health to allow health networks their progress on clinical HEDIS measures in the P4V program. Performance on each measure is compared to the overall CalOptima Health performance, as well as to the National Medicaid HEDIS benchmarks established by NCQA.	The overall health network quality rating (HNQR) is the weighted average of the network's HEDIS and CAHPS measure ratings, as well as accreditation bonus points and is calculated on a scale of 0-5 (5 being the highest). The final HNQR is usually complete after the final HEDIS and CAHPS results are available in the fourth quarter of the following year.	
Program Oversight	Improvement Projects OneCare 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 for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	end of 2Q2023	Helen Syn	Melissa Morales	Baseline Data: **PR Report February 2023** **HbA1C <8 Total (HBD):** MC: Num 4,801/ Den 43,251 = 11.10% OC: Num 528/ Den 3,707 = 14.24% **HbA1c>9 Total (Poor Control) (HBD):** MC: Num 37,427/ Den 43,251 = 86.53% OC: Num 3,088/ Den 3,707 = 83.30% **Eye Exam for Patients with Diabetes (EED):** MC: Num 9,967/ Den 43,251 = 23.04% OC: Num 1,140/ Den 3,707 = 30.75% **Kidney Health Evaluation for Patients with Diabetes (KED):** MC: Num 3,961/ Den 43,707 = 9.06% OC: Num 473/ Den 4,586 = 10.31% **Statin Use in Persons with Diabetes (SUPD) OC only:** Pending data 1) Diabetes Member Mailers: MC Total sent: 34,773 members, OC Total sent: 3,547 2) SPD Statin mailers (bi annual): MC Total sent: 6,606 members, OC Total sent: 651 members. 3) Text Message Campaign A1C and Diabetes Eye Exam: Pending 4) IVR Campaign A1C and Diabetes Eye Exam: slated for Q3 2023/Q4 2023 5) Live Call Outreach: Pending 6) VSP Eye Exam Reminder Letters: MC Total sent in Q1 2023: 1,276, OC Total sent in Q1 2023: 533 7) Member Incentive: MC A1C Test: 19 approved, 2 denials, MC Eye Exam: 38 approved, 4 denials OC none, slated for distribution mid/late May 2023.	1) Track submitted diabetes member incentive forms 2) Continue Statin Mailer in Q3 2023 3) Obtain results from text message campaign 4) Obtain results from IVR campaign 5) Obtain results from Live Call Outreach campaign 6) Obtain results from VSP Eye Exam Reminder Letters	
Program Oversight	Improvement Projects Medi-Cal PIP	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP - Health Disparity remediation for W30 6+ measure (Jan Pending January Module Training January 2023 projected. Please note that the focus for the Clinical and Non-Clinical PIP topics is related to DHCS' "50 by 2025: Bold Goals Initiatives"- See links for more information on the Bold Goals Initiatives: https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/Equity-and-Practice-Transformation-Grants-May-Revise.pdf or https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf	Quarterly Status update on modules as they are completed.	Helen Syn	Michelle Nobe	1) Clinical PIP - focuses on DHCS' statewide goals is to reduce the disparity among the Black/African American population for the Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure. Assigned 3/15/23: 2023–26 W30–6 Clinical PIP Topic Data Form.	1) Identify CalOptima Health's Black/African American W30-6+ population to complete the 2023–26 W30–6 Clinical PIP Topic Data Form. Submission due 4/11/23. 2) While the PIP deliverable will focus on the specific Black/African American sub-population, for purposes of a more thorough health equity assessment, the improvement project will include a broader health plan level project.	

2023 QI Work Plan 1Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Support Staff	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
Program Oversight	Improvement Projects Medi-Cal PIP(BH)	Meet and exceed goals set forth on all improvement projects	Non-Clinical PIP - FUM/FUA 1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	Jeni Diaz	FUM/FUA update provided under Quality of Clinical Care Behavioral Health section below.	FUM/FUA next steps provided under Quality of Clinical Care Behavioral Health section below.	
Program Oversight	Managed Care Accountability Set (MCAS)	Achieve 50th percentile on all MCAS measures in 2021	Share results to Quality Improvement Committee annually	end of 3Q 2023	Paul Jiang		There is no update for Q1. No results until July		
Program Oversight	OneCare Performance measures	Achieve 4 or above	1) Implement Star Improvement Program 2) Track measures monthly 3) Implement OC Pay4Value	1. 1Q2023 2. 1Q2023 3. 3Q2023	Linda Lee	Sandeep Mital	Preliminary prospective rates published for OneCare Star and Pay4Value measures. Rates will be tracked monthly throughout year.	1) Stars/CAHPS work groups underway- five work groups (provider, medical management, pharmacy, customer service, and member material development) began on 4/14/2023. Work groups will meet weekly and report bimonthly to Steering Committee. 2) Stars dashboard- plan and Health Network level published beginning 4/7/2023. Dashboard updated and published monthly going forward. 3) OC Pay4Value program underway. Pay4Value score card updated and published monthly beginning 4/7/2023.	
Program Oversight	PPME/QIPE: HRA and ICP	3.2 ICP completion 90 days Benchmark 90% adjusted. 2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted.	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks.	1Q23 (5/9 QIC) 2Q23 (8/8 QIC) 3Q23 (11/14 QIC) 4Q23 (February 2024 QIC)	S. Hickman/D. Hood/M. Dankmyer/H. Kim		Regulatory reporting is currently in development and scheduled to be completed by end of April 2023. Communication with Networks has been initiated during Q1 to support tracking and completion to meet ICP benchmarks.	1)Finalize regulatory reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Continue and enhance communication with Networks for tracking outreach and completion to meet benchmarks.	
Program Oversight	NCQA Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and **NCQA Health Equity Accreditation by no later than January 1, 2026.**	1) Continue to Work with Business owners to collect all required documents for upcoming HP re-accreditation.(Must collect all Year one required documents by 2Q2023. 2) Comple Gap Analysis for Health Equity Accreditation.	1) end of 1Q2023 2) end of 2Q2023	Veronica Gomez	Marsha Choo	1)Continued to work with Business owners on the collection of Year one reports. Dashboard with status update will be presented at the April 10 NCQA Committee. Performed mock audits on CCM File review with Health Networks and CalOptima Health Staff. Will be closing Year one document required by end of 2Q2023. Will be performing UM Denial, Appeal, CR mock audits with Health Networks and CalOptima Health Staff. 2) Working with NCQA Consultant on Health Equity Timeline and performing GAP Analysis and next steps.	Upcoming File Review Mock Sessions w/Consultants Credentialing w/Sub-delegates (4/26/2023) Credentialing w/Health Networks (5/3/2023) Credentialing CCN (5/4/2023) UM Medical Denials w/Health Networks (5/8/2023) UM Medical Denials CCN (5/10/2023) Appeals CCN (5/11/2023)	
Program Oversight	Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	1 Implement SBHIP DHCS targeted interventions 2. bi-quaterly reporting to DHCS	1) 4Q2023 2) 4Q2023	Diane Ramos/ Natalie Zavala	Sherie Hopson	1) Completed DHCS follow-up requests for Milestone 1 - Needs Assessment and 4 Targeted Intervention Project Plans 2) Received DHCS approval for funding for Milestone 1 on 3/8/23 3) SBHIP MOU review with Contracting 1/12 4) OCHCA and BHI work session 2/6 5) Executive Director/Manager attended the OCDE Mental Health Workshop meetings - 1/20, 2/10, and 3/3 6) 3/8 Meeting with OCDE purpose was to share with the group the current status of the program, and upcoming deliverables and expectations 7) Initial discussions with potential telehealth vendor, OCDE, and OCHCA regarding their services to support the LEA BH needs - 3/8, 3/27	1) Begin SBHIP MOU development 2) Collect data for upcoming bi-quarterly report due to DHCS end of 2nd quarter 3) Executive Director / Manager continue to attend OCDE Mental Health Workshop meetings 4) COBAR - prepare for May BOD to approve SBHIP funding strategy/plan	
Quality of Clinical Care	Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	MY 2023 Goals: CCS: MC 62.53% BCS: MC 61.27% OC 70% COL: OC 71%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	1) Quarterly Updates 2) Per Quality Initiatives Calendar - ongoing updates	Helen Syn	Melissa Morales	1) 2023 Member Health Rewards processed as of 3/31/23: CCS: Processed 74 approved 72 for MC BCS: Procesed 102 approved 84 for MC Processed 0 for OC COL: Processed 0 for OC 2) Member, Community and Provider Engagement IVR: CCS Texting: CCS Social Media (Passive): CCS completed January; COL completed March Social Media (Paid): CCS, COL Digital Ad: CCS, COL Print Ad: COL Radio: CCS PBS: BCS, CCS Community Connections: CCS completed January Provider Press: Screening Recommendations. Provider Updates: CCS, COL 3) 2023 February Prospective Rates (PR): Cervical Cancer Screening MC: 42.63% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Goal is set to the 75th Percentile. Breast Cancer Screening MC: 42.21% Measure is performing lower than same time last year and below the 50th percentile (MPL).Goal is set to the 90th Percentile. OC: 48.60% Measure is performaing lower than same time last year. Currently at 2 Star of 43% Goal is set to 4 Star of 70% Colorectal Cancer Screening OC: 47.05% Measure is performing higher than same time last year for OC. Currently at 2 Star of 43% Goal is set to 4 Star of 71%.	1) Continue to track BCS, CCS and COL member health reward. 2) Member, Community and Provider Engagement Mailing: CCS Mailing Schedule April. COL Mailing Schedule May BCS Mailing Schedule June IVR: COL scheduled May BCS Scheduled June Texting: BCS Schedule April Social Media (Passive): Women's Social Media (Paid): COL Digital Ad: COL Member Newsletter: MC Spring 2023 (drop 5/5); BCS COL OC Fall 2023; CCS, BCS, COL MC Fall 2023 Community Connections: CCS, BCS, COL scheduled April for National Cancer Awareness Provider Press: Cancer Screening for July Provider Updates: CCS, BCS, COL (April general cancer screening month)	

2023 QI Work Plan 1Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Support Staff	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
Quality of Clinical Care	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	1) Assess community infrastructure capacity for cancer screening and treatment 2) Establish the the Comprehensive Cancer Screening and Support Program Stakeholder Collaborative (in our Case I want to leverage OC3) 3) Develop comprehensive outreach campaign to outreach to members due for cancer screenings (mobile mammography, outbound calls, community health workers) 4) Integrate new community health worker benefit into cancer outreach and treatment services.	1) 1Q2023 2) 2Q2023 2) 3Q2023 3) 4Q2023	Katie Balderas/ Barbara Kidder	Barbara Kidder	1) Worked with the Coalition of Orange County to assess capacity of Community Helath Centers to screen for breast, colorectal, cervical and lung cancer - 7 FQHCs reported having on-site equiptment to screen for breast cancer. 3) Developed a mammograp screening pilot for CCN members in partnership with City of Hope. Pilot exprected to launch early May 2023.	Launch mammogram pilot. Explote other efforts such as cancer screening access points with FQHCs that have on-site equiptment and setting up a mobile mammography pilot. Develop cancer screening campaign and landing page in the CalOptima Health Website	
Quality of Clinical Care	COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (18 and over).	1) Communication Strategy of COVID vaccination incentive program through June 30, 2023 end date, focusing on unvaccinated, and missed booster opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for boosters	1) end of 1Q2023 2) end of 4Q2023	Helen Syn	Linette Lorenzo	1. Targeted Ad Campaign in Q1 for encouraging starting COVID-19 Vaccinations by June 30, 2023 to qualify for a health reward 2. Social Media Outreach about the new program guidelines (i.e. Facebook, Instagram) 3. Internal communication to member-facing staff of program end date via internal FAQ 4. Updated COVID-19 Vaccine Incentive Program (VIP) website to reflect new guidelines 5. Worked with internal stakeholders to update the system flow and logic for faster delivery of outstanding gift cards to members 6. Reached 70.65% vaccination rate for CalOptima members (18 and older).	Texting campaign to address new eligibility guidelines. COVID-19 VIP processing continues as we begin planning for the official end date of the program.	
Quality of Clinical Care	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2023 Goal: MC - Init Phase - 42.77% MC -Cont Phase - 51.78%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on provider responsibilities on related to follow-up visits. 3) Continue member outreach (through mutiple modalities telephonic, newsletter, mobile device) to improve appointment follow up adherence.	1. 2Q2023 2. 4Q2023 3. 3Q2023	Diane Ramos/ Natalie Zavala	Valerie Venegas	PR HEDIS Rates Q1 (February): Initiation Phase- 40.11%, Continuation and Maintenance Phase- 51.15% 1) Continued member outreach for members that filled initial ADHD Rx 2) Worked with Communications on article for Treatment for Children with ADHD to educate members on ADHD to be included in the Medi-Cal Member Newsletter Spring 2023 edition 3) Met with PHM and recieved training on the process to send out text messages to members; drafted 2- way Text Message Script	1) Continue member outreach for those who filled an initial ADHD prescription 2) Pull report to identify trends in compliant and non-compliant providers 3) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback 4) Treatment for Children with ADHD to be included in the Medi-Cal Member Newsletter Spring 2023 Ed.	
Quality of Clinical Care	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2023 Goal: MC 77.48% OC (Medicaid only)	1) Identify members through internal data reports in need of diabetes screening test. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) 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.	1. 2Q2023 2. 3Q2023 3. 2Q2023	Diane Ramos/ Natalie Zavala	Nathalie Pauli	PR HEDIS Rates Q1 (February): M/C: 26.89% OC: N/A 1) Barriers: No data 1st quarter from ITS Data Warehouse Team 2) Met with PHM and recieved training on the process to send out text messages to members as a potential opportunity for measure; drafted Text Message Script	1) Continue to work with ITS for Q1 data 2) Identify members in need of diabetes screening test and their prescribing providers 3) Remind prescribing [roviders of best practice, provide list of members to complete screening with PCP contact information for each member to promote coordination of care 4) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS MY2023 Goal: MC 30-Day: 54.51%; 7 day: 31.97% OC (Medicaid only)	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	Jeni Diaz	PR HEDIS Rates Q1 (February): 30 day- 19.42%, 7 day- 13.02% 1) Received Training from CalOptima Health vendor to recieve real-time Emergency Department (ED) data from local participating hospitals in Orange County 2) Idenified process to pull and review real-time ED data from vendor 3) Met with PHM and recieved training on the process to send out text messages to members as a potential opportunity for measure; drafted Text Message Script	1) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback 2) BHI and QA devleop process to share real-time ED Data with Health Networks	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	MY2023 Goals: MC: 30-days: 21.24%; 7-days: 8.93%	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilites on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	Valerie Venegas	PR HEDIS Rates Q1 (February): 30 day- 17.48%, 7 Day Total- 9.31% 1) Received Training from CalOptima Health vendor to recieve real time ED data from local participating hospitals in Orange County 2) Idenified process to pull and review real-time ED data from vendor 3) Met with PHM and recieved training on the process to send out text messages to members as a potential opportunity for measure; drafted Text Message Script	1) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback 2) BHI and QA will devleop process to share real-time ED Data with Health Networks	
Quality of Clinical Care	Depression Remission or Response for Adolescents and Adults (DRR-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening, treatment, and follow up 3)Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow-up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	Mary Barranco/Alvin Ortin	PR HEDIS Rates Q1 (February): N/A; Not at risk for meeting the standard due to no benchmark set 1) Data collection continues to be a major challenge due to the lack of mechanisms for capturing provider data 2) Completed provider fax blast document encouraging screening for depression and best practice guidelines with member educational material on Understanding Depression 3) Met with PHM and recieved training on the process to send out text messages to members as a potential opportunity for measure; drafted Text Message Script 4) Submitted Understanding Depression article for OneCare (OC) and Medi-Cal Member Newsletter Fall 2023 edition	1) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback 2) Collaborate with Communcations to finalize article for Member Newsletter Fall 2023 Ed. 3) Distribute provider fax blast	

2023 QI Work Plan 1Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Support Staff	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
Quality of Clinical Care	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening and treatment 3)Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	Mary Barranco/Alvin Ortin	PR HEDIS Rates Q1 (February): N/A; Not at risk for meeting the standard due to no benchmark set 1) Data collection continues to be a major challenge due to the lack of mechanisms for capturing provider data 2) Completed provider fax blast document encouraging screening for depression and best practice guidelines with member educational material on Understanding Depression 3) Met with PHM and recieved training on the process to send out text messages to members as a potential opportunity for measure; drafted Text Message Script 4) Submitted Understanding Depression article for OC and Medi-Cal Member Newsletter Fall 2023 edition	1) Review Text Message Script draft at BHQI Workgroup and finalize based on feedback 2) Collaborate with Communcations to finalize article for Member Newsletter Fall 2023 Ed. 3) Distribute provider fax blast	
Quality of Clinical Care	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2023** Goals: MC: 30.9%; OC: 17%	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation	Helen Syn	Melissa Morales	1)Member Incentive: MC A1C Test: 19 approved, 2 denials, 2) Member Engagement: Diabetes Member Mailers: MC Total sent: 34,773 members, OC Total sent: 3,547 Social Media (Passive): Social Media (Paid): Diabetes in January Digital Ad: Diabetes in January Radio: Diabetes January Provider Press: encourage members for A1c testing sent March to 2910 providers. 3) PR Report February 2023 HbA1C <8 Total (HBD): MC: Num 4,801/ Den 43,251 = 11.10% OC: Num 528/ Den 3,707 = 14.24% HbA1c>9 Total (Poor Control) (HBD): MC: Num 37,427/ Den 43,251 = 86.53% OC: Num 3,088/ Den 3,707 = 83.30%	2) Member, Community and Provider Engagement IVR: slated for Q3 2023/Q4 2023 Text: **Scheduled for May.** Will go to 10,136 Medi-Cal members.	
Quality of Clinical Care	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)	MY2023 HEDIS Goals:: MC 63.75% OC: 79%;	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures 3) VSP Collaborative gaps in care bridging efforts.	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation 3) End of Q2 2023	Helen Syn	Melissa Morales	1) Member Incentive: MC Eye Exam: 38 approved, 4 denials 2) Member Engagement Diabetes Member Mailers: MC Total sent: 34,773 members, OC Total sent: 3,547 Social Media (Paid): Diabetes in January Digital Ad: Diabetes in January Radio: Diabetes January VSP Eye Exam Reminder Letters: MC Total sent in Q1 2023: 1,276, OC Total sent in Q1 2023: 533 3)PR Report February 2023 Eye Exam for Patients with Diabetes (EED): MC: Num 9,967/ Den 43,251 = 23.04% OC: Num 1,140/ Den 3,707 = 30.75%	1) Member Incentive OC slated for distibution mid/late May 2023 2) Member, Community and Provider Engagement IVR: slated for Q3 2023/Q4 2023 Text: **Scheduled for May.** Will go to 10,136 Medi-Cal members.	
Quality of Clinical Care	Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot	1) Lower HbA1c to avoid complications (baseline: A1c ≥ 8%; varies by individual); 2) Improve member and provider satisfaction	<u>Final Pilot Program Design:</u> 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement <u>Planned Activities:</u> Finalize member stratification Outreach to high volume PCPs Launch the pilot program	Finalize member stratification - end of Jan 2023 Outreach to high volume PCPs - end of Q1 Launch the pilot program - end of Q1	Joanne Ku	Nicki Ghazanfarpour/ Jocelyn Johnson/Elisa Mora	Finalized member stratification in Jan 2023. Presented the pilot project status to QIC in Mar 2023. Began outreach to high volume PCPs in Q1. <u>Challenge</u>: Most high volume PCPs are FQHCs, and they already have a Clinical Pharmacist, a Health Educator or a multidisciplinary team to care for their patients with uncontrolled diabetes. Unable to launch the pilot program in Q1.	Continue outreach to CCN PCPs and look for partnership. Present the program at the June CCN Lunch & Learn to attract potential partners. Aim to launch the pilot - end of Q2/early Q3.	
Quality of Clinical Care	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP) Care Management, Comprehensive Diabetes Care (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	Linda Lee	Helen Syn	Analyzed measures and prioritized SNP Care Management, HbA1c Control, and COA for intervention. Interventions assigned to business owners and quality initiatives for implementation	Quality initiatives team and business owners to implement and monitor monthly.	
Quality of Clinical Care	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2023 Goal: Postpartum: 84.18% Prenatal: 91.89%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 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) Expand member engagement through direct services such as the Doula benefit and educational classes	1) Annual Evaluation 2) Per quality initiatives calendar - ongoing updates 3) Ongoing updates 4) 4Q2023 5) 3Q2023	Ann Mino/ Helen Syn	Leslie Martinez	1.Postpartum Member Incentive: 143 submissions, all approved. 2. Community partnerships: WIC, OC Perinatal Council, First 5 OC, OC Health Care Agency, OC Home Visiting Collaborative, OC Family Task Force. Presented Doula Benefit at 2 community collaborative groups. 3. Member engagement: - Bright Steps Program: 916 new PNRs, 343 Postpartum Assessments completed, 732 total unique outreaches to members. - Community events: Baby Shower Educational Event planned for Q2. 4. W30 Data Workgroup: Early Identification and Data Gap Bridging Remediation for early intervention. - Working to identify data sources for the early identification of pregnancies for member engagement. **February 2023 Prospective Rates:** Timeliness of Prenatal Care: Reporting issues with current rate on the latest PR report. Rate for this measure to be reported on next quarterly updated. Postpartum Care: Performing higher than last year in February 2022, but MPL not met. Rate: 55.999%, MPL Rate: 77.37%	1. Planned: Member engagement once data source is established to identify members: - Mailing (planned) for the promotion of postpartum care once data source is established to identify members. - Medi-Cal member newsletter article, slated for Q2. 2. Provider Engagement: - Provider Press Newsletter, slated for Q2 to promote Medi-Cal enrollment and postpartum Care.	
Quality of Clinical Care	MCAS Performance Measures Improvement Plan: Plan, Do, Study, Acts - PDSAs	Meet and exceed MPL for DHCS MCAS Corrective Action	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.	Quarterly Status update on modules as they are completed.	Helen Syn	Michelle Nobe	Well-Child Visits in the First 30 Months (W30-2+) PDSA Cycle 1: 11/4/22 - 3/17/23 SMART AIM Goal 1: By 02/28/2023, complete a minimum of 2 outreach call attempts, which includes both unsuccessful-unanswered calls and successful-answered calls by parent or guardian, to at least 90% of members (N=319) on the target list. Intervention Implementation Period: 2/1/23 - 2/10/23. Telephonic call campaign completed by 2 staff members, in-house. Outcomes: The results of this interventions indicated that 100% (313/313) of members were outreached at least 1 time, and 55.27% (173/313) of members were outreached at least 2 times. In order to meet the SMART AIM Goal there should have been at least 564 call attempts, but overall there were only 486. Therefore, the SMART AIM Goal 1 was not met. However, it was also evident that a 2nd attempt was not indicated in instances due to disconnected/wrong phone number/member refusal. Submitted Cycle 1 to DHCS: 3/23/23.	Well-Child Visits in the First 30 Months (W30-2+) PDSA 1) Proceed with Cycle 2: 3/24/23 - 7/14/23. Cycle 2 intervention will include in-house telephonic call campaign and a birthday card mailer.	

2023 QI Work Plan 1Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Support Staff	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
Quality of Clinical Care	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 **MY2023** Goal CIS-Combo 10: 49.76% IMA-Combo 2: 48.42% W30-First 15 Months: 55.72% W30-15 to 30 Months: 69.84% WCV (Total): 57.44%	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. Examples: EPSDT DHCS promotional campaign; Back-to-School Immunization Clinics with Community Relations; expansion of Bright steps comprehensive maternal health program through 1 year postparum to include infant health, well-child visits, and immunization education and support 3) Early Identification and Data Gap Bridging Remediation for early intervention.	1) 3Q2023 2) Per quality initiatives calendar - ongoing updates 3) End of Q22023	Helen Syn	Michelle Nobe	1) Targeted member engagement and outreach campaigns in coordination with health network partners. - Met with Health Networks to share Quality Initiatives Activities Calendar for CY2023 **2) Strategic Quality Initiatives Intervention Plan** - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. - Well-Child Visits 0-30 Months Text Message Campaign (2/22-2/28/23): 8,183 messages sent, 152 members responded to text message; Well-Care Visits 3-17 Years Text Message Campaign (2/28-3/11/23): 72,870 messages sent, 3,887 members responded to text meesage; Plans to expand Bright Steps Program Well-Child Outreach Calls to include a 6 months old and 12 months old follow-up. 2-weeks high priority and 3-months old outreach calls are continued; IVR scripts are in development Updated and/or created artwork for the following: - Health Guide 0-2 Years Newsletter with Blood Lead Screening; Health Guide 3-6 Years Newsletter; Health Guide 7-12 Years Newsletter; Health Guide 18-21 Years Newsletter; Well-Child Visits Flyer Newsletter; First Birthday Card + Second Birthday Card. Artwork is complete and dashboard is developed. Working with Procurement to set up a monthly mailing cadence. **3) Early Identification and Data Gap Bridging Remediation for early intervention.** W30 Data Strategies Workgroup: - Improved HN monthly Gap Reports to include more measures and details - Developing W30 Gap Report for HNs. Will pilot with 1 HN in Q2 for feedback. **4) February 2023 Prospective Rates** CIS-Combo 10: 21.58%, performing lower than last year (2.72%), have not met goal (49.76%) IMA-Combo 2: 33.99%, performing lower than last year (35.45%), met the 33rd percentile, have not met goal (48.42%) W30-First 15 Months: 15.56%, performing better than last year (8.12%), have not met goal (55.72%). +7.44% improvement W30-15 to 30 Months: 51.96%, performing better than last year (46.87%), have not met goal (69.84%) WCV (Total): 2.50%, performing better than last year (2.20%), have not met goal (57.44%)	1) Continue targeted member engagement and outreach campaigns in coordination with health network partners. 2) Continue with Strategic Quality Initiatives Intervention Plan. - Well-Child Visits 0-30 Months Text Message Campaign, slated for May - Well-Care Visits 3-17 Years Text Message Campaign, slated for June - Implement Bright Steps Program Well-Child Outreach Calls to include a 6 months old and 12 months old follow-up starting late April. - IVR scripts 1) W30: 0-14 months, 2) W30: 15-30 months, 3) WCV 3-17 years, and 4) WCV 18-21 Years scripts to be recorded in Q2. Tentative launch for W30 IVR campaigns in May-June. Mailings: - Health Guide 0-2 Years Newsletter with Blood Lead Screening, slated for April - Health Guide 3-6 Years Newsletter, slated for Q2 - Health Guide 7-12 Years Newsletter, slated for Q2 - Health Guide 18-21 Years Newsletter, slated for Q2 - Well-Child Visits Flyer Newsletter - First Birthday Card, slated for late April and June - Second Birthday Card, slated for late April and June 3) Continue efforts for early Identification and Data Gap Bridging Remediation for early intervention. W30 Data Strategy Workgroup plans to come up with recommedation to present at May BOD.	
Quality of Clinical Care	Blood Lead Screening DHCS APL	1) Comply with APL requirements including quarterly reports of members missing blood lead screening 2) Increase Rates of successfully screened members to #% 3) Put process in place ot identify refusal of blood lead consent forms	- PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. - Update Policy GG.1717 to include Health Network Attestation and conduct Health Network/Provider education - Add blood lead screening resources to CalOptima Health website: Comprehensive Health Assessment Forms, CDPH anticipatory guidance handout, - Launch IVR campaign to members with untested children - Member mailing campaign to members - Lead texting campaign for members - Medi-Cal member newsletter article(s)	All activities will be complete by 3Q, 2023	Helen Syn	Leslie Martinez	1. Policy GG.1717 updated to include attestation process for Health Networks and CCN providers to attest to operational and regulatory requirements for lead which include: documental of blood lead refusals, proper coding, provision of anticipatory guidance, following standards of care for lead testing. 2. PBS television ad campaign conducted in February and March 2023 to advise parents/guardians that a lead test is the only way to identify lead exposure. Total impressions: February 2023 = 20,390; March 2023= 9,439. 3. Anticipatory Guidance and Blood Lead Refusal form that was developed in house to support providers with documentation of blood lead refusals and anticipatory guidance was posted on the CalOptima Health Website along with Clinical Practice Guidelines. 4. IVR campaign launched in March 2023. Population approach was used to target members within the age ranges of a lead test. IVR left message or successfully played message to 3,801 members. 5. Provider Education via Provider Monthly Update to inform providers of operational and regulatory requirements pertaining to blood lead testing. 6. Provider Portal enhancements completed to include a blood lead screening dasbhoard to display quarterly reports for CCN providers, alerts for attestations. 7. Email alerts created for CCN Provider Portal users to be advised of the availiability of new blood lead reports. 8. Blood Lead Screening Guide developed for Provider Portal users that outlines regulatory requirements for lead, steps for accessing quarterly blood lead reports and completing attestations on the Provider Portal, resources for lead testing, etc. **February 2023 Prospective Rates:** Currently performing higher than last year in February 2022, but has not met MPL. Rate: 53.97%, MPL rate: 63.99%.	- Mailing (in progress): Health Guide 0-2 Years Newsletter with - - Blood Lead Screening, slated for Q2. - Lead texting campaign for members slated for April 2023. - Medi-Cal member newsletter article, slated for Q2. - Improvement of blood lead quarterly reports to align with standards of care for lead testing, slated for Q3. - Development of outreach report to proactively identify members that will be due for a 12 and 24 month blood lead test. - Provider Press article slated for Q3. - Bright Steps Program Well-Child Outreach Calls to include a 6 months old and 12 months old follow-up with blood lead testing education, slated for April 2023.	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Reduce OON requests by 25%	1) Actively recruit top 3 out-of-network (OON) specialties as shown on QMRT 2) Targeted outreach campaign and incentive to open their panels 3) Business consideration to require providers to participate in all programs. 4) Provider incentive for transportation vendor	by end of 4Q, 2023	Marsha Choo		Provider/HN workgroup has been created to focus on expanding the network. The worgroup has met twice to review data on the following provider types: PCPs and impacted specialists: cardiology, GI, pulmonology (tier 2- Neuro, Rheum, Urology	Workgroup will determine if lower ratios or increased use of physician extenders is needed for these provider types.	
Quality of Service	Improve Timely Access: Appointment Availability	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	1) Provider incentive to meet timely access standards 2) Provider incentive for extending office hours	by end of 2Q, 2023	Marsha Choo		Planning to begin in Q3, pending budget.	Draft scope of work and pull universe to faciliate 2023 Timely Access survey.	
Quality of Service	Improve Access: Telephone Access	Live Contacts Rate After 3 Attempts to meet 80%	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)	by end of 4Q, 2023	Marsha Choo		1. Providers/HNs have met compliance for provider directory validation and have provided provider's attestations timely overall. 2. Assigned HNs to follow-up with providers who recieved a 2nd year notice of non-compliance for educational purposes.	1a. Continue to work closely with all HNs to ensure directory validation accuracy continues to progress as needed. 1b. HN will evaluate their process and workflow to improve communications with providers as needed. 2. Continue to monitor and educate.	
Quality of Service	Improve Access: Access Dashboard	Develop an access dashboard for HN performance	1) Identify access measures to include in performance monitoring 2) Develop a methodology to monitor performance	by end of 2Q, 2023	Marsha Choo		Provider/HN workgroup has been created to focus on expanding the network and a dashboard templatehas been created for this workgroup to track accomplishments, milestones and outcomes.	Workgroup is working towards implementing initiatives to expand the network and will utilize the draft dashboard template to report to committee.	
Quality of Service	Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access	by end of 4Q, 2023	Marsha Choo		Complete SNC submission to DHCS for the four elements and is now under review with Enterprise PMO. All HNs met Provider to Member Ratios and CCN is the only HN to meet Time/Distance for Medi-Cal LOB.	Finalize SNC submission and submit by end April.	
Quality of Service	Increase primary care utilization	Increase rates of Initial Health Appointments for new members, annual wellness visits for all members.	1) Increased Health Network/Provider education and oversight 2) Enhanced member outreach (IVR, digital engagement)	1) 1Q2023 2) 2Q2023	Katie Balderas	Anna Safari	1. PHM presented at the Feb. Health Network Forum, three Joint Operations Meetings, and the March CCN Provider Lunch & Learn. 2. Obtained DHCS approval on IHA IVR campaign, established automated reports with ITS, IVR Call Campaign to launch Q2.	Update provider reference guide with current IHA codes, update IHA table logic with ITS to exclude specialists from universe, update reports with ITS to create actionable information for providers in portal.	
Quality of Service	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan	1) by end of 4Q2023	Linda Lee	Javier Sanchez	Analyzed measures and prioritized CAHPS composites and overall ratings. Interventions assigned to Stars/CAHPS work groups for implementation. TTY/Foreign language interpreter monitored by Stars/CAHPS Customer Service work group.	Stars/CAHPS work groups underway- five work groups (provider, medical management, pharmacy, customer service, and member material development) began on 4/14/2023. Work groups will meet weekly and report bimonthly to Steering Committee.	

2023 QI Work Plan 1Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Support Staff	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
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS to meet goal	1) Issue an RFI to obtain information on CAHPS improvement vendors and strategies, contract and launch program 2) Member outreach to all OneCare members 3) Track measures for monitoring individual provider performance (ie. number of grievances, number of CAPs issued) and take action based on committee action	by end of 3Q, 2023	Marsha Choo	Carol Matthews	1) The RFI was converted to a RFP. An enjoined RFP with the Member Engagement Platform was issued 3/23/2023 with proposals due 4/25/23.	1) Evaluation meeting scheduled 5/4/2023 with the goal of a vendor award on 5/29/2023.	
Safety of Clinical Care	Emergency Department Diversion Pilot	Pilot has been implemented. In 2023 plan to expand the program to additional hospital partners.	1. Promoting communication and member access across all CalOptima Networks 2. Increase CalAIM Community Supports Referrals 3. Increase PCP follow-up visit within 30 days of an ED visit 4. Decrease inappropriate ED Utilization	by end of 4Q, 2023	Michelle Findlater	Scott Robinson	Data shows that 177 Unique members were seen in the ED during the pilot timeframe. The data from these members was tested against a control group of 2,515 who visited the St. Joseph's during the months of November and December 2022 who did not participate in the Pilot program. 1.The members included in the ED Diversion pilot have much higher ED utilization (both prior and post ED visit at St. Joseph's) than the control group. In the six months prior to the St. Joseph's DOS, members included in the pilot program had an average of 1.39 ED visits PMPM compared to 0.18 ED visits PMPM for the control group. Similarly, in the 30 days post-DOS, members included in the pilot program had an average of 1.56 ED visits PMPM compared to 0.32 ED visits PMPM for the control group. 2.The members included in the ED Diversion pilot program have much higher ECM enrollment in comparison to the control group. Prior to the St. Joseph's ED Visit, 5.08% of the members in the pillot program were enrolled in ECM compared to only 0.28% of the control group. In the 30 days post ED visit, 29.38% of the members in the pilot were enrolled ECM compared to only 0.08% of the control group. However, many of the members from the pilot who were enrolled in ECM did not stay enrolled. 39 of the 52 members from the pilot enrolled within 30 days are not currently enrolled in ECM. Today, 10.73% of the pilot members are enrolled in ECM compared to 0.32% of the control group. 3.The ED Diversion pilot had a much higher percentage of members identified as potentially eligible for a POF (in particular POF #2, High Utilizers). In the POF identification run immediately proceeding the ED visit at St. Joseph's, 48.02% of the pilot members were identified as potentially eligible for a POF while only 12.29% of the control group was. In the most recent POF identification run, 64.97% of the pilot members were identified as potentially eligible for a POF while only 14.91% of the control group was. 4.The ED Diversion program had a higher percentage of members with a CS authorization within 30 days of DOS than the control group. There was an CS authorization for 12.99% of the pilot members compared to only 1.71% of the control group.	The ED Pilot program at St. Joseph's is now officially complete. Next steps in the program will be to transition the program to a virtual model. This will be executed by a combination of LTSS, CCR and Prior Auth staff members. The plan is for direct communication to occur with the focus transitioning to safe and expeditious discharges. The CalAIM referral process will fall back to the staff in the ED the referral forms as appropriate and not for the CalOptima Health Staff to complete them on the member's behalf. The CalOptima Health staff will maintain a log of all members who participated in the program so that there can be data pulls at designated intervals in the future.	
Safety of Clinical Care	Plan All-Cause Readmissions (PCR)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving PCP follow up post discharge rate by ~~1~~0.5% each quarter (focus on getting discharge plans w/ PCP appt from hospitals)	Planned Activities: 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Setting up the workgroup - end of 1Q 2023 Updating the UTC letter - end of 2Q 2023	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	***Setting up the workgroup*** – Not met: There has been a TCS Workgroup established to discuss TCS requirements outlined in the PHM Guide. However, it was noted that the TCS Workgroup was not the most suitable forum to discuss strategies to increase post hospital visits with the PCP. Therefore, we plan to set up a separate Transitions of Care Workgroup dedicated to post discharge PCP visit by the end of Q2 2023. ***Updating the UTC letter*** – Met: The post discharge UTC letter has been approved and is now available in GuidingCare. The post discharge CM DTP has been also updated to reflect that new letter when a member is unable to be reached post hospitalization. Clinical Operations also developed a Hospital Memo for hospital partners.	Set up a separate Transitions of Care Workgroup dedicated to post discharge PCP visit by the end of Q2 2023. The goals/reporting metrics are still pending; continue defining the goals/metrics by Q3 2023.	

2023 QI Work Plan 2Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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 - Caution Green - On Target
Program Oversight	2023 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Quality Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIHEC-BOD; QI Work Plan-QIHEC-QAC	Annual Adoption by April 2023	Marsha Choo	Approved: QIHEC 2/14/2023, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2022 Quality Improvement Program Evaluation	Complete Evaluation 2022 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by January 2023	Marsha Choo	Approved: QIHEC 2/15/2022, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2023 Utilization Management and Case Management Program	Obtain Board Approval of 2023 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Approved: UMC Committee via eVote on 4/7/2023, QIHEC 4/11/2023		
Program Oversight	2022 Utilization Management Program Evaluation	Complete Evaluation of 2022 UM Program	UM Program will be evaluated for effectiveness on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Approved: UMC Committee via eVote on 4/7/2023, QIHEC 4/11/2023		
Program Oversight	Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Cultural and Linguistic Services Program and Cultural and Linguistic Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by April 2023	Carlos Soto	Approved: QIHEC 4/11/2023		
Program Oversight	Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted.	2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted.	
Program Oversight	**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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Laura Guest	I. FSR/PARS/NF/CBAS: A. FSR: Initials=12; Periodic=5; CE CAPs=36; FSR CAPs=21. Initial MRR=15, Periodic MRRs=13; MRR CAPs=40; On-Site Interims=49; Failed FSRs=1; Failed MRRs=7. B. PARS: PARS=85; Basic=37 (45%); Limited=48 C. CBAS: No Critical Incidents reported; Non-critical=27; Falls=10; COVID=1 Audit=12; CAPs=10; Unannounced Visits=0. D. NF: No Critical Incidents were reported in Q2. Audit=3; CAPs=0; Unannounced Visits=0 II. Credentialing: CCN initial credentialing=61, recredentials= 151, BH initial credentialing=46, BH Recredentialing=37 III. A. PQIs 162 cases closed in Q2. There 19 were QOC;13 (9%) PQI cases presented to CPRC. Medical Care: Mismanaged Care was the greatest category/subcategory of PQIs. QOC Grievances 532; 67 declined grievances. TAT of PQIs = 68% reviewed by MD in 90 days; declined grievances 94% reviewed in 30 days. Requested additional staffing to accommodate additional workload. B. No PPCs identified in Q2.	I. FSR/PARS/NF/CBAS A. FSR: Continue to audit. B. PARS: Continue to audit. C. CBAS:Continue to audit and remind centers to report critical incidents. D. NF: Re-evaluate current processes. Current QI Nurse Specialist will retire at the end of July 2023. 2 positions will be open. Currently recruiting for one position. Look at cross-training existing staff to fill position in interim. II. A. Credentialing:. Continue to perform credentialing and recredentialing if CCN and BH providers. We have started the process to engage a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliess of the intial credentialing and recredentialing of files. We have are also in the process of reviewing all the credentialing processes with Ankura which will identify gaps and improve overall workflow. A credentialing manager will be starting with the organization on 8/14. We have also engaged Sympler for additional Cactus training for the credentialing staff. III. PQI: Continue to monitor volume of PQIs and QOC grievances, and TAT of PQIs and declined grievances. Follow-up on request for additional staffing. Continue to review claims data for PPCs.	
Program Oversight	**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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Tyronda Moses	Q1 2023 metrics, performance, trends and remediation efforts were presented to the Committee on May 8, 2023. GARS reported that the combined (CS and GARS) grievance totals for the Medi-Cal line of business decreased from Q4 2022; however, there was an increase in QOS complaints. These were related to new members who experienced some issues with their benefits. QOS complaints also include those related to transportation, where that volume has gone down but remains a trending issue. (Medi-Cal)The Health Plans over the 5 per 1000 NCQA benchmark in Q1 were CCN at 6.65 per 1000 memnbers, Kaiser at 9.09 per 1000 members and Monarch at 5.25 per 1000 members. GARS met with Optum to discuss the metrics for Monarch. There was a system conversion that caused delays in referrals with providers having difficulty accessing the system and the GARS team experiencing long hold times. The issues decreased in the latter part of Q1. Kaiser has reported their top issues to be behavior - discourteous/rude, diagnosis treatment or care and clinical service/item - service or item not sufficient or defective, they reported that this informaiton is reported to the respective departments for possible training. GARS continues to report identified issues to A&O for review. CCN identified issues included delays in referrals, appointment availability and transportation services. Remediation actions for CCN included a review with UM on current process for possible process changes, coordination with Provider Relations on excessive wait times and the creation of a dedicated transportation team to identify true trends (locations and times). (Medicare)The Health Plans trending high for Q1 icluded CCN, Monarch, Prospect and Talbert - identified trends were mainly related to the OCC to OC conversion. Delays in eligibility reports caused many issues with providers/vendors verifying eligibility and authorizations not covering the transition dates. This information has since been updated and we began seeing a decreased in complaints by the end of Q1. Additionally, as with Medi-Cal, Optum's system conversion played a part in the higher volume of complaints and this conversion is now completed.	GARS will continue to monitor and report as appropriate.	
Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2023 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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Marsha Choo	In Q2, MemX committee has reviewed/disussed the following: 5/17/23 •Charter updates and finalized •BHI Text Message •Access and Availability Updates: ○SNC Submissions ○Timely Access Survey •CAHPS Update: ○HN CAP ○CAHPS Improvement Vendor RFP •Member Experience Improvement Program •OneCare Member Satisfaction Survey	In Q3 MEMX Committee has one meeting scheduled, August 22	
Program Oversight	**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.	1Q23 update (4/11 QIHEC) 2Q23 update (7/11 QIHEC) 3Q23 update (10/10 QIHEC) 4Q23 update (Jan 2024 QIHEC)	Stacie Oakley	UMC met 5/25/23 and is on track to meet quarterly. Meeting minutes are available for review. Quarterly Utilization Metrics Quartertly updates for (Pharmacy, BH and LTSS update). The BMSC 3/22/2023 minutes were presented & approved at the 5/25/23 meeting.	The next UMC meeting is scheduled for 8/24/23. The next BMSC will report to UMC meeting on 8/24/23.	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.		1) Meet quarterly to provide clinical and behavioral service advice regarding Whole Child Model operations **2023 Meeting Schedules** WCM CAC Q1: February 21, 2023 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (4/11 6/13QIHEC) 2Q23 update (7/11 6/13 QIHEC) 3Q23 update (10/10 9/12 QIHEC) 4Q23 update (Jan 2024 12/12 QIHEC)	T.T. Nguyen, MD/H.Kim	1) WCM CAC met 5/16/23 - See meeting minutes for details. A copy of those meeting minutes were presented along with the WCM CAC report at the June 13, 2023 QIHEC.	1) Q3 meeting is scheduled for August 15, 2023. The Transition Workgroup will be added as a standing item to WCM CAC meeting for regular updates to the Committee.	
Program Oversight	Pediatric Risk Stratification Process (PRSP) monitoring		Discuss annually the Pediatric Risk Stratification algorithm with the CCS program	Aug-23	H. Kim	PRSP was presented at 5/16/23 WCM CAC and at the 5/25/23 UMC. Concluded with 47 ICD-10 diagnosis code sets for automatic high-risk and 8 ICD-10 diagnoses related to hearing and vision set for high-risk if claims/encounters within 12 months.	Update is scheduled to report to the August QIHEC. PRSP added as a standing item to WCM CAC meeting for annual updates to the Committee	

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Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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 - Caution Green - On Target
Program Oversight	Managed Care Accountability Set (MCAS)	Achieve 50th percentile on all MCAS measures in 2021	Share results to Quality Improvement Committee annually	end of 3Q 2023	Paul Jiang	HEDIS MY2022 results has been presented to QIHEC on 7/11. LSC didn't meet MPL.	Quality improvement team is working on the improvement plan.	
Program Oversight	Health Network Quality Rating	Achieve 4 or above	Will share HN performance on all P4V HEDIS Measures via prospective rates report each month	end of 4Q 2023	Sandeep Mital	The Pay for Value (P4V) team generates a Prospective Rate (PR) report each month for all participating health networks and CalOptima Health to allow health networks monitor their progress on clinical HEDIS measures in the P4V program. Performance on each measure is compared to the overall CalOptima Health performance, as well as to the National Medicaid HEDIS benchmarks established by NCQA.	The overall health network quality rating (HNQR) is the weighted average of the network's HEDIS and CAHPS measure ratings, as well as accreditation bonus points and is calculated on a scale of 0-5 (5 being the highest). The final HNQR is usually complete after the final HEDIS and CAHPS results are available in the fourth quarter of the following year.	
Program Oversight	CalAIM	Improve Health & Access to care for enrolled members	1) Launch ECM Academy; a pilot program to bring on new ECM providers. 2) Increase CalOptima Health's capacity to provide community supports through continued expansion of provider network. 3) Continue to increase utilization of benefits. 4) Establish oversight strategy for the CalAIM program. 5) Implement Street Medicine Program 6) Select and fund HHIP projects through Notice of Funding Opportunity. 7) Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	1) 1Q 2023 2) 4Q 2023 3) 4Q 2023 4) 3Q 2023 5) 1Q, 2Q 2023 6) 1Q 2023 7) 3Q 2023	Mia Arias	1) One cohort w/ 20 providers completed, second one with another 20 providers launched 7/1. 2) As of 8/01, we will have 66 providers of community supports. 3) There are 21,603 members receiving unique ECM and/or CS services as of 7/26. 4) We are waiting to onboard a CalAIM Medical Director before defining this process. 5) As of 06/30, Healthcare in Action has outreached to 176 individuals and had 85 active members. 6) We continue to monitor these grants projects. 7) The Notice of Funding Opportunity for this project will be released in Q4 with anticipated project start dates in Q1 of 2024.	Each of these projects will continue to be stewarded forward. No changes to the plan.	
Program Oversight	Health Equity	Increase member screening and access to resources that support the social determinants of health	1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	1) 4Q 2023 2) 4Q 2023 3) 3Q 2023	Katie Balderas	1) Sources of data will include SDOH screening from AWV, HIF/MET, Care Management System, and provider documentation. The only data point that has baseline for comparison is provider documentation as the other sources are newly collecting this information. 2) Pending direction on next steps. PHM worked with EPMO to do a market analysis of close-loop referrals options and co-developed a SOW 3.B) HL4E Certificate Program - Currently 149 sign-ups from 23 departments; 5 total have completed the program 3.B) HL4E Organizational Assessment - currently at 104 submissions; goal is set to 300+ completions	1) Identify how many providers have completed the SDOH screening as part of the AWV Incentive program, Obtain DHCS Approval to include SDOH screening question in HIF/MET, establish uniform SDOH screening questions across all assessments built in to the Jiva Care Management platform, and develop regular cadence to monitor provider utilization of SDOH Z-Codes 2) Pending organization wide direction on acquisition of a close-loop referral system 3) Continue to promote completion of HL4E certificate program and promote submission of organizational assessment survey.	
Program Oversight	Improvement Projects Medi-Cal PIP(BH)	Meet and exceed goals set forth on all improvement projects	Non-Clinical PIP - FUM/FUA 1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	Improve the percentage of members enrolled into care management, complex care management (CCM), or enhanced care management (ECM), within 14-days of a provider visit where the member was diagnosed with SMH/SUD.	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis for CCN and COD members. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. BHI will conduct the outreach and provide information about case managment including ECM and referrals. 3) Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CCN members identified who meet FUM/FUA criteria.	
Program Oversight	Improvement Projects OneCare 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 for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	end of 2Q2023	Helen Syn	Baseline Data: PR Report May 2023 HbA1C <8 Total (HBD): MC: 26.76% OC: 36.3% HbA1c>9 Total (Poor Control) (HBD): MC: 68.09% OC: 57.71% Eye Exam for Patients with Diabetes (EED): MC: 33.89% OC: 44.93% Kidney Health Evaluation for Patients with Diabetes (KED): MC: 25.06% OC: 31.74% Statin Use in Persons with Diabetes (SUPD) OC only: 84.22% 1) Diabetes Member Mailers: MC Total sent: 34,773 members, OC Total sent: 3,547 2) SPD Statin mailers (bi annual): MC Total sent: 6,606 members, OC Total sent: 651 members. 3) Text Message Campaign A1C and Diabetes Eye Exam: MC: 10,163 members 4) VSP Eye Exam Reminder Letters: MC Total sent in Q2 2023: 978, OC Total sent in Q2 2023: 179 5) Member Incentive: A1C Test for MC Processed 47 approved 42 for OC Processed 2 approved 2 Eye Exam for MC Processed 89 approved 77 for OC Processed 1 approved 1 6) Member Newsletter: HBD, EED, BPD, SPD article Spring 2023	1) Track submitted diabetes member incentive forms 2) Continue Statin Mailer in Q3 2023 3) Obtain results from text message campaign 4) pending IVR campaign 5) pending Live Call Outreach campaign 6) Obtain results from VSP Eye Exam Reminder Letters	
Program Oversight	Improvement Projects Medi-Cal PIP	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP - Health Disparity remediation for W30 6+ measure (Jan Pending January Module Training January 2023 projected. Please note that the focus for the Clinical and Non-Clinical PIP topics is related to DHCS' "50 by 2025: Bold Goals Initiatives"- See links for more information on the Bold Goals Initiatives: https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/Equity-and-Practice-Transformation-Grants-May-Revise.pdf or https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf	Quarterly Status update on modules as they are completed.	Helen Syn	1) Completed the identification of CalOptima Health's Black/African American W30-6+ population to complete the 2023–26 W30–6 Clinical PIP Topic Data Form. Submitted PIP Topic Data Form 4/11/23. HSAG approved 4/14/23. DHCS approved the W30-6 Measure Rate Among Black/African-American Population as CalOptima's 2023-26 Clinical PIP topic, 4/17/23. 2) Continue to conduct literature review and refine discovery phase to develop an intervention with a health equity lense. The improvement project will include a broader health plan level project, beyond the focus on Black/African-American population.	1) Develop W30-6 intervention plan based on literature review with a health equity lense. 2) Complete PIP Design: Complete Steps 1-6 of PIP Submission Form and submit by 9/28/23.	
Program Oversight	OneCare Performance measures	Achieve 4 or above	1) Implement Star Improvement Program 2) Track measures monthly 3) Implement OC Pay4Value	1. 1Q2023 2. 2Q2023 3. 3Q2023	Linda Lee	Preliminary prospective rates published for OneCare Star and Pay4Value measures. Rates will be tracked monthly throughout year.	1) Stars/CAHPS work groups underway- five work groups (provider, medical management, pharmacy, customer service, and member material development) began on 4/14/2023. Work groups will meet weekly and report bimonthly to Steering Committee. 2) Stars dashboard- plan and Health Network level published beginning 4/7/2023. Dashboard updated and published monthly going forward. 3) OC Pay4Value program underway. Pay4Value score card updated and published monthly beginning 4/7/2023.	

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Program Oversight	Plan Performance Monitoring and Evaluation (PPME): HRA and ICP	3.2 ICP completion 90 days Benchmark 90% adjusted. 2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted.	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks.	1Q23 (5/9 QIHEC) 2Q23 (8/8 QIHEC) 3Q23 (11/14 QIHEC) 4Q23 (February 2024 QIHEC)	S. Hickman/M. Dankmyer/H. Kim	3.2 ICP completion 90 days Benchmark 90% adjusted. Q12023 DHCS reporting of members reached and willing and completed care plan is 31% and variables contributing: Large volume of OCC to OC transition members as seen in 1/1/2023 enrollment of 7686. February enrollment of 1028 members; and, March enrollment of 866 members can be used for comparison. All members enrolled in Q1 2023 were referred for ICP development. For January through June 2023 Oversight process reflects 100% review of every ICP. There is backlog in review of these ICPs. As thes ICPs are reviewed, Case Management would expect ICP completion rate to increase. DHCS has also sent guidance on 5/22/2023 of their awareness that ICP rates may appear to be depressed due to crosswalked HRA/ICPs from 2022 for the transition members. The oversight process changed on 7/1/2023 with sampling audit and Health Networks will move to a monthly tracking file report. The tracking file will be used for 2.1 and 3.2 Regulatory Reporting. Q2 2023 not yet submitted and we expect variables affecting to continue. 2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted. Q1 2023 DHCS reporting of members who where reached and willing to complete an assessment was 99% Q2 2023 not yet submitted we expect to be >95%	Q1 3.2 ICP completion 90 days Benchmark 90% adjusted. Q2 2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted. Core reports are not finalized and remain as "adhoc" in interim, Case management is using CC0258 to monitor HRA and ICP completion. Communications to Health Networks regarding ICPs that are coming due/overdue for return. With oversight restructure, data will pull from monthly tracking file versus PCC tracking script. Compliance aware of bundle review backlog and data to DHCS based on our current complete information. There is potential that Q1 may undergo revision and resubmission. Q2 data not available. Same approach will be used for Q2 as in Q1 with potential for revision and resubmission.	
Program Oversight	NCQA Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and **NCQA Health Equity Accreditation by no later than January 1, 2026.**	1) Continue to Work with Business owners to collect all required documents for upcoming HP re-accreditation.(Must collect all Year one required documents by 2Q2023. 2) Comple Gap Analysis for Health Equity Accreditation.	1) end of 1Q2023 2) end of 2Q2023	Veronica Gomez	1)Collected 98% of all HP accreditation documents due. Performed File review mock audits: File Review Mock Sessions w/Consultants - Credentialing w/Sub-delegates (4/26/2023) - Credentialing w/Health Networks (5/3/2023) - Credentialing CCN (5/4/2023) - UM Medical Denials w/Health Networks (5/8/2023) - UM Medical Denials CCN (5/10/2023) - Appeals CCN (5/11/2023) 2) Developed Health Equity Timeline and currently performing GAP Analysis and next steps. Meeting with different departments in 3Q2023.	1) HP Accreditation: Dashboard with status updates and Year 2 documents docs due will be presented at the July 10th NCQA Committee meeting and August 8th QIHEC. 2) Health Equity Accreditation: Will be scheduling meetings to review Health Equity standards and collect documents for initial consultant review. Consultant to give HE update the next steering committee.	
Program Oversight	Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	1 Implement SBHIP DHCS targeted interventions 2. bi-quarterly reporting to DHCS	1) 4Q2023 2) 4Q2023	Diane Ramos/ Natalie Zavala/Carmen Katsarov	1) SBHIP MOU completed and effective by June 13 for SBHIP Partners: Hazel Health, Western Youth Services, and CHOC 2) 4 Bi-quarterly reports completed by June 30 due date; resubmitted the SBHIP Transition Plan Part 1 with Kaiser contact. 3) Executive Director / Manager attended OCDE's SBHIP monthly meetings and workgroups. 4) SBHIP Funding Plan COBAR approved during May 4 BOD Meeting. 5) SBHIP leadership team continues meetings with stakeholders to explore partnership opportunities.	1) Continue meeting with OCDE re 1/1/24 billing readiness (meetings to include SMEs from Claims, additional internal departments will be included in future meetings). 2) Prepare for SBHIP Implementation Update meeting scheduled July 18, this meeting is to provide program progress update to CalOptima Health business units that may be impacted to support the SBHIP implementation. 3) Coordinate with Contracting to begin developing Master Service Agreements for Western Youth Services and Hazel Health. 4) Finalize the OCDE SBHIP MOU. 5) Continue monthly meetings with all SBHIP partners.	
Quality of Clinical Care	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	1) Assess community infrastructure capacity for cancer screening and treatment 2) Establish the the Comprehensive Cancer Screening and Support Program Stakeholder Collaborative (in our Case I want to leverage OC3) 3) Develop comprehensive outreach campaign to outreach to members due for cancer screenings (mobile mammography, outbound calls, community health workers) 4) Integrate new community health worker benefit into cancer outreach and treatment services.	1) 1Q2023 2) 2Q2023 2) 3Q2023 3) 4Q2023	Katie Balderas/ Barbara Kidder	1.A) Developed and launched a Mammography Capabilities and Processes Survey to assess contracted clinics and FQHC's capacity related to breast cancer screening. o Survey released on July 10, 2023, to a total of 31 community health centers. As of July 24, 2023, 9 surveys were received. 1.B) Developed the Colorectal Cancer Screening Capabilities and Processes survey for Primary Care Providers and a separate survey for Gastro/Colorectal Specialist. o Surveys to be built into survey monkey in early August. 2) PHM Manager continues to attend the OC3 meetings 3.A) Working with Communications to develop a comprehensive members and communication campaign for members and providers 3.B) Working with communications to develop and launch a Cancer Screening landing page o Established an AdHoc workgroup to develop content for website o Developed proposals to share website vision and obtain approval from Comprehensive Community Cancer Screening and Support Core Team (Core Team). o Developed website mockups and met with Communications to confirm feasibility of adding a Cancer Screening and Support component to the CalOptima Health website. 4) Integration of new community workers pending organization wide contracting process	1.A. Survey results will be analyzed and presented to the Cancer Screening Core Group for intervention/pilot design considerations 1.B. Surveys to be built into survey monkey in early August. Gastro/Colorectal Specialist survey may take a bit more time to get released given additional data combing to get a reliable list of providers 2. Continue to attend the OC3 meetings, provide updated on the program and seek input on future developments 3.A. Communications to develop the Comprehensive Campaign plan for PHM to seek Board approval of funding allocation 3.B. Continue to work on website content development to launch the Cancer Screening landing page by end of Q4 4. Pending organization wide contracting, onboarding and implementation of CHWs.	
Quality of Clinical Care	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP) Care Management, Comprehensive Diabetes Care (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	Linda Lee	Q2 Update: CM has implemented process improvements to improve SNP Care Management measure including increasing HRA call attempts to 4 outreach calls, CDC and COA measures showing month over month increases.	Q3: Launch live call campaign to remind and assist members with PCP visits., provide education, and member incentive.	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS MY2023 Goal: MC 30-Day: 54.51%; 7-day: 31.97% OC (Medicaid only)	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q2 (MAY): 30 day- 28.81%, 7 day- 18.06% 1) The main barrier has been not havng the bandwidth to outreach to members that we have been receiving on a daily basis. 2) Leadership is working on identifying a solution in collaboration with ITS and the Health Network relations to establish a secure method to share real time ED data with Health Networks. a) Several meetings have occured between Health Network relations, ITS and BHI Leadership.	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis. 2) Currently in the process of creating methods of disseminating data via sFTP with Health Networks on a daily basis. 3) Ticket has been submitted to ITS for assistance with establishing protocols to send and receive data through CalOptima Health sFTP site. 4) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM criteria. 5) Explore with ITS options for notification of ED admits to assign PCP.	
Quality of Clinical Care	Blood Lead Screening DHCS APL	1) Comply with APL requirements including quarterly reports of members missing blood lead screening 2) Increase Rates of successfully screened members to #% 3) Put process in place ot identify refusal of blood lead consent forms	- PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. - Update Policy GG.1717 to include Health Network Attestation and conduct Health Network/Provider education - Add blood lead screening resources to CalOptima Health website: Comprehensive Health Assessment Forms, CDPH anticipatory guidance handout, - Launch IVR campaign to members with untested children - Member mailing campaign to members - Lead texting campaign for members - Medi-Cal member newsletter article(s)	All activities will be complete by 3Q, 2023	Helen Syn	**1) Quality Interventions:** - Lead Screening Text Message Campaign, dropped 4/11/2023. Message campaign used a population approach to target members ages 10-35 months and are within the age of a catch up lead test, Live-Call Outreach (partnership with CalOptima Health's Bright Steps Program), went live on 4/19/2023. Well- child outreach calls at 6 month and 12 months of age include education on why children should test for lead and timing. This is in response to parent/guardian feedback at BTS events where parents/guardians have expressed lack of awareness on the importance of lead testing. - Member Medi-Cal Newsletter, dropped 5/5/23, sent to 593,671 members. Total reflects all threshold languages combined. Article "Testing Your Child for Lead: What You Need to Know." Additional newsletter slated for Q3, 2023. - Pediatric Mailing, Mailing included Health Guide 0-2 Years Newsletter, Well-Child Visits Flyer and Blood Lead Screening Flyer, mailing dropped 5/22/23 to 30,249 members. - PBS TV Ad Campaign, ran in May and June 2023. Campaign advises parents/guardians that a lead test is the only way to identify lead exposure. Total Impressions: May = 20,071, June = 18,335. - Digital Ads, ran June 2023 in various outlets targeting English, Spanish, and Vietnamese langauges. Total impressions: 209,180. - Developed script for radio ad, slated for Q4, 2023. **2) May 2023 Prospective Rates: 58.05%:** Prospective rates are trending higher than May of last year. **3) Preliminary Root Cause Analysis** of provider barriers to testing identified through medical record review of MY2022 LSC HEDIS measure and preliminary conversations with high volume health networks. **4) Provider Focused Interventions:** Blood Lead Testing Best Practices Guide for Providers: In development, slated for Q3 2023,Blood Lead Outreach Report: New report as of June 2023. Report identifies child members that will be due for lead testing at 12 and 24 months of age within 1-3 months of the report date. Shared monthly with Health Networks., Shared Q2 Blood Lead Performance report on July 13 in accordance with APL 20-016. Report contains members that have not tested for lead, CCN Virtual Meeting on June 14 to present on requirements, current rates, preliminary root causes related to lead testing and recommended solutions, CE/CME for Blood Lead: Coordinating CE with Childhood Lead Poisioning Prevention Branch and CE team, slated for Q3 2023.	1) Continue targeted member engagement and outreach campaigns in coordination with health network partners. 2) Finalize root cause analysis with high volume Health Networks by Q3 to identify the barriers for testing children for lead. 3) Continue with provider focused interventions.	

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Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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 - Caution Green - On Target
Quality of Clinical Care	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2023 Goal: Postpartum: 84.18% Prenatal: 91.89%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 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) Expand member engagement through direct services such as the Doula benefit and educational classes	1) Annual Evaluation 2) Per quality initiatives calendar - ongoing updates 3) Ongoing updates 4) 4Q2023 5) 3Q2023	Ann Mino/ Helen Syn	1) Member Interventions - Postpartum Care Incentive; 303 incentives processed through Q3 (cumulative). - Implemented First Baby Shower Event for CalOptima members on June 2 with 100 attendees. Parnted with numerous community organizations to provide pregnant or members who recently delivered received resources addressing SDOH needs. - SSA Newborn Eligibility Flyer; inclusion of information on keeping eligibility for newborn in Bright Steps Program packet and member informing article in the Spring Medical Newsletter. - Bright Steps Program; 962 new pregnancy notification reports received for member outreach, 2,449 Bright Steps assessments completed. Each assessment provides outreach at different trimesters; 2,212 2) Community partnerships with various organizations such as OC Health Care, Her Story Inc, independent doulas, First 5. Goal is to enhance our MediCal services to pregnant members (e.g., connecting members to doula services) in order for BSP program to address member needs in a holistic way vs only providing medical needs. 3) Early identification of members who delivered. Began conversations with PointClickCare, a vendor that provides CalOptima Health with hospital data on deliveries. Have assessed data available. 4) Media Campaigns (prenatal care) - Digital Ads, ran June 2023 in various outlets targeting English, Spanish, and Vietnamese langauges. Total impressions: 209,180. 5) Provider Press Newsletter to promote Medi-Cal enrollment of newborns. 6) May 2023 Prospective Rates: - Timeliness of Prenatal Care: 45.94%, performing lower than this same time last year. - Postpartum Care: 65.07, performing higher than this same time last year.	1) Continue targeted member engagement and outreach campaigns in coordination with health network partners. 2) Operationalize the available delivery data to support targeted member outreach for postpartum and well-child.	
Quality of Clinical Care	COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (18 and over).	1) Communication Strategy of COVID vaccination incentive program through December 31, 2023, end date, focusing on unvaccinated, and missed booster opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for boosters	1) end of 1Q2023 2) end of 4Q2023	Helen Syn	1. Internal communication to member-facing staff of program end date 2. Worked with internal stakeholders to update the system flow and logic to incorporate CDC's simplified vaccination recommendations 3. Reached 70.1% vaccination rate for CalOptima members (18 and older)	Texting campaign to address new eligibility guidelines and end date of the program. Update COVID-19 Vaccine Incentive Program (VIP) website to reflect new guidelines. COVID-19 VIP processing continues as we bewgin planning for the official end date of the program on 12/31/2023.	
Quality of Clinical Care	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)- **NEW**	HEDIS MY2023 Goals: Blood Glucose-All Ages:54.36% Cholesterol-All Ages: 36.17% Glucose and Cholesterol Combined-All Ages: 34.30%	1) Identify members in need of metabolic monitoring through internal data reports. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) 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. 4) Member outreach viaText Messaging Campaigns.	2Q2023 update(7/11)	Diane Ramos/ Natalie Zavala	PR HEDIS RATES Q2 (MAY): Blood Glucose all ages: 35.01%, Cholesterol all ages: 20.54%, Glucose & Cholesterol Combined all ages: 19.37% 1) Working with ITS/BHI Data Analyst to identify report specs a) Meetings have been scheduled. 2) Drafted the following materials: a) Text Messaging script. b) Drafted APM Provider Tip Sheet. c) Drafted Provider Best Practices Letter. d) Drafted Provider Fax Blast Letter. 3) Collaboration meeting with BH Medical Director to explore and develop standing lab order for children and adolescents working prescribing providers/PCPs	1) Submit Text Messaging draft for internal review process. 2) Submit Provider Tip sheet for internal review process. 3) Submit Provider Best Practices Letter for internal review process. 4) Submit Provider Fax Blast Letter for internal review.	
Quality of Clinical Care	Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	MY 2023 Goals: CCS: MC 62.53% BCS: MC 61.27% OC 70% COL: OC 71%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	1) Quarterly Updates 2) Per Quality Initiatives Calendar - ongoing updates	Helen Syn	1) 2023 Member Health Rewards processed as of 6/30/2023: CCS: Processed 646 approved 545 for MC; BCS: Procesed 202 approved 167 for MC Processed 12 approved 10 for OC; COL: Processed 10 approved 10 for OC 2) Member, Community and Provider Engagement Mialing: CCS MC: 97,860 BCS MC: 28,973 OC: 2,279 COL OC: 33,172 IVR: COL OC: 3,157 Texting: BCS Social Media (Passive): BCS, CCS Social Media (Paid): COL Digital Ad: COL Radio: CCS Community Connections: BCS, CCS, COL Member Newsletter: BCS, CCS, COL 3) 2023 May Prospective Rates (PR): Cervical Cancer Screening MC: 44.59% Breast Cancer Screening MC: 40.95% OC: 51.74% Colorectal Cancer Screening OC: 49.69%	1) Continue to track BCS, CCS and COL member health reward. 2) Member, Community and Provider Engagement Mailing: CCS Mailing Schedule April. COL Mailing Schedule May BCS Mailing Schedule June IVR: COL scheduled May BCS Scheduled June Texting: BCS Schedule April Social Media (Passive): Social Media (Paid): BCS, CCS, COL Q3 Digital Ad: BCS, CCS Q3 Print Ad: COL Q3 Radio Ad: CCS, COL Q3 Member Newsletter:BCS COL OC Fall 2023; CCS, BCS, COL MC Fall 2023 Community Connections: BCS Q4 Provider Press: Cancer Screening for July Provider Updates:	
Quality of Clinical Care	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)	MY2023 HEDIS Goals:: MC 63.75% OC: 79%;	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures 3) VSP Collaborative gaps in care bridging efforts.	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation 3) End of Q2 2023	Helen Syn	1)Member Incentive: MC A1C Test: 19 approved, 2 denials, 2) Member Engagement: **Diabetes Member Mailers:** MC Total sent: 34,773 members, OC Total sent: 3,547 **Text:** MC: 10,136 **Radio:** Diabetes April **Community Connections**: April **Newsletter:** MC and OC member newsletters 3) PR Report May 2023 HbA1C <8 Total (HBD): MC: 26.76% OC: 36.3% HbA1c>9 Total (Poor Control) (HBD): MC: 68.09% OC: 57.71%	1) Continue to track A1c member health reward. 2) Member, Community and Provider Engagement IVR: Q4 2023 Social Media (Passive): Q4 Social Media (Paid): Q4 Radio Ad: Q4 Print Ad: Q4 Digital Ad: Q4	
Quality of Clinical Care	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2023** Goals: MC: 30.9%; OC: 17%	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation	Helen Syn	1) 2023 Member Health Rewards processed as of 6/30/23: Member Incentive: MC Eye Exam: 89 Processs 77 approved OC Eye Exam: 1 Processed 1 approved. 2) Member Engagement Diabetes Member Mailers: MC Total sent: 34,773 members, OC Total sent: 3,547 Text: MC:10,136 Radio: Diabetes April Community Connections: April Newsletter: May 3)VSP Eye Exam Reminder Letters: MC Total sent in Q2 2023: 978, OC Total sent in Q2 2023: 179 4)PR Report May 2023 Eye Exam for Patients with Diabetes (EED): MC: 33.89% OC: 44.93%	1) Continue to track Eye Exam member health reward. 2) Member, Community and Provider Engagement IVR: Q4 2023 Social Media (Passive): Q4 Social Media (Paid): Q4 Radio Ad: Q4 Print Ad: Q4 Digital Ad: Q4 3) Continue track VSP mailing	
Quality of Clinical Care	MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs	Meet and exceed MPL for DHCS MCAS Corrective Action	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.	Quarterly Status update on modules as they are completed.	Helen Syn	Well-Child Visits in the First 30 Months (W30-2+) PDSA 1) **Cycle 2: 3/27/23 - 7/28/23**. Cycle 2 intervention included in-house telephonic call campaign and a birthday card mailer. **SMART AIM Goal:** By June 30, 2023, successfully outreach to 50% of members on outreach list (n=462) who are: Ages: 12 – 30 months old, Eligible CalOptima Health Medi-Cal member, Identify their ethnicity as: Guamanian, Laotian, Alaskan Native or American Indian, Samoan, Japanese, Black, Native Hawaiian, Asian or Pacific Islander, Asian Indian, or Amerasian. **Intervention Implementation Period:** 5/22/23 - 6/30/2023 . Telephonic call campaign completed by 1 staff member, in-house. **Outcomes:** There was a total of 624 call attempts made for the 454 members on the target list (removed members who were not eligible). Of the members outreached, only 171 members were successfully outreached, which yields a call success rate of 37.67%. Unfortunately, the SMART Aim Goal of successfully outreaching to 50% of the members on the outreach list was not met by -12.33%. Cycle 2 Worksheet is due to DHCS: 7/28/23.	Well-Child Visits in the First 30 Months (W30-2+) PDSA 1) Proceed with Cycle 3: 7/31/23 - 11/30/23. Cycle 3 intervention will include in-house telephonic call campaign and a birthday card mailer.	

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Quality of Clinical Care	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 **MY2023** Goal CIS-Combo 10: 49.76% IMA-Combo 2: 48.42% W30-First 15 Months: 55.72% W30-15 to 30 Months: 69.84% WCV (Total): 57.44%	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. Examples: EPSDT DHCS promotional campaign; Back-to-School Immunization Clinics with Community Relations; expansion of Bright steps comprehensive maternal health program through 1 year postparum to include infant health, well-child visits, and immunization education and support 3) Early Identification and Data Gap Bridging Remediation for early intervention.	1) 3Q2023 2) Per quality initiatives calendar - ongoing updates 3) End of Q22023	Helen Syn	**1) Targeted member engagement and outreach campaigns in coordination with health network partners.** Met with Health Networks to share Quality Initiatives Activities Calendar for CY2023 and Presented W30 Findings and Strategic Plan at CCN Virual Meeting on 6/14/23. **2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. This includes targeted ad campaigns on digital newspaper platforms, PBS television, and social media available to the public. Targeted efforts are as follows.** **Text/IVR Campaigns:** IVR scripts 1) W30: 0-14 months, 2) W30: 15-30 months, 3) WCV 3-17 years, and 4) WCV 18-21 Years scripts and recordings are complete and available; Well-Child Visits 0-30 Months Text Message Campaign, dropped 5/11/23 to 8,716 members; Well-Child Visits 0-14 Months IVR dropped 6/1/23 to 3,998 members; Well-Child Visits 15-30 Months IVR dropped 6/13/23 to 3,938 members; Well-Care Visits 3-17 Years Text Message Campaign, dropped 6/27/23 to 87,923 members. **Live-Call Outreach:** Bright Steps Program Well-Child Outreach Calls to include a 6 months old and 12 months old follow-up went live 4/19/23. **Mailings:** Pediatric mailings included well-child visits flyer. Health Guide 0-2 Years Newsletter with Blood Lead Screening, dropped 5/22/23 to 30,249 members; Health Guide 3-6 Years Newsletter, slated for Q2, mail dropped 6/10/23 to 46,264 members; Health Guide 7-12 Years Newsletter, slated for Q2, mail dropped 6/10/23 to 66,737 members; Health Guide 13-17 Years Newsletter,mail dropped 6/10/23 to 71,409 members; Health Guide 18-21 Years Newsletter, slated for Q2, mail dropped 5/30/23 to 58,187 members. **Ongoing Mailing:** First Birthday Card, mailing completed for April-June Birthdays = 2,588 members. Will continue on a monthly basis for July - Dec 2023; Second Birthday Card, mailing compelted for April-June Birthdays = 2,789 members. Will continue on a monthly basis for July - Dec 2023. **3) Early Identification and Data Gap Bridging Remediation for early intervention** W30 Data Strategies Workgroup: Improved HN monthly Gap Reports to include more measures and details; Developing W30 Gap Report for HNs. First report slated to go out in July; Plans to present W30 Findings and Strategies at various forums and meetings. **4) May 2023 Prospective Rates. Change in methodology to remove continuous enrollment criteria*** CIS-Combo 10: 27.12%, performing lower than last year (28.66%), have not met MPL (34.79%); IMA-Combo 2: 38.16%, performing lower than last year (40.52%), met MPL (35.04%); W30-First 15 Months: 22.13%, performing lower than last year (21.34%), have not met MPL (55.72%); W30-15 to 30 Months: 58.01%, performing lower than last year (60.80%), have not met MPL (65.83%)); WCV (Total): 14.67%, performing lower than last year (15.98%), have not met MPL(48.93%)	1) Continue targeted member engagement and outreach campaigns in coordination with health network partners. 2) Continue with Strategic Quality Initiatives Intervention Plan. 3) Continue efforts for early Identification and Data Gap Bridging Remediation for early intervention. This includes working with health networks to establish supplemental data submission process.	
Quality of Clinical Care	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2023 Goal: MC 77.48% OC (Medicaid only)	1) Identify members through internal data reports in need of diabetes screening test. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) 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.	1. 2Q2023 2. 3Q2023 3. 2Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q2 (May): M/C:50.14% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report. 2) Conducted telephonic outreach to prescribing providers, then sent 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). 3) Barriers included: Receiving timely data, obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. Other difficulties we have come to know is that some members with this diagnosis do not see their PCP regularly.	1) 3rd Quarter Report will be pulled in July. 2) Continue tracking members in need of diabetes screening test. 3) Continue outreach to prescibing providers	
Quality of Clinical Care	Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot	1) Lower HbA1c to avoid complications (baseline: A1c ≥ 8%; varies by individual); 2) Improve member and provider satisfaction	<u>Final Pilot Program Design:</u> 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement <u>Planned Activities:</u> Finalize member stratification Outreach to high volume PCPs Launch the pilot program	Finalize member stratification - end of Jan 2023 Outreach to high volume PCPs - end of Q1 Launch the pilot program - end of Q1	Joanne Ku	<u>Progress/Accomplishments:</u> 1. Presented the pilot program at the CalOptima Health Community Network (CHCN) Virtual Learn on 6/13/23 2. Received one application from Family Health Matters; Planned Parenthood also expressed interest but has not submitted an application. 3. Met with Family Health Matters on 6/28/23 and obtained their buy in; they already have a clinical pharmacist in the clinic so we need to further discuss in what capacity we can help without duplicating any efforts. Family Health Matters expressed that their members will benefit from our Health Education resources. <u>Challenge:</u> Lack of provider interest or participation	1. With PR's help, this pilot program will be featured in the July provider update. 2. Meeting scheduled with Family Health Matters' Clinical Pharmacist on 7/13/23 to discuss each other's roles. 3. Goal is to start the pilot with Family Health Matters' CHCN members in the fall 2023. 4. Brainstorm other ways to promote this pilot opportunity.	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	MY2023 Goals: MC: 30-days: 21.24%; 7 days: 8.93%	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q2 (May): 30 day- 19.00%, 7 Day Total- 10.06% 1) The main barrier has been not havng the bandwidth to outreach to members that we have been receiving on a daily basis. 2) Leadership is working on identifying a solution in collaboration with ITS and the Health Network relations to establish a secure method to share real time ED data with Health Networks. a) Several meetings have occured between Health Network relations, ITS and BHI Leadership.	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis. 2) Currently in the process of creating methods of disseminating data via sFTP with Health Networks on a daily basis. 3) Ticket has been submitted to ITS for assistance with establishing protocols to send and receive data through CalOptima Health sFTP site. 4) BHI is in the process of developing a Pilot project for CCN members identified who meet FUA criteria. 5) Explore with ITS options for notification of ED admits to assign PCP.	
Quality of Clinical Care	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2023 Goal: MC - Init Phase - 42.77% MC -Cont Phase - 51.78%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on provider responsibilities on related to follow-up visits. 3) Continue member outreach (through multiple modalities telephonic, newsletter, mobile device) to improve appointment follow up adherence.	1. 2Q2023 2. 4Q2023 3. 3Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q2 (May): Initiation Phase- 47.43%, Continuation and Maintenance Phase- 52.06% 1) Continued member telephonic outreach for members that filled initial ADHD Rx. 2) Article for Treatment of Children with ADHD to educate members on ADHD has been included in the Medi-Cal Member Newsletter Spring 2023 edition. 3) Pulled report and Identidied the non-complaint providers. 4) Updated Provider best practices letter to include current medical director's signature.	1) Continue member outreach for those who filled an initial ADHD prescription. 2) Intiate fax for Provider best practices letter and tip sheet to non-compliant providers.	
Quality of Clinical Care	Reporting of Communicable Diseases	Improve provider reporting of communicable disease	1) Educate provider on the requirements and process to report communicable disease	1. 2Q2023 2. 4Q2023 3. 3Q2023	Marsha Choo	1) Updated Policy GG.1630 to include language from the 2024 DHCS Contract.	1) Include requirements and process in the provider manual	
Quality of Service	Increase primary care utilization	Increase rates of Initial Health Appointments for new members, annual wellness visits for all members.	1) Increased Health Network/Provider education and oversight 2) Enhanced member outreach (IVR, digital engagement)	1) 1Q2023 2) 2Q2023	Katie Balderas	1) Presented at 9 Health Network Joint Operations Meetings, held Continuing Medical Education (CME) event on IHA completion. Developing Chart Review process to validate IHA completion. 2) Launched IVR Campaign for new members in May 2023, conducting outreach to approximately 9,000 new Medi-Cal members per month.	1) Pilot IHA Chart Review Process. Refine process and distribute chart review tool to Health Networks and providers. 2) Monitor outcomes of IVR Campaign. Explore additional methods for digital outreach.	
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS to meet goal	1) Issue an RFI to obtain information on CAHPS improvement vendors and strategies, contract and launch program 2) Member outreach to all OneCare members 3) Track measures for monitoring individual provider performance (ie. number of grievances, number of CAPs issued) and take action based on committee action	by end of 3Q, 2023	Mike Wilson	1) RFP was launched for CAHPS Improvement March 2023 with vendor selection occurring May 2023. 2) Woking to develop member material to educate members on such things as pharmacy benefits, etc	1) Vendor is currently reviewing the contract with goal to execute contract in August. 2) Will continue to monitor and track data on member satisfaction data through various Member Experience workgroup and committees.	
Quality of Service	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan	1) by end of 4Q2023	Linda Lee	Q2 Update: CAHPS improvement work teams have implemented short term interventions to improve CAHPS composites, preliminary TTY and disenrollment rates demonstrate improvement.	CAHPS improvement work teams developing mid and long term interventions and goals; Director Medicare Stars/Quality Initiatives presenting best practices.	

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Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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 - Caution Green - On Target
Quality of Service	Provider Data Improvement	Improve Provider Data in Facets	1) Develop and implement a process to utilize Lexis Nexis data correct provider data errors 3)Establish process for ongoing review and maintenance of data	by end of 4Q, 2023	Debra Gonzalez	07/25/23: Task assigned.	Follow up actions: 1) Create new CORE report for auditing of the Facets data. 2) Work with the Lexis Nexis team to automate update into Facets.	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Reduce OON requests by 25%	1) Actively recruit top 3 out-of-network (OON) specialties as shown on **QMRT** 2) LOA project to outreach and recruit providers that are currently receiving letters of agreements.	by end of 4Q, 2023	Adriana Ramos	Progress: Initated a plan to outreach and recruit providers currently listed in our system using letters of agreements to have them enter in full contract. Progress is slower than expected as provider data is not current and requires multiple outreach/persons for decision making.	Continue as planned for outreach and recuirement activities using LOA provider list.	
Quality of Service	Improve Timely Access: Appointment Availability	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	1) Provider incentive to meet timely access standards 2) Provider incentive for extending office hours	by end of 2Q, 2023	Mike Wilson	Timely Access scope of work currently being drafted for 2023 survey and will include a 2-month extension to contract to end 12/31.23. Updating business requirements and working with PDMS to pull 2023 universe. Working with vendor to update compliance calculations so they are in alignment with CMS changes for PC and BH providers. This also caused a delay with the release of 2022 reports, as more time was required from the vendor to make modifications and QC the reports. Prep for In-Office Wait TIme Survey to be fielded in Q3. Pull universe and identify support staff to make outreach calls to members to validate time spent in provider office before seeing provider.	Finalize 2023 Timely Access Scope in July/August and fielding to begin in Sept. Start RFP for 2024 and include In-Office Wait Time survey. QC and finalize 2022 Timely Access Reports Field In-office Wait TIme survey Q3	
Quality of Service	Provider Data Improvement	Improve HN Provider data	1) Develop and implement process for auditing HN Directory data to meet SB 137 requirements 2) Create score cards for HN directory data accuracy 3) Establish process for auditing provider directory attestations	by end of 4Q, 2023	Silvia Peralta	1. Working in collaboration with Analytics Sr. Manager in creating a process to merge HNs Provider Directory Universe files and compare data discrepancies to meet SB137 requirements. 2. Working with HNR dept to communicate to HNs of the provider directory validation frequency change from Quarterly to Semi-annual and Annual attestation submission 3. Finalizing scorecard and submit to HNs with findings	1. Prepare and submit 3rd quarter directory universe validations to HNs and audit data responses. 2.Tabulate HN score by area to determine Met/Not Met Feedback to HN (meeting/email) Scorecard and audit data. 3. For the Annual Provider Attestation Validation, CalOptima 's Audit department will distribute selections by email to designated CCN/HN staff by January 5th of each calendar year	
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Submit SNC to DHCS 2) Develop a process for remediating and Capping efforts 3) Communicate results and remediation process to HN 4) Monitor for improvement	by end of 4Q, 2023	Quynh Nguyen/Mike Wilson	1. SNC Submtited to DHCS 2. Health Networks with deficiencies have been identified 3. Team in process of documenting process for monitoring	1. Discussion are in place to determine remediation efforts needed 2. Develop an SOP 3. Present Program and roll out plan to internal leadership/dept 4. Roll out to HNs 5. Monitor HN efforts 6. Assess results for escalation	
Safety of Clinical Care	~~Plan All-Cause Readmissions (PCR)~~ Transitional Care Services (TCS)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving PCP follow up post discharge rate by ~~4~~95% each quarter (focus on getting discharge plans w/ PCP appt from hospitals)	Planned Activities: 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Setting up the workgroup - end of 1Q 2023 Updating the UTC letter - end of 2Q 2023	Stacie Oakley Hannah Kim Scott Robinson	1) Decided to discuss the plan all-cause readmissions (PCR) measure in the existing TCS workgroup in lieu of creating a separate workgroup. MET 2) Updated the UTC letter (specific TCS language that contains the NCQA requirement). MET	1) Collaborate and finalize the post discharge assessment tool to improve follow-up with members post-discharge to mitigate readmission. 2) Identify if we have an existing report for PCR measure or HEDIS data (baseline for PCR). 3) Enhance bed day goals to include readmissions. UM is working to remove LTAC and admin days from the calculation so we can re-run 2022 bed days. 4) Update the DTPs (CM/LTC) to finalize processes for post-discharge follow-ups with high-risk PHM members, in order to decrease risk of readmission.	
Safety of Clinical Care	Emergency Department Diversion Pilot	Pilot has been implemented. In 2023 plan to expand the program to additional hospital partners.	1. Promoting communication and member access across all CalOptima Networks 2. Increase CalAIM Community Supports Referrals 3. Increase PCP follow-up visit within 30 days of an ED visit 4. Decrease inappropriate ED Utilization	by end of 4Q, 2023	Scott Robinson	Progress: Initated a plan to implement a virtual communication process between UCI ED and CalOPtima Health UM/LTSS utilizing TEAMS. The project has not proceeded as expected due to PHI security processes that needed to be resolved. The security processes have now been resolved and we are in process of establishing the Teams channel with UCI. Next steps: UCI/CalOptima IT and clinical teams to finalize set-up, communication process and DTP. Goal is to go live by 9/1/2023.	Next steps: The UCI/CalOptima ITS and clinical teams to finalize connection, communication process, DTP and training. Goal: Go live on 9/1/2023.	

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Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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
Program Oversight	2023 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Quality Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIHEC-BOD; QI Work Plan-QIHEC-QAC	Annual Adoption by April 2023	Marsha Choo	Approved: QIHEC 2/14/2023, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2022 Quality Improvement Program Evaluation	Complete Evaluation 2022 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by January 2023	Marsha Choo	Approved: QIHEC 2/15/2022, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2023 Utilization Management and Case Management Program	Obtain Board Approval of 2023 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Approved: UMC Committee via eVote on 4/7/2023, QIHEC 4/11/2023, BOD 8/3/2023		
Program Oversight	2022 Utilization Management Program Evaluation	Complete Evaluation of 2022 UM Program	UM Program will be evaluated for effectiveness on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Approved: UMC Committee via eVote on 4/7/2023, QIHEC 4/11/2023, BOD 8/3/2023		
Program Oversight	Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Cultural and Linguistic Services Program and Cultural and Linguistic Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by April 2023	Carlos Soto	Approved: QIHEC 4/11/2023		
Program Oversight	Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	Revised PHM Strategy to prepare for submission to DHCS, due 10/31. Held initial meeting with OC Health Care Agency (HCA) on 9/11 to discuss new PHM Requirements to include shared SMART objective. HCA and CalOptima teams agreed on blood lead screening objective. Have not been able to schedule further discussions with HCA despite multiple follow ups.	Continuing to outreach to HCA, discussing alternative objectives that we may be able to work on in addition to or instead of blood lead screening. Presenting revised PHM strategy to QIHEC for approval on 10/10/2023.	
Program Oversight	**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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Laura Guest	**I. FSR/MRR/PARS, NF and CBAS** A. FSR: Initial FSRs=9 Initial MRRs=13 Periodic FSRs=41 Periodic MRRs= 35 On-Site Interims=22; CAPs: CE=30 FSR=41 MRR=45 Failed FSRs=3 Failed MRRs=10 B. PARS: Completed PARS=61 BASIC Access=24 LIMITED Access=37 C. CBAS: No Critical Incidents reported. Non-Critical=30 Falls=10 COVID=15 Completed Audits=11 CAPs=9 Unannounced Visits=0 D. SNF: No Critical Incidents were reported in Q3. Completed Audits=0 CAPs=0 Unannounced Visits=0 **II. Credentialing:** CCN initial credentialing=73; recredentialing=101; BH initial credentialing=78; BH recredentialing=41 III. A. PQI - 165 PQIs were opened and 125 cases closed were in Q3 . TAT - 41% of PQIs were initially reviewed by a Medical Director in 90 days; 40% of declined grievances were reviewed by a medical director in 30 days.. The number of cases open at the end of Q3 is 389. Seven (7)% of the cases were presented at CPRC. Seventy-one of the case were regarding Medical Care; 45 of those regarding Mismanaged Care. Nineteen cases (15%) were leveled QOC 1, 2 or 3. There were 587 QOC grievances reviewed in Q3. Two new positions have been submitted; 1 RN and 1 PS. The RN position has been posted for recruitment. We are in the the process of testing a new system, Jiva, for the QOC grievances which is expected to be implemented in Q1 2024. B. PPCs - There were 2 PPCs identified through claims review.	**I. FSR/MRR/PARS, NF and CBAS** A. FSR: Continue to audit. Close issued CAPs by due dates. B. PARS: Completed PARS=61 BASIC Access=24 LIMITED Access=37 C. CBAS: Continue to complete annual audits and remind centers to report Critical Incidents. D. SNF: Currently recruiting for two QI Nurse Specialist-LVN positions. Re-evaluate current processes and procedures when new staff are hired. Consider cross-training existing staff to fill positions in interim. **II. Credentialing:** Continue to credentialing and recredentialing of CCN and BH providers. Started to engage a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliess of the intial credentialing and recredentialing of files. Also in the process of reviewing credentialing processes with Ankura (Consulting Group) to dentify gaps and improve overall workflow. Credentialing mgr started on 8/14. Engaged Symplr (Cactus Provider mgmt Platform) for additional Cactus training for the credentialing staff. III. PQI - Continue to monitor the volume and TAT of PQIs, DC and QOC Grievances. Hire and train new staff. Continue to test and train team on Jiva.	
Program Oversight	**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 netwks. Trends and results are presented to the committee quarterly.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Tyronda Moses	GARS Committee met on August 15 where management of GARS presented trends and remediation activities for Q2 2023. Trends discussed were as follows: **Medi-Cal Grievances:** Increase across all categories with significant increases in QOS and Access; QOS Increase * Transportation - driver behavior/attitude and timeliness * Delay of referral provider/plan - Access Increase * Appointment availability (extended wait times) * Telephone Accessibility (answering the phone / not returning calls) * No significant provider trends identified **Medicare Grievances:** Increase of 13% from Q1 - related to transportation; Decrease of 35% from Q1 - contributing the the decrease was the OCC to OC eligibility issues being resolved by Q2; Increase of 77% from Q1 - billing issues related to Hospitals, ER and urgent care facilities (members not presenting cards or facilities unable to verify benefits during transition) **Grievance Remediation Activities**: **Transportation:** Dedicated transportation team within GARS was formed in May 2023, Continued collaboration with vendor. **Access:** Appointment Availability: Reporting extended wait times for scheduling appointments for PR contact for education, Trending Specialties reported for contracting opportunities - neurologist, cardiologist, pulmonologist **Medi-Cal Appeals:** Increase of 58% from Q1 2023 - Contributing to the increase are authorization denials issued for medical necessity not met for services or redirections from tertiary level provider; Top Helth Networks contributing Monarch and CCN; Overturn rate decreased; No significant trends in the Oveturned appeals **Medicare Appeals:**Increase of 47% from Q1 2023 - Many of the Q2 appeals were carryovers from the OCC to OC transition with those members being seen and having authorization issues;Top Health Networks contributing were Monarch, CCN and Prospect; Overturn rate at 40% with 25 of 62 (Monarch - Total 30 with 10 Overturned = 9 medical necessity with records received during appeal + 1 denied in error as provider OON. Monarch was educated.; Prospect - driven by 1 member who appealed 5 separate denials of payment for genetic testing ordered by a contracted Oncologist. Overturned due to Plan directed Care; Family Choice - Total 4 with 3 Overturned = 2 for specialty care at UCI not available in network + 1 denied for records received during appeal showing medical necessity **Clinical Appeals Remediation Activities:** CCN Authorizations denied as non-benefit in error - issue was communicated to UM Leadership in May 2023. PA team was re-educated on the TAR benefit lists and the issue has since been resolved.	GARS to continue to monitor and report as appropriate. Next GARS Committee meeting scheduled for November 14.	
Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2023 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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Marsha Choo	In Q3, MemX Committee has reviewed/discussed the following: 8/22/23 **Committee overview & purpose:** •NCQA Reports - High level findings and action plan •Timely Access Survey - CAPS Close Out - 2022 Survey Results - 2023 Survey Fielding •Provider CAP Plan- Access •SNC Certification Update •CAHPS Update - 2023 Medi-Cal CAHPS Results Plan and HN - CAP CAHPS Closure - 2023 Survey Fielding	Committee requested an additional meeting is scheduled in October. Meeting dates for Q4 will include: October 30 and November 28th.	

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Program Oversight	**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.	1Q23 update (4/11 QIHEC) 2Q23 update (7/11 QIHEC) 3Q23 update (10/10 QIHEC) 4Q23 update (Jan 2024 QIHEC)	Stacie Oakley	UMC met 8/24/23 and is on track to meet quarterly. Meeting minutes are available for review. Quarterly Utilization Metrics Quartertly updates for (Pharmacy, BH and LTSS update).The BMSC 3/22/2023 minutes were presented & approved at the 6/21/23 meeting. UM data was presented at the 9/12/23 & UM is on track to report quarterly. Meeting minutes are available for review.	The next UMC meeting is scheduled for 11/16/23. The next BMSC will report to UMC meeting on 10/25/23.	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.		1) Meet quarterly to provide clinical and behavioral service advice regarding Whole Child Model operations **2023 Meeting Schedules** WCM CAC Q1: February 21, 2023 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (4/11 6/13QIHEC) 2Q23 update (7/11 6/13 QIHEC) 3Q23 update (9/12 QIHEC) 4Q23 update (Jan 2024 12/12 QIHEC)	T.T. Nguyen, MD/H.Kim	WCM CAC met 8/16/23 they presented and discussed the following: -Behavioral Health SBHIP program updates. -Pediatric CalAIM. No available data since 7/1/23 launch. -UM Transition Workgroup was placed on hold until 2024. -WCM Member Inquiries data -Network Adequacy. Mike Wilson reported that Regal was non compliant for Ortho. -Case Management provided update on DHCS Audit & WCM Health Needs Assessment -Pediatric Quality Measure, Pharmary, and GARS were deferred to the November meeting due to data unavailability. -In open discussion, Kaiser as a new Managed Care Plan transition effective 1/1/2024 and DHCS provider rate increase were discussed.	As a follow up, an email with information were sent on 8/16/23 to Committee members on: 1) Budget summary with information on the rate increase in the Medi-Cal Program 2) Information and flyers on CalOptima Health hosting a Back-to-School Event on Saturday, August 26th 2023. WCM CAC update will be provided to QIHEC on 9/12/23. The next WCM CAC meeting is scheduled for 11/7/2023.	
Program Oversight	Pediatric Risk Stratification Process (PRSP) monitoring		Discuss annually the Pediatric Risk Stratification algorithm with the CCS program	Aug-23	Hannah Kim	Presented at UM and QIEHC committee and will presented next in August 2024	Quarterly review to confirm that members risk stratified appropriately and then taper to annually.	
Program Oversight	Managed Care Accountability Set (MCAS)	Achieve 50th percentile on all MCAS measures in 2021	Share results to Quality Improvement Committee annually	end of 3Q 2023	Paul Jiang	HEDIS MY2022 results were presented to QIHEC on 7/11. LSC didn't meet MPL.	Quality improvement team is working on the improvement plan.	
Program Oversight	Health Network Quality Rating	Achieve 4 or above	Will share HN performance on all P4V HEDIS Measures via prospective rates report each month	end of 4Q 2023	Sandeep Mital	The Pay for Value (P4V) team generates a Prospective Rate (PR) report each month for all participating health networks and CalOptima Health to allow health networks monitor their progress on clinical HEDIS measures in the P4V program. Performance on each measure is compared to the overall CalOptima Health performance, as well as to the National Medicaid HEDIS benchmarks established by NCQA.	The overall health network quality rating (HNQR) is the weighted average of the network's HEDIS and CAHPS measure ratings, as well as accreditation bonus points and is calculated on a scale of 1-5 (5 being the highest). The final HNQR for MY2022 for the Medi-Cal line of business for all participating health networks was presented at the QIHEC Committee meeting on September 12, 2023.	
Program Oversight	CalAIM	Improve Health & Access to care for enrolled members	1) Launch ECM Academy; a pilot program to bring on new ECM providers. 2) Increase CalOptima Health's capacity to provide community supports through continued expansion of provider network. 3) Continue to increase utilization of benefits. 4) Establish oversight strategy for the CalAIM program. 5) Implement Street Medicine Program 6) Select and fund HHIP projects through Notice of Funding Opportunity. 7) Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	1) 1Q 2023 2) 4Q 2023 3) 4Q 2023 4) 3Q 2023 5) 1Q, 2Q 2023 6) 1Q 2023 7) 3Q 2023	Mia Arias	1) A second academy cohort has launched with 15 ECM providers. 2) As of 10/1 there are 70 CS providers onboarded. 3) As of 10/13/23 there are 37,225 members receiving ECM, CS or both. 4) We are waiting to onboard a CalAIM Medical Director before defining this process. 5) As of 9/30 Healthcare In Action has reached out to 271 individuals and there are 102 active members in the program. 6) HHIP NOFO Round 2 awarded $52.3M in grants to 15 capital projects to bring online affordable and permanent supportive housing. A Round 3 will be made available before the end of the year to provide additional support for systemic change in the continuum of homeless services. 7) A Notice of Funding Opportunity was released and providers will be selected and contracted to provide services as of 1/1/2024.	Continue with the plan as listed.	
Program Oversight	Health Equity	Increase member screening and access to resources that support the social determinants of health	1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	1) 4Q 2023 2) 4Q 2023 3) 3Q 2023	Katie Balderas	1) Proposed screening questions to be integrated into JIVA 2) Drafted the Closed-Loop Referral Platform SOW and initiated vendor management RFP process. 3) As of the end of this quarter, 157 CalOptima Health staff from 22 departments enrolled in the Health Literacy for Equity program with 22 successfully completing the certification program	1) Jiva questions finalized and being programmed into system. Will launch with Jiva implementation in January 2024. Added SDOH screening question to Health Information Form/Member Evaluation Tool (HIF-MET) and pending DHCS approval. ITS is developing SDOH screening in member portal using CMS Accountable Communities for Health questions. 2) Release Closed Loop Referral System RFP 3) Continue to encourage staff to complete the Health Literacy for Equity certficate program, get leadership support for completion of certificate	
Program Oversight	Improvement Projects Medi-Cal PIP(BH)	Meet and exceed goals set forth on all improvement projects	Non-Clinical PIP - FUM/FUA 1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	Improve the percentage of members enrolled into care management, complex care management (CCM), or enhanced care management (ECM), within 14-days of a Emergency Dept visit where the member was diagnosed with SMH/SUD. 1) Submitted BH Non-Clinical PIP to DHCS 9/29/23, awaiting feedback.	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis for CCN and COD members. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. BHI will conduct the outreach and provide information about case managment including ECM and referrals. 3) Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CCN members identified who meet FUM/FUA criteria. 4) Working with internal depts to identify baseline data for CM, CCM, and ECM enrollment.	

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Program Oversight	Improvement Projects OneCare 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 for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	end of 2Q2023	Helen Syn	Baseline Data: PR Report May 2023 HbA1C <8 Total (HBD): MC: 35.04% OC: 48.03% HbA1c>9 Total (Poor Control) (HBD): MC: 59.00% OC: 44.77% Eye Exam for Patients with Diabetes (EED): MC: 41.13% OC: 55.72% Kidney Health Evaluation for Patients with Diabetes (KED): MC: 35.60% OC: 46.02% Statin Use in Persons with Diabetes (SUPD) OC only: 86.09% 3)VSP Eye Exam Reminder Letters: MC Total sent in Q3 2023: 1000, OC Total sent in Q3 2023: 142 5) Member Incentive: A1C Test: Processed 785 approved 741 for MC; Processed 165 approved 160 for OC EED: Processed 631 approved 558 for MC; Processed 139 and approved 126 for OC	1) Track submitted diabetes member incentive forms 2) Continue Statin Mailer in Q4 3) Text message campaign for medication adherence (SPD) 4) IVR campaign for HBD/SPD Q4 5) Planned OC Live Call Outreach campaign for Q4 6) Obtain results from VSP Eye Exam Reminder Letters	
Program Oversight	Improvement Projects Medi-Cal PIP	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP - Health Disparity remediation for W30 6+ measure (Jan Pending January Module Training January 2023 projected. Please note that the focus for the Clinical and Non-Clinical PIP topics is related to DHCS' "50 by 2025: Bold Goals Initiatives"- See links for more information on the Bold Goals Initiatives: https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/Equity-and-Practice-Transformation-Grants-May-Revise.pdf or https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf	Quarterly Status update on modules as they are completed.	Helen Syn	1) Identified CalOptima Health's Black/African American W30-6+ population. 2) Identified proposed intervention: Survey to identify barriers among Black/African American members in completing well-child visits. Survey developed. 3) September 2023 - Submitted the proposed clinical PIP design for review and approval.	1) Approval for clinical PIP design is expected October 2023. Proceed with implementation strategy once approved.	
Program Oversight	OneCare Performance measures	Achieve 4 or above	1) Implement Star Improvement Program 2) Track measures monthly 3) Implement OC Pay4Value	1. 1Q2023 2. 2Q2023 3. 3Q2023	Linda Lee	Monthly prospective rate reports for OneCare Star and Pay4Value measures are in production. Second plan preview of 2024 Star measures received and reviewed in Sept 2023.	Identified Star measures for focused interventions for remainder of CY. Initiatives underway.	
Program Oversight	Plan Performance Monitoring and Evaluation (PPME): HRA and ICP	Retired: 3.2 ICP completion 90 days Benchmark 90% adjusted. 2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted. NEW: Successful transition to revised Oversight process.	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	1Q23 (5/9 QIHEC) 2Q23 (8/8 QIHEC) 3Q23 (11/14 QIHEC) 4Q23 (February 2024 QIHEC)	S. Hickman/M. Dankmyer/H. Kim	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance: Reporting benchmarks for 3.2 retired due to revised Oversight audit process. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks: ITS continues to build validation process for MOC tracking file data. Ongoing communication with Networks for ICP bundles continues. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring: Audit tool was created and distributed to Networks. Training was provided to Networks. 2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted. Q3 Pending. Results for Q2 are 100% adjusted.	Develop communication process with Networks for tracking outreach and completion to meet benchmarks. ITS continues to build validation process for MOC tracking file data. Ongoing communication with Networks for ICP bundles continues. 2.1 Initial HRA collected in 90 days from eligibilty Benchmark: 95% adjusted. Q3 Pending,Q3 submission to DHCS due on 11/31/2023 anticipate benchmark to be met.	
Program Oversight	NCQA Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and **NCQA Health Equity Accreditation by no later than January 1, 2026.**	1) Continue to Work with Business owners to collect all required documents for upcoming HP re-accreditation.(Must collect all Year one required documents by 2Q2023. 2) Comple Gap Analysis for Health Equity Accreditation.	1) end of 1Q2023 2) end of 2Q2023	Veronica Gomez	1) Finishing up Year-one of look-back peirod (4/30/2022-4/30/2023). Currently working with Business owner on the collection of Year-two documents needed (4/30/2023-Current). W 2) Developed Health Equity Timeline and currently waiting on GAP Analysis from NCQA Consultant on documents reviewed.	1) Continue to work with Business owners to collect all required documetns for upcoming HP re-accreditation. (Must collect all Year-one required documetns by 2Q2023) 2) NCQA Consultant to complete GAP Analysis report for Health Equity Accreditation.	
Program Oversight	Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	1 Implement SBHIP DHCS targeted interventions 2. bi-quarterly reporting to DHCS	1) 4Q2023 2) 4Q2023	Diane Ramos/ Natalie Zavala/Carmen Katsarov	1) Met with OCDE regarding billing readiness; OCDE decided not to use SBHIP funds for a 3rd party billing vendor; each school district will be directed to submit BH claims directly to CalOptima Health's clearinghouse. 2) 7/18/23 SBHIP Implementation Update meeting held; SMEs from CalOptima Health internal departments attended and provided how SBHIP impacts their departments. 3) Contracting process in progress for Western Youth Services and Hazel Health. 4) OCDE SBHIP MOU finalized and executed 7/13/23. 5) 8/9/23 BHI Manager attended a meeting with City of Anaheim representatives (Sandra Lozeau – Deputy Director, Grace Ruiz-Stepter – Director of Housing and Community Development, Dave Barry – EMS Director, Captain/Paramedic Manager providing a general update on the collaboration with all 29 LEAs, and OCDE and our OC partners OHCA, CHOC, WYS. 6) 8/8/23 BHI Director did a radio interview with KNX regarding SBHIP. 7) 9/15/23 received quarterly progress reports from SBHIP partners (CHOC, Hazel Health, WYS, and OCDE).	1)Prepare 4 Biquarterly reports to submit to DHCS by 12/31/2023. 2) Bi-weekly meetings with OCDE focusing on targeted interventation tasks and timelines; participate in the upcoming meetings OCDE witll coordinate for school district representative to attend and focus on completing targed intervention tasks. 3) Quarterly progress reports from the SBHIP partners expected 01/24. 4) Expect DHCS to publish BH billing fee schedule, once received meet with claims and other depts impacted by ythe new BH billing fee schedule. 5) Monitor credentialing process for western youth services, Hazel Health and the scholl districts. 6) Expecting bi-quarterly funding from DHCS for June 2023 deliverables.	
Quality of Clinical Care	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	1) Assess community infrastructure capacity for cancer screening and treatment 2) Establish the Comprehensive Cancer Screening and Support Program Stakeholder Collaborative (in our Case I want to leverage OC3) 3) Develop comprehensive outreach campaign to outreach to members due for cancer screenings (mobile mammography, outbound calls, community health workers) 4) Integrate new community health worker benefit into cancer outreach and treatment services.	1) 1Q2023 2) 2Q2023 2) 3Q2023 3) 4Q2023	Katie Balderas	1) Assessment completed via meetings, survey and listening session with community stakeholders such as the University of California, Irvine Chao Family Comprehensive Cancer Center, Orange County Cancer Coalition (comprised of 19 organizations) and the Coalition of Orange County Community Health Centers; drafted COBAR for a Notice of Funding Opporunities (NOFO) in respond to the assessments and identified needs and opportunities. 2) CalOptima Health Staff continues to attend the OC3 meetings 3) COBAR going to the Board in November for a Comprehensive Cancer Screening Awarness and Education Campaing 4) No progress on integration of CHW into Cancer Screening Program as of this quarter.	1) Finalize development of the NOFO for released by January 2024 2) Continue to attend OC3 meetings and report on Cancer Screening program opportunities 3) Work with vendor to develop the Comprehensive Cancer Screening Awarness and Education Campaing 4) Work with the CalAIM team to strategized on integration of CHWs for cancer screening outreach and education	

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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
Quality of Clinical Care	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP) Care Management, Comprehensive Diabetes Care (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	Linda Lee	Live call campaign to remind and assist members with PCP visits, provide education, and member incentives underway. Developing IVR/text outreach for remainder of year for high priority members.	Continue member outreach for HRA completions, transitions of care, and care for older adults.	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS MY2023 Goal: MC 30-Day: 54.51%; 7-day: 31.97% OC (Medicaid only)	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q3 (August): 30 day- 38.75%, 7 day- 23.88% 1) The main barrier has been not havng the bandwidth to outreach to members that we have been receiving on a daily basis. 2) Leadership is working on identifying a solution in collaboration with ITS and the Health Network relations to establish a secure method to share real time ED data with Health Networks. a) Several meetings have occured between Health Network relations, ITS and BHI Leadership. b) sFTP folders have been established, ITS is in the process of testing and validating data.	1) Working with CalOptima Health Vendor to receive applicable Real-Time ED data on a daily basis. 2) Currently in the process of creating methods of disseminating data via sFTP with Health Networks on a daily basis. 3) Ticket has been submitted to ITS for assistance with establishing protocols to send and receive data through CalOptima Health sFTP site. 4) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM criteria. 5) Explore with ITS options for notification of ED admits to assign PCP. 6) Data Analyst pull data for text messaging 7) PHM to schedule a meeting with vendor for Text Messaging Campaign	
Quality of Clinical Care	Blood Lead Screening DHCS APL	1) Comply with APL requirements including quarterly reports of members missing blood lead screening 2) Increase Rates of successfully screened members to #% 3) Put process in place ot identify refusal of blood lead consent forms	- PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. - Update Policy GG.1717 to include Health Network Attestation and conduct Health Network/Provider education - Add blood lead screening resources to CalOptima Health website: Comprehensive Health Assessment Forms, CDPH anticipatory guidance handout, - Launch IVR campaign to members with untested children - Member mailing campaign to members - Lead texting campaign for members - Medi-Cal member newsletter article(s)	All activities will be complete by 3Q, 2023	Helen Syn	**1) Quality Interventions:** - Blood Lead Outreach Report - Report was first introduced in June 2023 to identify members that will be due for least testing at 12 and 24 months of age in the next 1 - 3 months. September 2023, this report was merged with the Blood Lead Performance Report to streamline information sharing with providers. - Ad campaigns- 1) Digital targeted ads ran from August to October 2023, 2) Radio Ad for blood lead ran in September 2023, 3) Targeted social media ads ran in September 2023 and 4) PBS TV campaign ran in September 2023. - Social Media Post- August 2023- Educating public on lead exposure and steps to prevent lead poisoning. - Text Campaign- August 2023 - Campaign to inform members that they may be due for a blood lead test. Targeting members 9 - 12 months and 21-24 months of age. - Pediatric Telephonic Call Campaign - phase 2 (7/28-8/10), phase 3 (8/11-9/20), phase 4 is in progress as of 9/25/23 - W30 focused campaings with education of lead testing. Note phase 1 conducted in Q2 2023. **2) August Prospective Rates - 59.91%** The measure is faring higher than this same time last year in August 2022. This rate is expected to be higher as it the final rate will show continuous enrollment criteria per HEDIS. **3) Provider Focused Interventions:** - Blood Lead Testing Guide for providers developed. Guide incorporated information on testing requirements, testing timeframes for children, coding. This effort was a result of the root cause analysis conducted in Q2 2023. - CCN Lunch and Learn - September 2023 - Introduced blood lead best practics (e.g., testing requirements, coding, optimizing office practices) & shared lead resources that include the documentation of lead refusals in member medical record and sharing of OCHCA's Lead Hazard Removal Program. - CE/CME in August 2023 - Conducted The Prevention of Childhood Lead Poisoning: Why Health Care Providers Should Counsel on Lead and Screen for Lead Exposure in collaboration with the Childhood Lead Poisoning Prevention Branch's Medical Officer.	1) Continue with ad campaigns to support increased awareness and education around blood lead. 2) Continue to monitor prospective rates for trends including high opportunity providers. 3) Continue with targeted messaging to parent/guardians of members that have not tested for lead. Complete an IVR in November 2023. 4) Consider implementation of a blood lead member incentive to drive testing rates.	
Quality of Clinical Care	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2023 Goal: Postpartum: 84.18% Prenatal: 91.89%	1) Track member health reward impact on HEDIS rates for postpartum care measure. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 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) Expand member engagement through direct services such as the Doula benefit and educational classes	1) Annual Evaluation 2) Per quality initiatives calendar - ongoing updates 3) Ongoing updates 4) 4Q2023 5) 3Q2023	Ann Mino/ Helen Syn	1) Quality Interventions/Programs: - Bright Steps Program: 888 PNRs received, 541 assessment completed,, 508 unique members served during Q3 2023. - Postpartum Care Incentive; XX incentives processed through Q3 (cumulative). - Doula - September 2023- Contract approved by board and expected to be effective as of October 2023. - Media Campaigns - Digital Ads August - September 2023, Targeted Social Media Ads - August - September 2023. 2) August Prospective Rates: Timeliness of Prenatal Care: 43.39%. Lower than this same time last year in August 2022. Postpartum Care: 68.37%. Lower than this same time last year in August 2022.	1) Continue targeted member engagement and outreach campaigns in coordination with health network partners. 2) Operationalize the available delivery data to support targeted member outreach for postpartum and well-child. 3) By the end of Q4 2023, will develop new PBS TV campaign content in support of maternal health to launch in 2024. 4) By the end of Q4 2023 will deploy text campaign to members to encourage the completion of postpartum visits. 5) Continue to work with HNs and HEDIS team to identify root causes of low prenatal rates compared to previous year.	
Quality of Clinical Care	COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (18 and over).	1) Communication Strategy of COVID vaccination incentive program through December 31, 2023, end date, focusing on unvaccinated, and updated dosage opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for updated doses.	1) end of 2Q2023 2) end of 3Q2023	Helen Syn	1. Internal communication to member-facing staff of program end date. 2. Texting campaign to address eligibility guidelines and end date of the program. 3. Updated COVID-19 Vaccine Incentive Program (VIP) website to reflect new guidelines. 4. Reached 70.3% vaccination rate for CalOptima members (18 and older).	COVID-19 VIP processing continues - official end date of the program is 12/31/2023.	
Quality of Clinical Care	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	HEDIS MY2023 Goals: Blood Glucose-All Ages:54.36% Cholesterol-All Ages: 36.17% Glucose and Cholesterol Combined-All Ages: 34.30%	1) Communication Strategy of COVID vaccination incentive program through December 31, 2023, end date, focusing on unvaccinated, and updated dosage opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for updated doses.	2Q2023 update(7/11)	Diane Ramos/ Natalie Zavala	PR HEDIS RATES Q3 (August): Blood Glucose all ages: 45.72%, Cholesterol all ages: 30.04%, Glucose & Cholesterol Combined all ages: 28.72% 1) Working with ITS/BHI Data Analyst to identify report specs. a) Meetings have been scheduled. i) Data Pull has begun. 2) The following materials have been submitted and approved: a) Text Messaging script.(DHCS) b) APM Provider Tip Sheet. c) Provider Best Practices Letter. d) Provider Fax Blast Letter. 3) Collaboration meeting with BH Medical Director to explore and develop standing lab order for children and adolescents for prescribing providers/PCPs.	1) Begin process to send Provider Tip sheet. 2) Begin process to send Provider Best Practices Letter. 3) Begin process to send Provider Fax Blast Letter. 4) Data Analyst pull data for text messaging. 5) PHM to schedule a meeting with vendor for Text Messaging Campaign	

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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
Quality of Clinical Care	Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	MY 2023 Goals: CCS: MC 62.53% BCS: MC 61.27% OC 70% COL: OC 71%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	1) Quarterly Updates 2) Per Quality Initiatives Calendar - ongoing updates	Helen Syn	1) 2023 Member Health Rewards processed as of 9/30/2023: CCS: Processed 924 approved 816 for MC; BCS: Procesed 763 approved 674 for MC Processed 139 approved 124 for OC; COL: Processed 109 approved 86 for OC 2) Member, Community and Provider Engagement Live Call Campaign: OC members due for BCS and COL Digital Ad: BCS, CCS Print Ad: COL Radio: CCS, COL Social Media (Paid): BCS, CCS, COL TV Ad: BCS, CCS (Women's Cancer Screenings) 3) 2023 August Prospective Rates (PR): Cervical Cancer Screening MC: 46.54% Breast Cancer Screening MC: 44.51% OC: 56.35% Colorectal Cancer Screening OC: 54.28%	1) Continue to track BCS, CCS and COL member health reward. 2) Member, Community and Provider Engagement Mailing: CCS Mailing Schedule Q4 Texting: BCS, CCS Schedule Q4 (Women Screening) Live Call Campaign for OC Medication Adherence cohort due for BCS and COL measure Digital Ad: BCS Q4 Print Ad: BCS Q4 Radio Ad: CCS Q4 Social Media (Paid): BCS, CCS Q4 Social Media (Passive): BCS Q4 Community Connections: BCS Q4	
Quality of Clinical Care	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)	MY2023 HEDIS Goals:: MC 63.75% OC: 79%;	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures 3) VSP Collaborative gaps in care bridging efforts.	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation 3) End of Q2 2023	Helen Syn	1) 2023 Member Health Rewards processed as of 9/30/23: EED: Processed 631 approved 558 for MC; Processed 139 and approved 126 for OC **2)** Member, Community and Provider Engagement Live Call Campaign: OC members due for EED 3)VSP Eye Exam Reminder Letters: MC Total sent in Q3 2023: 1000, OC Total sent in Q3 2023: 142 4)PR Report May 2023 Eye Exam for Patients with Diabetes (EED): MC: 41.13% OC: 55.72%	1) Continue to track Eye Exam member health reward. 2) Member, Community and Provider Engagement Live Call Campaign for OC Medication Adherence population for EED measure Digital Ad: Q4 Print Ad: Q4 Radio Ad: Q4 Social Media (Paid): Q4 Television Ad: Development of Script Social Media (Passive): Q4 3) Continue tracking VSP mailing	
Quality of Clinical Care	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2023** Goals: MC: 30.9%; OC: 17%	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation	Helen Syn	1)2023 Member Health Rewards processed as of 9/30/2023: A1C Test: Processed 785 approved 741 for MC; Processed 165 approved 160 for OC 2) Member, Community and Provider Engagement Live Call Campaign: OC members due for HBD 3) PR Report May 2023 HbA1C <8 Total (HBD): MC: 35.04% OC: 48.03% HbA1c>9 Total (Poor Control) (HBD): MC: 59.00% OC: 44.77%	1) Continue to track A1c member health reward. 2) Member, Community and Provider Engagement IVR: Q4 2023 Live Call Campaign for OC Medication Adherence population for HBD poor control measure Digital Ad: Q4 Print Ad: Q4 Radio Ad: Q4 Social Media (Paid): Q4 Television Ad: Development of Script Social Media (Passive): Q4	
Quality of Clinical Care	MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs	Meet and exceed MPL for DHCS MCAS Corrective Action	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.	Quarterly Status update on modules as they are completed.	Helen Syn	Well-Child Visits in the First 30 Months (W30-2+) PDSA 1) Cycle 3 intervention period: 7/31/23 - 11/30/23. Cycle 3 intervention will include in-house telephonic call campaign and a birthday card mailer. The in-house telephonic call campaign started on September 25, 2023.	Well-Child Visits in the First 30 Months (W30-2+) PDSA 1) Evaluation of Cycle 3 Intervention for period: 7/31/23 - 11/30/23.	
Quality of Clinical Care	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 **MY2023** Goal CIS-Combo 10: 49.76% IMA-Combo 2: 48.42% W30-First 15 Months: 55.72% W30-15 to 30 Months: 69.84% WCV (Total): 57.44%	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. Examples: EPSDT DHCS promotional campaign; Back-to-School Immunization Clinics with Community Relations; expansion of Bright steps comprehensive maternal health program through 1 year postpartum to include infant health, well-child visits, and immunization education and support 3) Early Identification and Data Gap Bridging Remediation for early intervention.	1) 3Q2023 2) Per quality initiatives calendar - ongoing updates 3) End of Q22023	Helen Syn	1) Pediatric Telephonic Call Campaign, phase 1 (6/27-7/27), phase 2 (7/28-8/10), phase 3 (8/11-9/20), phase 4 is in progress as of 9/25/23. 2) Hosted CCN Lunch and Learn Pediatric Quality Measures Meeting to educate offices on new MCAS measures, 9/28/23. 3) W30 text message campaign 9/5/23 to 13,949 unique phone numbers. 4) W30 Member Detail Report is now available to health networks via sFTP. Started with June 2023 PR (July posting). 5) In alignment with the detail report, sent W30 opportunities report with potential to imapct rate to Health Networks, 9/13/23 6) Mom and Baby W30 Chase Logic successfully implemented and reflected in August 2023 PR. Impacts W30-First 15 Months Measure* 7) August 2023 Prospective Rates (noCE): CIS-Combo 10: 28.58%, performing lower than last year (30.37%), have not met MPL (34.79%); IMA-Combo 2: 41.31%, performing lower than last year (43.68%), met MPL (35.04%); W30-First 15 Months: 38.51%*, performing higher than last year (30.85%), have not met MPL (55.72%); W30-15 to 30 Months: 64.72%, performing lower than last year (66.75%), have not met MPL (65.83%); WCV (Total): 28.87%, performing lower than last year (30.43%), have not met MPL (48.93%).	1) Continue targeted member engagement and outreach campaigns. A) Evaluate pediatric telephonic call campaign (June-October 2023). 2) Continue with Strategic Quality Initiatives Intervention Plan. A) Launch WCV text message campaign for year-end push, 2) Build out Pediatric/Adolescent text campaign with new vendor. 3) W30 Member Detail Report. A) Update report to include ICD10/CPT codes for each respective DOS. B) CCN Provider Portal solution to share gap report.	
Quality of Clinical Care	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2023 Goal: MC 77.48% OC (Medicaid only)	1) Identify members through internal data reports in need of diabetes screening test. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) 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.	1. 2Q2023 2. 3Q2023 3. 2Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q3 (Aug): M/C:63.28% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report. 2) Conducted telephonic outreach to prescribing providers, then sent 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). 3) Barriers included: Receiving timely data, obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. Other difficulties we have come to know is that some members with this diagnosis do not see their PCP regularly. 4) In process of developing new outreach strategies working with internal depts (Case Management) to help out to members. 5) Text Messaging approved by DHCS.	1) 4rd Quarter Report will be pulled in October. 2) Continue tracking members in need of diabetes screening test. 3) Continue outreach to prescibing providers. 4) Data Analyst pull data for text messaging. 5) PHM to schedule a meeting with vendor for Text Messaging Campaign.	
Quality of Clinical Care	Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot	1) Lower HbA1c to avoid complications (baseline: A1c ≥ 8%; varies by individual); 2) Improve member and provider satisfaction	<u>Final Pilot Program Design:</u> 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement <u>Planned Activities:</u> Finalize member stratification Outreach to high volume PCPs Launch the pilot program	Finalize member stratification - end of Jan 2023 Outreach to high volume PCPs - end of Q1 Launch the pilot program - end of Q1	Joanne Ku	On August 7, 2023, Medical Management leadership decided to sunset this project as we have not had the needed commitment from our provider partners to continue this effort.		

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Quality of Clinical Care	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	MY2023 Goals: MC: 30-days: 21.24%; 7-days: 8.93%	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q3 (August): 30 day- 20.79%, 7 Day Total- 10.83% 1) The main barrier has been not having the bandwith to outreach to members that we have been receiving on a daily basis. 2) Leadership is working on identifying a solution in collaboration with ITS and the Health Network relations to establish a secure method to share ED data with Health Networks. a) Several meetings have occured between Health Network relations, ITSand BHI leadership. b) sFTP folders have been established, ITS is in the process of testing and validating data.	1) Working with CalOptima Health Vendor to receive applicable Real-Time ED data on a daily basis. 2) Currently in the process of creating methods of disseminating data via sFTP with Health Networks on a daily basis. 3) Ticket has been submitted to ITS for assistance with establishing protocols to send and receive data through CalOptima Health sFTP site. 4) BHI is in the process of developing a Pilot project for CCN members identified who meet FUA criteria. 5) Explore with ITS options for notification of ED admits to assign PCP. 6) Data Analyst pull data for text messaging. 7) PHM to schedule a meeting with vendor for Text Messaging Campaign.	
Quality of Clinical Care	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2023 Goal: MC - Init Phase - 42.77% MC -Cont Phase - 51.78%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on provider responsibilities on related to follow-up visits. 3) Continue member outreach (through multiple modalities telephonic, newsletter, mobile device) to improve appointment follow up adherence.	1. 2Q2023 2. 4Q2023 3. 3Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q3 (August): Initiation Phase- 48.15%, Continuation and Maintenance Phase- 52.04% 1) Continued member telephonic outreach for members that filled initial ADHD Rx. 2) In process of developing new outreach strategies for members regarding medication compliance. 3) Text messaging approved by DHCS	1) Continue member outreach for those who filled an initial ADHD prescription. 2) Meeting scheduled with Case Management to develop strategy to outreach members. 3) Data Analyst pull data for text messaging. 4) PHM to schedule a meeting with vendor for Text Messaging Campaign	
Quality of Clinical Care	Reporting of Communicable Diseases	Improve provider reporting of communicable disease	1) Educate provider on the requirements and process to report communicable disease	1. 2Q2023 2. 4Q2023 3. 3Q2023	Marsha Choo	Policy GG. 1630 was updated as of 9/7/23 and the updated policy was shared with the HNs as part of the regular poliyc communication process. QI staff is currently working to develop a provider communication to educate the providers on this requirement.	The developed provider communication to educate provider of this requirement will be sent out in the next quarter.	
Quality of Service	Increase primary care utilization	Increase rates of Initial Health Appointments for new members, annual wellness visits for all members.	1) Increased Health Network/Provider education and oversight 2) Enhanced member outreach (IVR, digital engagement)	1) 1Q2023 2) 2Q2023	Katie Balderas	1) Presented at QIHEC, CCN Virtual Learning Session and at 7 JOMs. Piloted the chart review process for IHA completion with one clinic. Provided updated IHA content for Provider Annual/Onboarding Training for implementation. Updated logic on IHA Reports CC0163 and CC0163B to ensure only qualified PCP types are given IHA credit, or specialists assigned to SPD members as PCP. 2) Developed and submitted PHM Key Performance Indicators to DHCS. Prototyped a dashboard to analyze by race/ethnicity, langauge, age, and other factors. Developed interactive text message campaign for unengaged members (members that haven't engaged with PCP in prior 9 months), currently with DHCS for approval.	1) Finalize chart review process and transition from pilot to regular implementation. Update IHA Reference Guide on website. Send quarterly communication to providers/health networks on relevant IHA updates. Validating new data logic and communicating logic changes to Health Networks and stakeholders. 2) Launch interactive campaign for unengaged members and develop regular process for monitoring outcomes. ITS to develop dashboard for PHM KPIs in 2024 (pending capacity from Jiva implementation.).	
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS to meet goal	1) Issue an RFI to obtain information on CAHPS improvement vendors and strategies, contract and launch program 2) Member outreach to all OneCare members 3) Track measures for monitoring individual provider performance (ie. number of grievances, number of CAPs issued) and take action based on committee action	by end of 3Q, 2023	Mike Wilson	Started working with Rex Wallace Consulting and Decision Point in an effort to improve the CAHPS results. Currently creating content and planning interventions/campaigns to happen potentially in Q4 and definitely in Q1 2024.	Continue building strategies and campaigns for deployment throughout 2024	

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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
Quality of Service	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan	1) by end of 4Q2023	Linda Lee	Member experience improvement teams have developed mid and long term interventions based on best practices. Conducted development meetings with USHUR for member engagement strategies for Q4 and just in time CAHPS outreach campaigns	Prioritize and implement USHUR campaigns for high priority campaigns.	
Quality of Service	Provider Data Improvement	Improve Provider Data in Facets	1) Develop and implement a process to utilize Lexis Nexis data correct provider data errors 3)Establish process for ongoing review and maintenance of data	by end of 4Q, 2023	Debra Gonzalez	1)The PDMS is reviewing and working the Lexis Nexis report monthly. We receive the report around the 5th monthly. The report is worked by contracted and non-contracted, and errors identified. 2) Non-contracted providers with no claim's history for the past 24 months are sent to ITS to deactivate in Facets. Contracted providers, PDMS works directly with Provider Relations/HN to obtain updated information.	Continue review of monthly report which include the following categories: 1- Inactive Practitioners 2- Opt out Practitioners 3- Bad Phone 4- Inactive Address 5- Inactive Other 6-Fed Board Action Practitioner	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Reduce OON requests by 25%	1) LOA project to outreach and recruit providers that are currently receiving letters of agreements.	by end of 4Q, 2023	Adriana Ramos	CalOptima Health has aggressively outreached and attempted to recruit providers with indentifed LOA and/or claim submissions as noncontracted. During outreach attempts and visits, providers do not want to pursue contract for multiple reasons, citing unable to open panel, already at capacity, and take on LOA's to assist members and/or unique cases.	Continue building strategies and campaigns for deployment throughout 2024	
Quality of Service	Improve Timely Access: Appointment Availability	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	1) Provider incentive to meet timely access standards 2) Provider incentive for extending office hours	by end of 2Q, 2023	Mike Wilson	There have been no talks of incentives for providers around access.	We are continuing to address appointment availability and timely access, but nothing in regard to incentives.	
Quality of Service	Provider Data Improvement	Improve HN Provider data	1) Develop and implement process for auditing HN Directory data to meet SB 137 requirements 2) Create score cards for HN directory data accuracy 3) Establish process for auditing provider directory attestations	by end of 4Q, 2023	Silvia Peralta	1. Currently working with Health Networks and collecting Provider Directory Universe files. Once all universe files have been received; Audit team will be working with Analytics manager and merging all data and maping discrepancies to meet SB137 requirements. 2. Score card will be applied to each Health Network based on findings by middle of Dec. 3. Audit team communicated to designated CCN/HN of the selected provider list that will be distributed by e-mail for Attestation to be submitted back to CalOptima Health by end of 4th Quarter.	1. Q3 Provider Directory Validation in progress (Findings shall be available end of 4th Quarter) 2. The results will include score card 3. Attestation will be collected at end of 4th Quarter Dec/Jan	
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Submit SNC to DHCS 2) Develop a process for remediating and Capping efforts 3) Communicate results and remediation process to HN 4) Monitor for improvement	by end of 4Q, 2023	Quynh Nguyen/Mike Wilson	•Director of Provider Ops presented CAPs process to leadership on 8/30/2023. •On September 13th and 14th, Health Network Certification Results were sent via email to networks, except KP. Email included HNs network adequacy results: Timely Access, Network Adequacy Scorecard, and SNC Results Letter. •Early October, it was confirmed CalOptima Health will not be sending KP individual Health Network results since they are teminating eff 12/31/2023, and therefore a CAP is not required if they are found non-compliant.	Review HNs Plan of Actions upon submission and determine next steps.	
Safety of Clinical Care	Transitional Care Services (TCS)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving successful interactions for TCS high-risk members within 7 days of their discharge.	<u>Planned Activities:</u> 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Setting up the workgroup - end of 1Q 2023 Updating the UTC letter - end of 2Q 2023	Stacie Oakley Hannah Kim Scott Robinson	Worked w/ ITS to modify the Post D/C Assessment report. It is done and live. Finalized the PCP D/C Notice.	Submit the PCP D/C notice through CAR (communications approval request) and work with Medical Management System Program Manager to configure the letter in GuidingCare. CM to continue outreaching to TCS high-risk members (started July 1, 2023).	
Safety of Clinical Care	Emergency Department Diversion Pilot	Pilot has been implemented. In 2023 plan to expand the program to additional hospital partners.	1. Promoting communication and member access across all CalOptima Networks 2. Increase CalAIM Community Supports Referrals 3. Increase PCP follow-up visit within 30 days of an ED visit 4. Decrease inappropriate ED Utilization	by end of 4Q, 2023	Scott Robinson	None to report	In process of establishing a virtual TEAM channel with St. Joseph's Hospital and UCI MC emergency departments. CalOptima Health ITS has reviewed and confirmed security clearance. Currently working with both hospital ITS departments to clear security.	

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Program Oversight	2023 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Quality Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIHEC-BOD; QI Work Plan-QIHEC-QAC	Annual Adoption by April 2023	Marsha Choo	Approved: QIHEC 2/14/2023, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2022 Quality Improvement Program Evaluation	Complete Evaluation 2022 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by January 2023	Marsha Choo	Approved: QIHEC 2/15/2022, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2023 Utilization Management and Case Management Program	Obtain Board Approval of 2023 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Approved: UMC Committee via eVote on 4/7/2023, QIHEC 4/11/2023, BOD 8/3/2023		
Program Oversight	2022 Utilization Management Program Evaluation	Complete Evaluation of 2022 UM Program	UM Program will be evaluated for effectiveness on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Approved: UMC Committee via eVote on 4/7/2023, QIHEC 4/11/2023, BOD 8/3/2023		
Program Oversight	Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Cultural and Linguistic Services Program and Cultural and Linguistic Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by April 2023	Carlos Soto	Approved: QIHEC 4/11/2023		
Program Oversight	Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	Hit one major milestone with the first ever submission of our PHM Strategy to DHCS. As part of the PHM Strategy, the PHM team worked with stakeholders from across the organization to identify gaps and opportunities to better serve the CalOptima Health population. Partnered with the Orange County Health Care Agency (OCHCA) to identify mutual priorities within their Community Health Assessment and Community Health Improvement Plan process to develop shared goals and SMART objectives that will be part of our 2024 PHM Strategy. Obtained approval from the Quality Improvement Health Equity Committee (QIHEC) to form a new PHM committee that will report up to the QIHEC and provide oversight and guidance on the PHM Strategy implementation	1) Implementation of PHM Strategy 2) Continue collaboration with the OCHCA to support development of goals and objectives for the CHIP and continue refining SMART objectives for the PHM Strategy 3) Commence the PHM Committee in Q1 2024	
Program Oversight	**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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Laura Guest	I. FSR/MRR/PARS, NF and CBAS II. Credentialing: CCN Initial Credentialing=64; CCN Recredentialing=98; BH Initial Credentialing=26; BH Recredentialing=33 III. A. PQI - In Q4 176 PQIs were opened, which has remained steady from Q2-Q4, and 121 were closed, which is a drop from Q1 and Q2. Six cases were presented at CPRC. 57% of the cases were categorized as Medical Care; 67% of those were Mismanaged care. 11% of the cases were leveled as 1, 2 or 3. 98% (improvement over Q3) of DG were reviewed in 30 days. At the end of Q4, 437 cases were in queue, a sharp rise from 343 at the end of Q1. 37% (drop from Q3) of PQIs were reviewed in 90 days. The number of QOC grievances reviewed in Q4 was 600, which was a 2%-17% increase over previous quarters. We interviewed for 1 new RN and 1 PS. We have been in involved with testing and training for a new system, Jiva for the QOC grievances, which will be implemented in Q1. B. PPCs - There were no PPCs identified through claims review in Q4.	**I. FSR/MRR/PARS, NF and CBAS** **A. FSR:** Initial FSRs=11 Initial MRRs=2 Periodic FSRs=30 Periodic MRRs=35 On-Site Interims=12 Failed FSRs=1 Failed MRRs=9 CAPs**:** CE=27 FSR=33 MRR=38 **B. PARS:** Completed PARS=78 BASIC Access=27 LIMITED Access=51 **C: CBAS:** Critical Incidents=5. All Critical Incidents reported were COVID cases. Non-Critical Incidents=14 Falls=9 Completed Audits=14 CAPs=10 Unannounced Visits=1 **NF**: No Critical Incidents were reported in Q4. Completed Audits=0 Unannounced Visits=0 **II. Credentialing:** Continue to credentialing and recredentialing of CCN and BH providers. Have engaged with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialling and recredentialing files. We have also hired temporary positions to assist in the high volume of initial credentialing providers. Additional training by Symplr (Cactus Provider Mgmt Platform), for the credentialing staff occured in the 4th Qtr of 2023. **III. A. PQI** - Continue to monitor the volume and TAT of PQIs, DC and QOC Grievances. Hire and train new staff. Contine to test and train team on Jiva for QOC grievances and prepare for the implementation of the PQI module. **B. PPCs** - Continue to review claims for PPCs and report them to the DHCS.	
Program Oversight	**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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Tyronda Moses	Meeting occurred on November 14, 2023 - Committee Approved Q2 GARS Committee minutes and reviewed Q3 trends by LOB. Trends and Remediation for Medi-Cal: Medi-Cal Grievances increased from 1.57 (Q2) to 1.77 (Q3) average rate per 1000/member months Atributing Factor: (NMT Transportation Q2 302 to Q3 612, MTM changed the Veyo members to align with the MTM system/platform on August 1, 2023 - significant hold times in the month of August,Calls answered by a national call center vs. a dedicated call center for CalOptima Health - this lead to incorrect benefits being quoted/services denied **Remediation, which continues:** - Benefits training by MTM for their staff on the rich CalOptima Health transportation benefits - Additional staff hired by MTM to answer calls - Frequent meetings as needed but no less than weekly - Effective April 2024, ModivCare will be the new servicing vendor for CalOptima Health transportation Trends and Remediation for OneCare: OneCare Grievances decreased from 19.06 (Q2) to 14.66 (Q3) aveage rate per 1000/member months Atributing Factors: (Decrease in Member Billing complaints Q2 112 to Q3 22, Decrease in Member Access complaints Q2 201 to Q3 65,Trending member dis-satisfaction, NMT Transportation,Provider Attitude) **Remediation, which continues:** - Benefits training on MTM for their staff on the rich CalOptima Health transportation benefits - Frequent meetings as needed but no less than weekly - Effective April 2024, MoivCare will be the new servicing vendor for CalOptima Health transportation - Provider and Health Network education and reminders on access standards - Provider and Health Network notification and/or request for training on any issues identified or perceived by our members	GARS to continue to monitor and report as appropriate. Next GARS Committee meeting scheduled for February 8	

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Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2023 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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Marsha Choo	In Q4, MemX Committee repurposed the ad-hoc meeting date of 10/30/2023 and met on 11/28/23 following its' quarterly cadence. Agenda items reviewed and discussed at November meeting are as follows: •Predictive Analytics RFP •Fast Facts Scorecard for Customer Service, Claims, GARS •CAHPS -Medi-Cal Plan/HN and MC HN Corrective Action -OneCare HN -Improve CAHPS •Member Experience Improvement Prgram -CY2024 OneCare Stars -Corrective Action Plan update •Increase Primary Care Utilization •Network Adequacy -Regulatory Updates -Reduce gaps in network and OON requests -Data analysis and reporting -Network Adequacy Workgroup •Timely Access -Regulatory updates -Timely Access SUrvey- Data Collection -Timely Access Workgroup	Met goal and continue to meet in 2024	
Program Oversight	**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.	1Q23 update (4/11 QIHEC) 2Q23 update (7/11 QIHEC) 3Q23 update (10/10 QIHEC) 4Q23 update (Jan 2024 QIHEC)	Stacie Oakley	UMC met 11/16/23 and is on track to meet quarterly. Meeting minutes are available for review. Quarterly metrics for UM, pharmacy, BHI, and LTSS are updated and presented. The BMSC meeting minutes from 8/30/23 and 9/20/23 were presented and approved.	An Ad Hoc UMC is scheduled for 1/25/24 and the next regular quarterly meeting is scheduled for 2/22/24	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.		1) Meet quarterly to provide clinical and behavioral service advice regarding Whole Child Model operations **2023 Meeting Schedules** WCM CAC Q1: February 21, 2023 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (4/11 6/13QIHEC) 2Q23 update (7/11 6/13 QIHEC) 3Q23 update (9/12 QIHEC) 4Q23 update (Jan 2024 12/12 QIHEC)	T.T. Nguyen, MD/H.Kim	WCM Met 11/7/2023. They presented and discussed the following: •Update by DCMO on redetermination efforts •Shared flyer with information regarding Medi-Cal Dental covered services •Care Coordination membership data and risk levels. •ECM and respite service for the CalAim program •WCM age-out process improvement efforts on hold and further discussion in Q1 2024 •WCM DHCS Assessment Report - Process improvement in pediatric risk stratification showed an increase in identified Hight Risk members •Transplant Program status update on continued efforts to obtain contracts with more hospitals. •Network Adequacy - All networks met the network adequacy requirement for WCM. •Utilization Management -- Admits and days PTMPY increased slightly, and all TAT goals were met. •Grievance and Appeals Resolution Services data - There were no significant changes for overall grievance and appeals in Q2 over Q1 however Behavioral Health grievances were trending lower. •Whole Child Model Member Inquiries - 7 of the 10 top categories remained the same. General questions received regarding the Medi-Cal Program more for WCM members than non WCM members; Questions regarding change of network were received by more non WCM members than WCM members. Inbound calls increased for behavioral health customer service since the pandemic but no trends have been identified •Pediatric Quality Measures -Well-Child Visits in the First 30 Months of Life: First 15 Months (W30) overall WCM rates are lower than the overall rates by about five points. All the other metrics for WCM surpasses the non WCM population. •Behavioral Health Quality Measures/Utilization - Increase in BHT excluding Kaiser members. Will monitor to see if this is a result of the effects from the pandemic. No significant changes on the number of members receiving ABA services. •Update - Student Behavioral Health Incentive Program, Pediatric California Advancing & Innovating Medi-Cal, and Pharmacy. •DHCS and CalOptima Health Policies affecting Whole Child Model - New release.	WCM CAC members requested consideration to include UM data for entire plan/MCP. CalOptima Health will discuss internally for data retrieval approach. The next meeting is scheduled for 2/20/24.	
Program Oversight	Pediatric Risk Stratification Process (PRSP) monitoring		Discuss annually the Pediatric Risk Stratification algorithm with the CCS program	Aug-23	Hannah Kim	Reviewed with QIHEC and no input/updates provided.	Review annually in 2024.	
Program Oversight	Managed Care Accountability Set (MCAS)	Achieve 50th percentile on all MCAS measures for MY2022	Share results to Quality Improvement Committee annually	end of 3Q 2023	Paul Jiang	Results presented.	Review annually in 2024.	
Program Oversight	Health Network Quality Rating	Achieve 4 or above	Will share HN performance on all P4V HEDIS Measures via prospective rates report each month	end of 4Q 2023	Sandeep Mital	The Pay for Value (P4V) team generates a Prospective Rate (PR) report each month for all participating health networks and CalOptima Health to allow health networks monitor their progress on clinical HEDIS measures in the P4V program. Performance on each measure is compared to the overall CalOptima Health performance, as well as to the National Medicaid HEDIS benchmarks established by NCQA.	The overall health network quality rating (HNQR) is the weighted average of the network's HEDIS and CAHPS measure ratings, as well as accreditation bonus points and is calculated on a scale of 1-5 (5 being the highest). The final HNQR for MY2022 for the Medi-Cal line of business for all participating health networks was presented at the QIHEC Committee meeting on September 12, 2023.	
Program Oversight	CalAIM	Improve Health & Access to care for enrolled members	1) Launch ECM Academy; a pilot program to bring on new ECM providers. 2) Increase CalOptima Health's capacity to provide community supports through continued expansion of provider network. 3) Continue to increase utilization of benefits. 4) Establish oversight strategy for the CalAIM program. 5) Implement Street Medicine Program 6) Select and fund HHIP projects through Notice of Funding Opportunity. 7) Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	1) 1Q 2023 2) 4Q 2023 3) 4Q 2023 4) 3Q 2023 5) 1Q, 2Q 2023 6) 1Q 2023 7) 3Q 2023	Mia Arias	1. ECM Academy has graduated 40 proividers. 2. The CalAIM provider network has grown to 77 providers. 3. The utilization of benefits has continued to grow and is now reaching levels of 44,000 members served. 4. Now that a CalAIM Medical Director has been onboarded; this oversight strategy will be developed. 5. Street Medicine has been operating in Garden Grove since April 2023; it will expand to Costa Mesa and Anaheim in the coming months. 6. HHIP Round 2 proposals were selected and approved in October 2023; $52.3 million was committed to 15 proposals to develop permanent housing. 7. HCAP will be re-launched as of January 1, 2024.	Work on these efforts will continue as described.	

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Program Oversight	Health Equity	Increase member screening and access to resources that support the social determinants of health	1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	1) 4Q 2023 2) 4Q 2023 3) 3Q 2023	Katie Balderas	1) Activities reported in Q3 carried on during Q4. SDOH questions finalized are being programmed into JIVA. Pending DHCS approval on the SDOH screening question added to the Health Information Form/Member Evaluation Tool (HIF-MET). ITS continued development of the SDOH screening in member portal using CMS Accountable Communities for Health questions. 2) Received and review closed-loop referrals RFPs 3) As of the end of this quarter, 159 CalOptima Health Staff from 22 departments enrolled in the Health Literacy for Equity program with 42 successfully completing the certificate program.	1) SDOH screening questions will launch with Jiva implementation in January 2024. Pending DHCS approval of SDOH questions added to the HIF-MET tool. Continue development of the SDOH Screening in the member portal 2) Continue RFP process and bring recommendation to CalOptima Health for approval of a closed-loop referral vendor 3) Continue to encourage staff to complete the Health Literacy for Equity certificate.	
Program Oversight	Improvement Projects Medi-Cal PIP(BH)	Meet and exceed goals set forth on all improvement projects	Non-Clinical PIP - FUM/FUA 1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	Improve the percentage of members enrolled into care management, complex care management (CCM), or enhanced care management (ECM), within 14-days of a Emergency Dept visit where the member was diagnosed with SMH/SUD. 1) Submitted BH Non-Clinical PIP to DHCS 9/29/23, awaiting feedback. 2) Feedback from DHCS recieved-Technical assistance was provided by DHCS. 3) Re-submitted PIP on 11/29/2023. 4) Received final 2023–24 PIP validation findings on 01/04/24 and no further action is required.	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis for CCN and COD members. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. BHI will conduct the outreach and provide information about case managment including ECM and referrals. 3) Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CCN members identified who meet FUM/FUA criteria. 4) Working with internal depts to identify baseline data for CM, CCM, and ECM enrollment.	
Program Oversight	Improvement Projects OneCare 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 for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	end of 2Q2023	Helen Syn	Live Call: CM and Dm Medication Adherence Call Campaign and due for other measures (HBD, EED, SPD, KED) Statin Mailer (SPD) Medication Adherence Text Campaign (SPD) IVR Campaign (HBD/SPD) Baseline Data: PR Report Nov 2023 HbA1C <8 Total (HBD): MC: 40.41% OC: 52.79% HbA1c>9 Total (Poor Control) (HBD): MC: 53.40% OC: 40.56% Eye Exam for Patients with Diabetes (EED): MC: 48.68% OC: 64.84% Kidney Health Evaluation for Patients with Diabetes (KED): MC: 42.38% OC: 53.07% Statin Use in Persons with Diabetes (SUPD) OC only: 82.87% 3)VSP Eye Exam Reminder Letters: MC Total sent in Q4 2023: 4521, OC Total sent in Q4 2023: 1199 5) Member Incentive: A1C Test: Processed 1556 approved 1498 for MC; Processed 337 approved 329 for OC EED: Processed 1341 approved 1243 for MC; Processed 309 and approved 291 for OC	1) Track submitted diabetes member incentive forms 2) Chronic Disease Management Group: Initiate Emerging Risk Diabetes Cohort. 3) Diabetes Live Call Outreach campaign 4) Continue VSP Eye Exam Reminder Letters 5) Continue multimodal member engagement and outreach campaigns.	
Program Oversight	Improvement Projects Medi-Cal PIP	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP - Health Disparity remediation for W30 6+ measure (Jan Pending January Module Training January 2023 projected. Please note that the focus for the Clinical and Non-Clinical PIP topics is related to DHCS' "50 by 2025: Bold Goals Initiatives"- See links for more information on the Bold Goals Initiatives: https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/Equity-and-Practice-Transformation-Grants-May-Revise.pdf or https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf	Quarterly Status update on modules as they are completed.	Helen Syn	1) CalOptima received final validation findings for PIP and was approved by HSAG	Next Steps - Working to identify staffing resources to support PIP intervention. Expecting to launch call campaign in Feb 2024	
Program Oversight	OneCare Performance measures	Achieve 4 or above	1) Implement Star Improvement Program 2) Track measures monthly 3) Implement OC Pay4Value	1. 1Q2023 2. 2Q2023 3. 3Q2023	Linda Lee	2024 Part C improved to 3.0 stars from 2.5 in the prior year. 2024 Part D and overall star rating remained at 3.5 an 3.0 stars, respectively.	Identified Star measures for focused interventions for remainder of CY. Initiatives underway.	
Program Oversight	Plan Performance Monitoring and Evaluation (PPME): HRA and ICP	Retired: 3.2 ICP completion 90 days Benchmark 90% adjusted. 2.1 Initial HRA collected in 90 days from eligibility Benchmark: 95% adjusted. NEW: Successful transition to revised Oversight process.	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring.	1Q23 (5/9 QIHEC) 2Q23 (8/8 QIHEC) 3Q23 (11/14 QIHEC) 4Q23 (February 2024 QIHEC)	S. Hickman/M. Dankmyer/H. Kim	1)Met 2023 Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance: December file used to provide feedback to Health Networks. 2) Met 2023 Develop communication process with Networks for tracking outreach and completion to meet benchmarks: December MOC tracking file analysis with feedback sent to Health Networks. 3) Met 2023Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring: This has been implemented and is ongoing with each Health Network reviewed on quarterly basis. 4) Met 2023 Initial HRA collection in 90 days from eligibility benchmark 95% adjusted for Core 2.1 reporting. Revision were submitted to DHCS for Q1, Q2, and Q3 as follows: Q1: Members unwilling to participate 10% (93) Members unable to be reached 26% (252) Members who completed assessment 64%(605) Members reached, willing and completed assessment 100% Q2: Members unwilling to participate 5% (45) Members unable to be reached 18% (159) Members who completed assessment 77%(675) Members reached, willing and completed assessment 100% Q3: Members unwilling to participate 3% (28) Members unable to be reached 18% (149) Members who completed assessment 78% (637) Members reached, willing and completed assessment 100% 5)Not Met 2023."Benchmark (90%) not met for 3.2 ICP completion 90 days in Q1-3. Root causes relate to mass transition of OCC to OC members 1/1/2023; and, DHCS revision of technical specifications on 11/17/2023 retroactive to 1/1/2023." Initial ICP collection in 90 days from eligibility for Core 3.2 which has been removed from QI Workplan: Reporting revised Q1/2/3 rates with DHCS resubmission: Q1 Members unwilling to participate 10% (99) Members unable to be reached 14% (133) Members who completed assessment 43%(406) Members reached, willing and completed care plan 56% Q2 Members unwilling to participate 9% (82) Members unable to be reached 20% (178) Members who completed assessment 54% (571) Members reached, willing and completed care plan 76%% Q3 Members unwilling to participate 15% (124) Members unable to be reached 23% (185) Members who completed assessment 371 (46%) Members reached, willing and completed care plan 73%	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance: Will require remediation with JIVA. 2) Continue with monthly communication to Networks for tracking ICP outreach and completion to meet benchmarks and establish MOC Tracking file error validation response process. 3) Ongoing quarterly audit of Health Networks using Oversight audit tool. Creation of tracking tool for score summary month by month. 4) Initial HRA collection in 90 days from eligibility benchmark 95% adjusted for Core 2.1 reporting.	

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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
Program Oversight	NCQA Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and **NCQA Health Equity Accreditation by no later than January 1, 2026.**	1) Continue to Work with Business owners to collect all required documents for upcoming HP re-accreditation.(Must collect all Year one required documents by 2Q2023. 2) Comple Gap Analysis for Health Equity Accreditation.	1) end of 1Q2023 2) end of 2Q2023	Veronica Gomez	A. Health Plan Accreditation 1. 95% of Year-One documents (4/30/2022-4/30/2023) have been collected. 2. 80% of Year-two documents (4/30/2023- 4/30/2024) have been collected. Staff completing final reviews and revisions to documents before submitting for final review by consultant. B. Health Equity Accreditation 1. Consultant completed a review of all the applicable standards. 2. Developed a work plan. 3. Several working sessions have taken place to meet with owners and identify gaps in meeting specific elements. 4. Consultant does not anticipate any difficulty in meeting the June 2025 target date for completing Health Equity accreditation.	The collection and completion of deliverables for both Health Plan and Health Equity accreditation will continue until the submission date. CalOptima's Health NCQA Consultant has developed a detailed work plan that outlines all the gaps, recommended actions and dates for actions that need to be completed for Health Equity Accreditation. The consultant will set up recurring meetings with CalOptima Health staff to go over the work plan and monitor the completion of tasks. The recurring meetings will also be used to answer questions for staff and go over their documents in a working session.	
Program Oversight	Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	1 Implement SBHIP DHCS targeted interventions 2. bi-quarterly reporting to DHCS	1) 4Q2023 2) 4Q2023	Diane Ramos/ Natalie Zavala/Carmen Katsarov	1) Completed and submitted 4 Biquarterly Reports, sent to RAC 12/28 prior to the DHCS due date of 12/31/23. 2) Conducted Bi-weekly meetings with OCDE to identify and prioritize SBHIP activities to be discussed during the monthly OCDE SBHIP collaborative meeting. 3) Received and reviewed the quarterly progress reports from SBHIP partners CHOC, WYS, OCDE, and Hazel Health. 4) Received the DHCS statewide multi-payer school-linked fee schedule; forwarded to internally impacted departments. 5) Credentialing completed for Hazel Health leading to the completion and execution of the Hazel Health and CalOptima Health provider service contract effective Jan 2024. WYS will not be able to proceed with a contract until they are Medi-Cal enrolled. 6) Received funding in Oct from DHCS for the June 2023 biquarterly submission.	1) Gather 1st quarter 2024 SBHIP partners implementation status on the services they are building/designing via SBHIP funding - OCDE, WYS, CHOC, and Hazel Health. 2) Identify and track partner deliverables stemming from the monthly OCDE and SBHIP Partner meetings. 3) Prepare workflow for school districts to become COH contracted providers, including assistance from IT, contracting, claims, and provider relations. 4) Continue to support OCDE reviewing school districts' budget plans for their SBHIP funds.	
Quality of Clinical Care	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	1) Assess community infrastructure capacity for cancer screening and treatment 2) Establish the Comprehensive Cancer Screening and Support Program Stakeholder Collaborative (in our Case I want to leverage OC3) 3) Develop comprehensive outreach campaign to outreach to members due for cancer screenings (mobile mammography, outbound calls, community health workers) 4) Integrate new community health worker benefit into cancer outreach and treatment services.	1) 1Q2023 2) 2Q2023 2) 3Q2023 3) 4Q2023	Katie Balderas	1) Community infrastructure and capacity for cancer screening and treatment was accomplished in Q3, information from assessments was used to develop a funding opportunity to address barriers and opportunities 2) This activity was accomplished early in 2023 with a CalOptima Health staff joining the Orange County Cancer Coalition and continuing participating in these meetings to provide updates, share opportunities and develop collaborative partnerships with the 19+ organizations who attend the OC3 meetings. 3) Kick off discovery phase with vendor for development of the Comprehensive Community Cancer Screening Awareness and Education Campaign. Began collaborative meetings with Northgate Market to plan a mobile mammography screening event. 4) No progress on integration of CHW into Cancer Screening Program as of this quarter, but facilitated e-introductions between organizations doing cancer and our CalAIM team leading the CHW benefit rollout.	1) Seek Board approval of funding opportunity to address barriers and opportunities identified during the brainstorming sessions. Release Notice of Funding opportunity and launch a community grant program. 2) Continue to attend OC3 meetings 3) Engage community partners to inform discovery phase for the Comprehensive Community Cancer Screening Awareness and Education Campaign 4) Continue to work with the CalAIM for the integration of CHWs to support members with their cancer screening and treatment journey.	
Quality of Clinical Care	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP) Care Management, Comprehensive Diabetes Care (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	Linda Lee	Based on MY2002 results, prioritize new star measures and lower performing measures including: transitions of care, plan all cause readmissions, and follow up after ED visit for people with multiple high-risk chronic conditions.	Current interventions will continue for remainder of Q4. Identified measures will be carried over and prioritizd for improvement activities in CY2024.	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS MY2023 Goal: MC 30-Day: 54.51%; 7-day: 31.97% OC (Medicaid only)	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q4 (November): 30 day- 35.75%, 7 day- 21.28% 1) The main barrier has been not havng the bandwidth to outreach to members that we have been receiving on a daily basis. 2) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis. 3) BI-weekly Member text messaging campaign. a. 1st wave sent in late November 2023 b. 2nd wave sent in Mid December 2023	1) Pull data for Data Analyst to send out bi-weekly text messages based on real time ED data. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. BHI will conduct the outreach and provide information about case managment including ECM and referrals. 3) Develop 2024 text message campaign schedule	
Quality of Clinical Care	Blood Lead Screening DHCS APL	1) Comply with APL requirements including quarterly reports of members missing blood lead screening 2) Increase Rates of successfully screened members to #% 3) Put process in place ot identify refusal of blood lead consent forms	- PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. - Update Policy GG.1717 to include Health Network Attestation and conduct Health Network/Provider education - Add blood lead screening resources to CalOptima Health website: Comprehensive Health Assessment Forms, CDPH anticipatory guidance handout, - Launch IVR campaign to members with untested children - Member mailing campaign to members - Lead texting campaign for members - Medi-Cal member newsletter article(s)	All activities will be complete by 3Q, 2023	Helen Syn	**1) Quality Interventions** - Quality Committee approval for member health reward for lead testing at 12 and 24 months of age which is in alignment with the clinical recommendations for testing. Member health reward expected to launch in QI 2024. - November 2023: Member IVR campaign launched to target members not compliant with HEDIS. - Campaigns (dates vary): PBS TV Campaign ran November 2023; Social media ad campaign ran October & November 2023; Radio ad campaign ran October & November 2023; Digital ad campaign ran October & November 2023. - November 29, 2023: Participated in HCCN Clinical Quality Champion meeting to provide key clinics with an overview of blood lead testing, current clinic rates and best practices to support increased testing. - October, November, December 2023- (ongoing effort) Health Networks and CCN providers were issued Blood Lead Screening Reports with member detail data of members who have not tested for lead in alignment with clinical guidelines. Reports also proactivley identify the members that will be due for lead testing at 12 and 24 months within 1-3 months of the report issue date. - October 2023 - Notified Health Networks of the availability of CalOptima Health Pediatric Quality Guide which contains a Blood Lead Testing Guide to support clinical best practices for lead testing. **- October - December 2023: Bright Steps completed 6 month (66 members) and 12 month well child follow-ups (5 members) and provided parents/guardians with education and lead testing requirements at 12 months of age.** **2) Community Focused Efforts:** December 2023-Participated in CalOptima Health Bright Steps Program baby shower and provider lead screening education to parents/guardians of child members; Began discussions with Orange County Health Care Agency (OCHCA) to partner and develop joint strategies that support the increase of blood lead testing. **3) November Prospective Rate: 60.66% (non continuous enrollment rate):** This measure is faring slightly higher thatn the same time last year in November 2022 (59.95%). The final rate is still pending and is expected to be higher as this is a hybrid measure. We are projecting that the LSC measure will meet the MY2023 minimum performance level.	Next Steps: - Launch the blood lead screening health reward for lead testing at 12 and 24 months of age. - Continue with various member and public facing campaigns to support education efforts to increase awareness of the importance of lead testing. - Update existing Protect Your Family from Lead Poisoning member education piece to - Continue to develop provider based efforts to increase blood lead testing rates. - Continue to monitor prospective rates for testing rates and high opportunity providers for collaboration. - Continue to work with OCHCA to develop initiatives to support an increase in blood lead testing. - Continue issuing the Blood Lead Performance Report to support identifcation of members not tested for lead in accordance with state requirements.	

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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
Quality of Clinical Care	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2023 Goal: Postpartum: 84.18% Prenatal: 91.89%	1) Track member health reward impact on HEDIS rates for postpartum care measure. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 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) Expand member engagement through direct services such as the Doula benefit and educational classes	1) Annual Evaluation 2) Per quality initiatives calendar - ongoing updates 3) Ongoing updates 4) 4Q2023 5) 3Q2023	Ann Mino/ Helen Syn	**1) Quality Interventions** - Bright Steps Program: 762 PNRs received, 810 assessment completed, 681 unique members served during Q4 2023. - Postpartum Care Incentive: A total of 511 postpartum incentives have been processed through Q4 (cumulative) - October 2023 Pospartum Text Campaign to 219 members that were not compliant with postpartum care that still had time to get the care. - October 2023 Telephone Outreach campaign to 165 members that were not compliant with postpartum care that still had time to get the care. - December 2023: Bright Steps Program baby shower. Total of 450 attendees. Provided information on timely postpartum visits, postpartum care health reward. - Campaigns (dates vary): Social media ad campaign ran October for prenatal care and ran November and December 2023 for postpatum care. - New PBS TV ad for prenatal care in production and preparing for launch in 2024. - November 29, 2023: Participated in HCCN Clinical Quality Champion meeting to provide clinics with an overview of prenatal and postpartum care including best practices and current rates per clinic. - Doula Services: CCN has contracted with 2 doulas and an additional 11 LOAs have been approved for doula services to support the PPC measure. **2) Community Focused Efforts:** Began discussions with Orange County Health Care Agency (OCHCA) to partner and develop joint strategies that support maternal mental health. **3) November Prospective Rates:** Timeliness of Prenatal Care: 46.15% and is performing lower than this same time last year in November 2022. Postpartum Care: 63.74% and is performing higher that this same time last year in November 2022.	Next Steps: - Continue with various member and public facing campaigns to support education efforts on prenatal and postpartum care - Continue to monitor prospective rates - Continue to work with OCHCA to develop initiatives to support comprehensive maternal mental health - Strategize delivery data to support targeted member outreach for postpartum care and the identification of early pregnancies. - Work with HNs and HEDIS team to identify root causes of low prenatal rate	
Quality of Clinical Care	COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (18 and over).	1) Communication Strategy of COVID vaccination incentive program through December 31, 2023, end date, focusing on unvaccinated, and updated dosage opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for updated doses.	1) end of 2Q2023 2) end of 3Q2023	Helen Syn	1. Internal communication to member-facing staff of program end date. 2. Texting campaign to address eligibility guidelines and end date of the program - goal met. 3. Reached 70% vaccination rate for CalOptima members (18 and older).	COVID-19 VIP processing continues - official end date of the program is 12/31/2023.	
Quality of Clinical Care	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	HEDIS MY2023 Goals: Blood Glucose-All Ages:54.36% Cholesterol-All Ages: 36.17% Glucose and Cholesterol Combined-All Ages: 34.30%	1) Communication Strategy of COVID vaccination incentive program through December 31, 2023, end date, focusing on unvaccinated, and updated dosage opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for updated doses.	2Q2023 update(7/11)	Diane Ramos/ Natalie Zavala	PR HEDIS RATES Q4 : Blood Glucose all ages: 53.61%, Cholesterol all ages: 35.32%, Glucose & Cholesterol Combined all ages: 34.13% 1) Barriers included: Receiving timely data and accurate information. 2) Identified members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report. 3) The following materials have been disseminated to Providers: a) Provider Best Practices Letter. b) APM Provider Tip Sheet. 4) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 6) Text Messaging Campaign was sent out to members in the month of December.	1) Develop 2024 text message campaign schedule. 2) Pull data for Data Analyst to send out monthly text messages. 3) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits.	
Quality of Clinical Care	Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	MY 2023 Goals: CCS: MC 62.53% BCS: MC 61.27% OC 70% COL: OC 71%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	1) Quarterly Updates 2) Per Quality Initiatives Calendar - ongoing updates	Helen Syn	1) 2023 Member Health Rewards processed as of 1/22/2023: CCS: Processed 1564 approved 1412 for MC; BCS: Procesed 1538 approved 1383 for MC Processed 282 approved 264 for OC; COL: Processed 196 approved 154 for OC 2) Member, Community and Provider Engagement Mailing: CCS Texting: BCS, CCS (women Screening) Live Call Campaign for OC Medication Adherence Cohort: OC members due for BCS and COL Digital Ad: BCS Print Ad: BCS Radio: CCS Social Media (Paid): BCS, CCS Social Media (Passive); BCS Community Update: BCS 3) 2023 November Prospective Rates (PR): Cervical Cancer Screening MC: 52.24% Breast Cancer Screening MC: 54.29% OC: 63.23% Colorectal Cancer Screening OC: 60.28%	1) Continue to track member health reward impact on HEDIS rates for cancer screening measures. New Colorectal Cancer Screening Reward added for Medi-Cal LOB. 2) Continue multimodal member engagement and outreach campaigns. 3) Addition of provider and health network engagement and collaborative efforts. 4) Development of new text message campaigns for cancer screening with new Vendor.	
Quality of Clinical Care	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)	MY2023 HEDIS Goals:: MC 63.75% OC: 79%;	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures 3) VSP Collaborative gaps in care bridging efforts.	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation 3) End of Q2 2023	Helen Syn	1) 2023 Member Health Rewards processed as of 1/22/23: EED: Processed 1341 approved 1243 for MC; Processed 139 and approved 126 for OC 2) Member, Community and Provider Engagement Live Call Campaign: OC Medication Adherence population for EED Digital Ad Print Ad Radio Ad Social Media (Paid) Television Ad: Diabetes PBS ad video in review 3)VSP Eye Exam Reminder Letters: MC Total sent in Q4 2023: xx, OC Total sent in Q4 2023: xx 4)PR Report Nov 2023 Eye Exam for Patients with Diabetes (EED): 48.68 MC: % OC: 64.84%	1) Continue to track member health reward impact on HEDIS rates for EED. 2) Continue multimodal member engagement and outreach campaigns. 3) Initiate Emerging Risk Diabetes Cohort. 4) Addition of provider and health network engagement and collaborative efforts. 5) Development of new text message campaigns for cancer screening with new Vendor.	

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Quality of Clinical Care	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2023** Goals: MC: 30.9%; OC: 17%	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation	Helen Syn	1)2023 Member Health Rewards processed as of 1/22/2024: A1C Test: Processed 1556 approved 1498 for MC; Processed 337 approved 329 for OC 2) Member, Community and Provider Engagement IVR Live Call Campaign for OC medication Adherence population for HBD poor control measure Digit Ad Print Ad Radio Ad Social Media (Paid) Television Ad: Diabetes PBS ad video in review Live Call Campaign: OC members due for HBD 3) PR Report Nov 2023 HbA1C Poor Control Total (HBD) MC: 53.4% OC: 40.56%	1) Continue to track member health reward impact on HEDIS rates for HBD. 2) Continue multimodal member engagement and outreach campaigns. 3) Initiate Emerging Risk Diabetes Cohort. 4) Addition of provider and health network engagement and collaborative efforts. 5) Development of new text message campaigns for cancer screening with new Vendor.	
Quality of Clinical Care	MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs	Meet and exceed MPL for DHCS MCAS Corrective Action	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.	Quarterly Status update on modules as they are completed.	Helen Syn	Well-Child Visits in the First 30 Months (W30-2+) PDSA Cycle 3: 7/31/23 – 11/30/23. Intervention included an in-house telephonic call campaign and a birthday card mailer. SMART Aim Goal: By October 31, 2023, successfully outreach to 45% of members who completed PDSA Cycle 2 (n=104) and who meet outreach criteria. Intervention Implementation Period: 09/25/23 – 10/26/23. Telephonic call campaign completed by 1 staff member, in-house. Results: 54.55% confirmed they attended their scheduled WCV. 46.94% confirmed they scheduled their child's next WCV. Outreach success rate of 50.96% to confirm Cycle 2 outcomes. The SMART Aim Goal of successfully met.	W30-2+ PDSA was approved on 1/21/2024. The findings concluded members who had 2 successful telephonic outreaches is impactful. Will plan to continue with telephonic outreach calls in the future.	
Quality of Clinical Care	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 **MY2023** Goal CIS-Combo 10: 49.76% IMA-Combo 2: 48.42% W30-First 15 Months: 55.72% W30-15 to 30 Months: 69.84% WCV (Total): 57.44%	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. Examples: EPSDT DHCS promotional campaign; Back-to-School Immunization Clinics with Community Relations; expansion of Bright steps comprehensive maternal health program through 1 year postparum to include infant health, well-child visits, and immunization education and support 3) Early Identification and Data Gap Bridging Remediation for early intervention.	1) 3Q2023 2) Per quality initiatives calendar - ongoing updates 3) End of Q22023	Helen Syn	1)Pediatric telephonic call campaigns. Phase 4: 9/25 – 11/1, outreached to 722 members. 2)1st and 2nd Birthday Card Mailing in October, November and December to 5,262 members. 3)W30 Member Detail Report continues to be available to health networks in alignment with PR data. 4)WCV 3-17 Years Text Campaign 10/6/23 to 67,891 members. 5)WCV 3-17 Years IVR Campaign 11/6/23 to 33,823 members. 6)November 2023 Prospective Rate (noCE): CIS-Combo 10: 28.95%, performing lower than last year (30.93%), have not met MPL, did not meet goal 49.76% pending medical record review*; IMA-Combo 2: 42.52%, performing lower than last year (44.90%), met MPL, have not met goal 48.42%. There has been an uptick in vaccine hesitancy in 2023. W30-First 15 Months: 41.96%, performing higher than last year (35.91%), has not met MPL, has not met goal (55.72%); W30-15 to 30 Months: 65.66%, performing lower than last year (68.37%), has not met MPL, has not met goal (69.84%); WCV-Total: 41.36%, performing lower than last year (42.34%), has not met MPL, has not met goal (57.44%). Well care visits continue to be a challenege.	1) Continue targeted member engagement and outreach campaigns. Leverage new avenues to reach members and providers. 2) Continue providing W30 Member Detail Report to health networks as aligned with Prospective Rates Report. 3) Build out new age-based, growth and development milestones text message campaign for pediatric and adolescent group.	
Quality of Clinical Care	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2023 Goal: MC 77.48% OC (Medicaid only)	1) Identify members through internal data reports in need of diabetes screening test. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) 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.	1. 2Q2023 2. 3Q2023 3. 2Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q4 (Nov): M/C:70.75% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report. 2) Conducted telephonic outreach to prescribing providers, then sent 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). 3) Barriers included: Receiving timely data, obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. Other difficulties we have come to know is that some members with this diagnosis do not see their PCP regularly. 4) In process of developing new outreach strategies working with internal depts (Case Management) to help reach out to members. 5) Text messaging outreach capaign sent out in December.	1) 1st Quarter Report will be pulled in April 2024 2) Continue tracking members in need of diabetes screening test. 3) Continue outreach to prescibing providers. 4) Data Analyst pull data for text messaging. 5) Text Messaging Campaign will continue on a monthly basis. 6) Use provider portal to communicate follow-up best practice and guidelines for Diabetes screening. 7) Develop 2024 text message campaign schedule	
Quality of Clinical Care	Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot	1) Lower HbA1c to avoid complications (baseline: A1c ≥ 8%; varies by individual); 2) Improve member and provider satisfaction	<u>Final Pilot Program Design:</u> 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement <u>Planned Activities:</u> Finalize member stratification Outreach to high volume PCPs Launch the pilot program	Finalize member stratification - end of Jan 2023 Outreach to high volume PCPs - end of Q1 Launch the pilot program - end of Q1	Joanne Ku	Although the pilot program received interest from one provider, due to the overall lack of provider engagement, CalOptima Health's senior leadership decided that it was in our best interest to sunset this pilot project and re-strategize future efforts.	N/A	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	MY2023 Goals: MC: 30-days: 21.24%; 7-days: 8.93%	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q4 (November): 30 day- 20.53%, 7 day- 10.79% 1) The main barrier has been not havng the bandwidth to outreach to members that we have been receiving on a daily basis. 2) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis. 3) BI-weekly Member text messaging. a. 1st wave sent in late November 2023 b. 2nd wave sent in Mid December 2023	1) Pull data for Data Analyst to send out bi-weekly text messages based on real time ED data. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. BHI will conduct the outreach and provide informatio 3) Develop 2024 text message campaign schedule	

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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
Quality of Clinical Care	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2023 Goal: MC - Init Phase - 42.77% MC -Cont Phase - 51.78%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on provider responsibilities on related to follow-up visits. 3) Continue member outreach (through multiple modalities telephonic, newsletter, mobile device) to improve appointment follow up adherence.	1. 2Q2023 2. 4Q2023 3. 3Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q3 (November): Initiation Phase- 48.15%, Continuation and Maintenance Phase- 53.66% 1) In process of developing new outreach strategies for members regarding medication compliance. 2) Continued member telephonic outreach for members that filled ADHD Rx. 3) Text messaging outreach campaign sent in December.	1) Pull monthly data for data analyst to scrub for text messaging. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Member Health Reward Incentives. 4) Develop 2024 text message campaign schedule	
Quality of Clinical Care	Reporting of Communicable Diseases	Improve provider reporting of communicable disease	1) Educate provider on the requirements and process to report communicable disease	1. 2Q2023 2. 4Q2023 3. 3Q2023	Marsha Choo	A Communication was developed explaining the responsibility for contracted Providers to report any suspected case(s) of any diseases or conditions listed on the California Department of Public Health (CDPH) website to the local health officer. The address, phone, and fax number was provided to the local Orange County Local Health Department. The communication was sent over to the Communications Department and provided in the January Provider Newsletter .	Work with our communciations department to set up a standing article for regular provider education on this topic.	
Quality of Service	Increase primary care utilization	Increase rates of Initial Health Appointments for new members, annual wellness visits for all members.	1) Increased Health Network/Provider education and oversight 2) Enhanced member outreach (IVR, digital engagement)	1) 1Q2023 2) 2Q2023	Katie Balderas	Activities presented in Q3 were accomplished as follows: 1a. Chart review process was transitioned from pilot to regular implementation. 1b. IHA Reference Guide was updated on the provider website page. 1c. Quarterly communications were sent to providers/health networks on relevant IHA updates. 1d. New data logic was validated. The Health Networks and providers/stakeholders were informed of new performance measure expectation. Challenges: The logic change was not shared with the Health Networks or providers/stakeholders as it held no relevance to the current goal. The focus was placed on educating the Health Networks and Providers of the new goal for the IHA completion rate. 2a. IVR were implemented as an interactive campaign for unengaged members. 2b. ITS developed a report on the provider portal that shows new members and the IHA due date. Challenges: In 2a. above, the plan from Q3 was to develop regular process for monitoring outcomes of the interactive campaign for unengaged members. However, this process has not started as the implementation of chart review took up more resources and time. We still plan on reviewing this data and decide on an appropriate intervention in 2024.	1) Track IHA completion rate among Health Networks and share results with the Health Networks, providers and QIHEC quarterly. 2) Monitor outcomes of the interactive campaigns for unengaged members and establish a follow up intervention.	
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS to meet goal	1) Issue an RFI to obtain information on CAHPS improvement vendors and strategies, contract and launch program 2) Member outreach to all OneCare members 3) Track measures for monitoring individual provider performance (ie. number of grievances, number of CAPs issued) and take action based on committee action	by end of 3Q, 2023	Mike Wilson	1) Contract was signed with Ushur/Decision Point. Implementation in process.	1) Met goal - initial call campaigns either have begun or will begin early Q1 2024, mailers are in final stages of approval before being sent to identified membership	
Quality of Service	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan	1) by end of 4Q2023	Linda Lee	2023 CAHPS scores remain largely unchanged compared to prior year results. One rate, Rating of Health Care Quality, improved significantly from one to three stars. Other member experience measures demonstrating improvement include: members choosing to leave the plan, timely decisions about appeals, reviewing appeals decisions, and call center foreign language interpreter and TTY availability.	Current interventions will continue for remainder of Q4. Identified measures will be carried over and prioritizd for improvement activities in CY2024.	
Quality of Service	Provider Data Improvement	Improve Provider Data in Facets	1) Develop and implement a process to utilize Lexis Nexis data correct provider data errors 3)Establish process for ongoing review and maintenance of data	by end of 4Q, 2023	Debra Gonzalez	Goals were not met. Resources needed to work with the vendor to understand the data output and develop a process for utilizing the data.	Meetings with Lexis Nexis to understand data specs. Pend until resources are availlable.	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Reduce OON requests by 25%	1) LOA project to outreach and recruit providers that are currently receiving letters of agreements.	by end of 4Q, 2023	Adriana Ramos	Met - Developed and implemented process for Letters of Interest Packets Met - Established application process for all provider types, streamline and expediting application through credentialing and contracting of new providers	Continue with plan and monitoring internvetntions being developed to address the letter of interest process.	
Quality of Service	Improve Timely Access: Appointment Availability	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	1) Provider incentive to meet timely access standards 2) Provider incentive for extending office hours	by end of 2Q, 2023	Mike Wilson	Timely access was still an area with many opportunities for improvement with our provider community. The most recent data (collected in Fall 2022) was shared with providers and health networks in Q4. This is still an area of emphasis and a point that is being addressed in multiple ways with our external partners.	Provided scripting to assist offices with scheduling, education for providers and health networks around the timely access standards, increased monitoring to have better access to real-time data	
Quality of Service	Provider Data Improvement	Improve HN Provider data	1) Develop and implement process for auditing HN Directory data to meet SB 137 requirements 2) Create score cards for HN directory data accuracy 3) Establish process for auditing provider directory attestations	by end of 4Q, 2023	Silvia Peralta	Met - Developed and implemented process for auditing HN Directory data to meet SB 137 requirements Met - Created score cards for HN directory data accuracy Met - Established process for auditing provider directory attestations	Plan will continue to be as listed.	
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Submit SNC to DHCS 2) Develop a process for remediating and Capping efforts 3) Communicate results and remediation process to HN 4) Monitor for improvement	by end of 4Q, 2023	Quynh Nguyen/Mike Wilson	SNC was submitted on time in Q4 and Health Networks were sent CAPs for non-compliance related to SNC. Work is ongoing to improve all areas of non-compliance including network adequacy and timely access.	Continue with plan with additional interventions being developed to address deficiencies.	

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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
Safety of Clinical Care	Transitional Care Services (TCS)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving successful interactions for TCS high-risk members within 7 days of their discharge.	Planned Activities: 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Setting up the workgroup - end of 1Q 2023 Updating the UTC letter - end of 2Q 2023	Stacie Oakley Hannah Kim Scott Robinson	1) Initiated audits on completion of outreach for members in need of TCS for High Risk Members. 2) Automation of validation process for Health Network monthly TCS files used for oversight and DHCS reporting. 3) Discussed TCS during Hospital Info Series 12/14/2023 with providers. 4) UM-working on enhanced PCP discharge notice	1) Use of Usher platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting. 5) Revision of Goals and Activities for 2024 TCS	
Safety of Clinical Care	Emergency Department Diversion Pilot	Pilot has been implemented. In 2023 plan to expand the program to additional hospital partners.	1. Promoting communication and member access across all CalOptima Networks 2. Increase CalAIM Community Supports Referrals 3. Increase PCP follow-up visit within 30 days of an ED visit 4. Decrease inappropriate ED Utilization	by end of 4Q, 2023	Scott Robinson	The UCI ED pilot was not started due to the inability to create a secure teams channel and execute a data useage agreement. Ther are currently no metrics to report.	Continue to work with the ITS, legal and contracting. The goal is to implement this program in Q1 2024.	

~~2023~~2024

QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

EFFECTIVE DATE: JANUARY 1, 2024 TO DECEMBER 31, 2024

~~2023~~ 2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

SIGNATURE PAGE

Quality Improvement and Health Equity Committee Chairpersons:

_____ _____

Richard Pitts, D.O., Ph.D. **Date**
CalOptima Health Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. **Date**

Board of Directors Chairperson:

_____ _____

Clayton M. Corwin **Date**

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ABBREVIATIONS

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Event
	ADA	Americans With Disabilities Act of 1990
	ADHD	Attention Deficit Hyperactivity Disorder
	APL	All Plan Letter
	AUD	Alcohol Use Disorder
B		
	BHI	Behavioral Health Integration
	BHT	Behavioral Health Treatment
	BHIIP	Behavioral Health Integration Incentive Program
	BMSC	Benefit Management Subcommittee
C		
	CalAIM	California Advancing and Innovating Medi-Cal
	CAHPS	Consumer Assessment of Healthcare Providers and Systems survey
	CAP	Corrective Action Plan
	CBAS	Community-Based Adult Services centers
	CCN	CalOptima Health Community Network
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COPD	Chronic Obstructive Pulmonary Disease
	COO	Chief Operating Officer
	COS	Chief of Staff
	COD-A	CalOptima Health Direct-Administrative
	CPRC	Credentialing and Peer Review Committee
	CQS	Comprehensive Quality Strategy
	CR	Credentialing
D		
	DC	Doctor of Chiropractic Medicine
	DCMO	Deputy Chief Medical Officer
	DDS	Doctor of Dental Surgery
	DHCS	California Department of Health Care Services
	DMHC	California Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ED-PHM	Executive Director, Population Health Management
	ED-BH	Executive Director, Behavioral Health Integration
	BH	Behavioral Health
	ED-CO	Executive Director, Clinical Operations
	ED-MP	Executive Director, Medicare Programs
	ED-NO	Executive Director, Network Operations

	ED O	Executive Director, Operations
	ED Q	Executive Director, Quality
F		
	FDR	First Tier, Downstream and Related Entities
	FSR	Facility Site Review
G		
	GARS	Grievance and Appeals Resolution Services
H		
	HEDIS	Healthcare Effectiveness Data and Information Set
	HIPAA	Health Insurance Portability and Accountability Act
	HMO	Health Maintenance Organization
	HN	Health Network
	HNA	Health Needs Assessment
	HOS	Health Outcomes Survey
	HRA	Health Risk Assessment
I		
	ICT	Interdisciplinary Care Team
	ICP	Individualized Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long-Term Care
	LTSS	Long-Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	Medical Doctor
	ME	Member Experience
	MED	Medicaid Module
	MEMX	Member Experience Committee
	MOC	Model of Care
	MOU	Memorandum of Understanding
	MRR	Medical Record Review
	MRSA	Methicillin resistant Staphylococcus aureus
	MSSP	Multipurpose Senior Services Program
	MY	Measurement Year
	NCQA	National Committee for Quality Assurance
	NET	Network
	NF	Nursing Facilities
O		
	OC	Orange County
	OCC	OneCare Connect
	OCHCA or HCA	Orange Country Health Care Agency
	OP	Organizational Providers
	OC SSA or SSA	County of Orange Social Services Agency
Q		
	QAC	Quality Assurance Committee
	QI	Quality Improvement
	QIHE	Quality Improvement Health Equity
	QICQIHEC	Quality Improvement Committee
	QIP	Quality Improvement Project
P		
	P4V	Pay for Value
	P&T	Pharmacy & Therapeutics Committee

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	PAC	Provider Advisory Committee
	PACE	Program of All-Inclusive Care for the Elderly
	PARS	Physical Accessibility Review Survey
	PBM	Pharmacy Benefit Manager
	PCP	Primary Care Provider
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician/Hospital Consortia
	PIP	Performance Improvement Project
	PPC	Personal Care Coordinator
	PQI	Potential Quality Issue
	PSS	Perinatal Support Services
S		
	SABIRT	Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
	SBHIP	Student Behavioral Health Incentive Program
	SDOH	Social Determinants of Health
	SNP	Special Needs Plan
	SNF	Skilled Nursing Facility
	SPD	Seniors and Persons with Disabilities
	SRG	Shared Risk Group
	SUD	Substance Use Disorder
T		
	TPL	Third Party Liability
U		
	UM	Utilization Management
	UMC	Utilization Management Committee
V		
	VS	Vision Service
	VSP	Vision Service Plan
W		
	WCM	Whole Child Model Program
	WCM CAC	Whole Child Model Clinical Advisory Committee
	WCM FAC	Whole Child Model Family Advisory Committee

CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders, and government agencies to achieve our mission and vision while upholding our values.

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~~ same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health (SDOH).

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.



Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2022~~3~~–2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in June 2022. Our core strategy is the "inter-agency" co-creation of services and programs, together with our delegated networks, providers and community partners, to support the mission and vision.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

CalOptima Health aligns our strategic plan with the priorities of our federal and state regulators.

Centers for Medicare & Medicaid Services (CMS) National Quality Strategy

The CMS national quality strategy aims to set and raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity and accessibility for all individuals, especially for people in historically underserved and under-resourced communities. The strategy focuses on a person-centric approach from birth to end of life as individuals journey across the continuum of care, from home or community-based settings to hospital to post-acute care, and across payer types, including Traditional Medicare, Medicare Advantage, Medicaid, ~~and~~ Children's Health Insurance Program (CHIP) and Marketplace coverage.

Quality Mission: To achieve optimal health and well-being for all individuals.~~All people receive equitable, high-quality and value-based care.~~

Quality Vision: As a trusted partner, shape a resilient, high-value American health care system to achieve high-quality, safe, equitable and accessible care for all.

CMS National Quality Strategy has four4 priority areas, each with ~~2~~two goals~~Goals.:~~

1. Outcomes and Alignment
    a. Outcomes: Improve quality and health outcomes across the care journey.
    b. Alignment: Align and coordinate across programs and settings.
2. Equity and Engagement
    a. Advance health equity and whole-person care.
    b. Engage individuals and communities to become partners in their care.
3. Safety and Resiliency
    a. Safety: Achieve zero preventable harm.
    b. Resiliency: Enable a respons~~e~~ive and resilient health care system to improve quality.
4. Interoperability and Scientific Advancement
    a. Interoperability: Accelerate and support the transition to a digital and data-driven health care system.
    b. Scientific Advancement: Transform health care using science, analytics~~,~~ and technology.

1. ~~Embed Quality into the Care Journey: Incorporate quality as a foundational component to delivering value as a part of the overall care journey. Quality includes ensuring optimal care and best outcomes for individuals of all ages and backgrounds as well as across service delivery systems and settings. Quality also extends across payer types.~~
2. ~~Advance Health Equity: Address the disparities that underlie our health system, both within and across settings, to ensure equitable access and care for all.~~
3. ~~Promote Safety: Prevent harm or death from health care errors.~~
4. ~~Foster Engagement: Increase engagement between individuals and their care teams to improve quality, establish trusting relationships, and bring the voices of people and caregivers to the forefront.~~
5. ~~Strengthen Resilience: Ensure resilience in the health care system to prepare for, and adapt to, future challenges and emergencies.~~
6. ~~Embrace the Digital Age: Ensure timely, secure, seamless communication and care coordination between providers, plans, payers, community organizations and individuals through interoperable, shared and standardized digital data across the care continuum.~~
7. ~~Incentivize Innovation & Technology: Accelerate innovation in care delivery and incorporate technology enhancements (e.g., telehealth, machine learning, advanced analytics, new care advances) to transform the quality of care and advance value.~~
8. ~~Increase Alignment: Develop a coordinated approach to align performance metrics, programs, policy and payment across CMS, federal partners and external stakeholders to improve value. Strive to create a simplified national picture of quality measurement that is comprehensible to individuals, their families, providers and payers.~~

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 CQS lays out DHCS' quality and health equity strategy that leverages a whole-system, person-centered, and population health approach to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and ~~stress~~ emphasize DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

CQS outlines specific clinical goals across the Medi-Cal program. Centered on specific clinical focus areas, the CQS introduces DHCS' Bold Goals: 50x2025 initiative that, in partnership with

stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025.

Bold Goals: 50x2025:

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow-up for mental health and substance disorder by 50%
- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

DHCS recognizes that inequities are embedded within our health care system. DHCS has developed a Health Equity Framework to identify, catalog, and eliminate ~~Health Equity Framework is a depiction of how DHCS intends to approach the elimination of~~ health disparities through:~~. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.~~

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

~~CQS outlines specific clinical goals across the Medi-Cal program. Centered on specific clinical focus areas, the CQS introduces DHCS' Bold Goals: 50x2025 initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025.~~

~~Bold Goals: 50x2025:~~

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- ~~Improve maternal and adolescent depression screening by 50%~~
- ~~Improve follow-up for mental health substance disorder by 50%~~
- ~~Ensure all health plans exceed the 50TH percentile for all children's preventive care measures~~

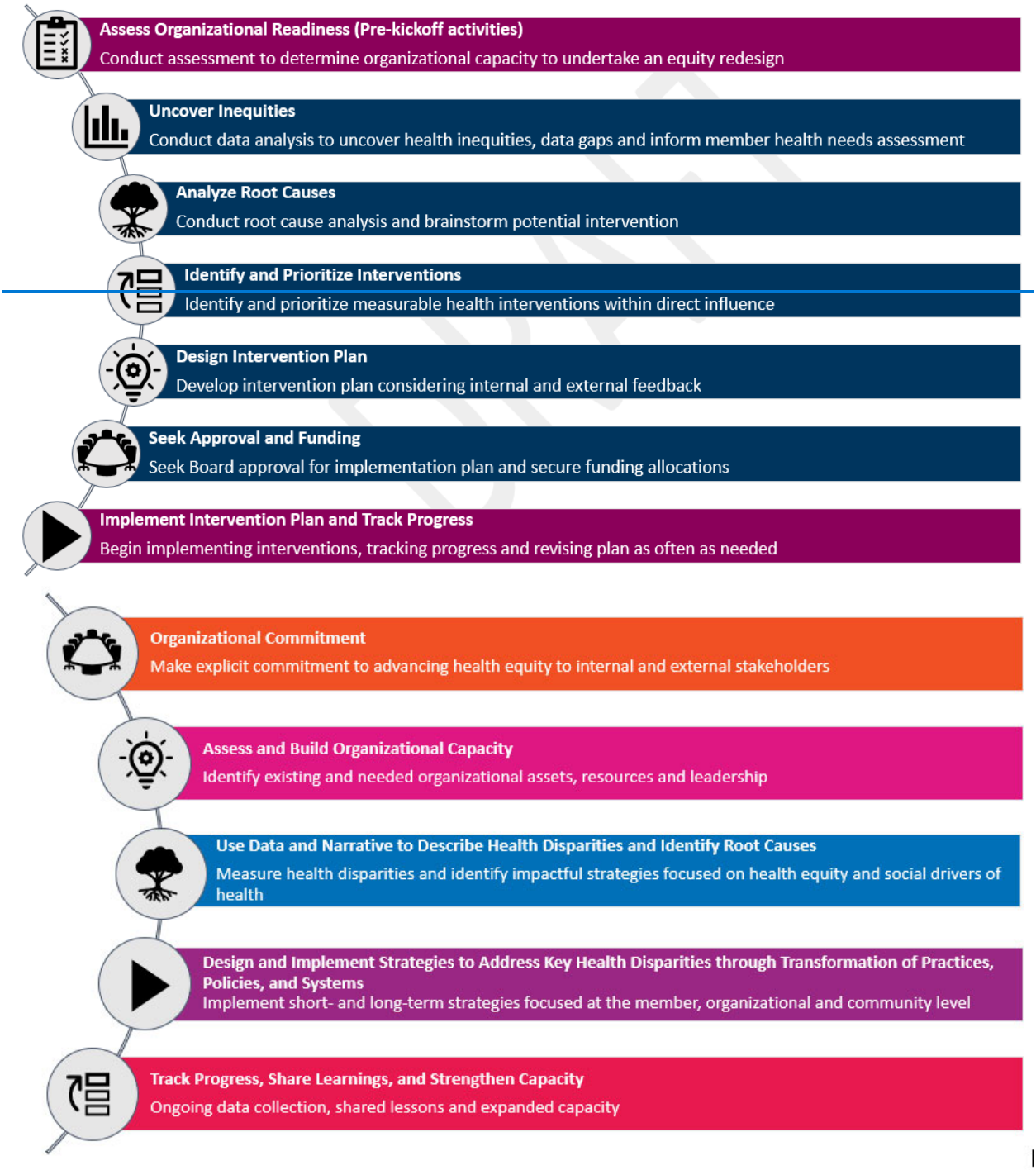
Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

~~Social Determinants of Health (~~SDOH~~)~~ are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptima Health's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive r~~R~~eadiness a~~A~~ssessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain

feedback from internal and external stakeholders and include their input in the intervention and design process.



~~Comprehensive Community Cancer Screening and Support Program~~

~~CalOptima Health strives to be the health care exemplar for all Orange County residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon and lung cancer in certain smokers. In other words:~~

- With rare exception, no one should die from breast cancer
- With rare exception, no one should die from cancer of the cervix
- With rare exception, no one should die from cancer of the colon
- With rare exception, no one should die from lung cancer in certain heavy smokers

CalOptima Health seeks to create a new Orange County health ethos with respect to cancer care by going after these four specific cancers that are relatively easy to detect compared with many more occult cancers. Early detection of these specific cancers has an incredible return on investment. CalOptima Health intends to build this new ethos by leveraging the key cancer centers and community opinion makers to the point where cancer detection for these specific cancers is part of the community's daily discussions. Additionally, having the lowest late-stage cancer detection in the nation will be a source of intense community pride.

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

It will create a culture of cancer prevention, early detection and collaboration with partners toward a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care. The program will use a phased-in approach to invest over the next five years in the following three pillars:

1) Increasing community and member awareness and engagement
2) Increasing access to cancer screening
3) Improving member experience throughout cancer treatment

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Of these cases, 480 are lung cancer, 565 are breast cancer, 120 are cervical cancer and 477 are colorectal cancer. The COVID-19 pandemic has significantly disrupted preventive care and cancer screenings, leading to a decrease in early detection and treatment. Between 2019 and 2021, Medi-Cal Healthcare Effectiveness Data and Information Set (HEDIS) rates decreased by approximately 5% for breast and cervical cancer screenings. Currently, more than one-third of eligible members have not received their cervical, breast or colorectal cancer screenings.

Increasing these cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs. For example, the five-year survival rate for colorectal cancer that has spread is only 15%, compared with a 90% survival rate when detected earlier at a localized stage. Yet every year in Orange County, an average of 1,500 community members are diagnosed with late-stage cancer of the breast, cervix or colon Additionally, trends in late-stage colorectal cancer diagnoses significantly increased over the most recent 10-year period in Orange County, and in 2022, colorectal cancer will likely continue to be the [1]second leading cause of cancer-related deaths following lung cancer[1].

Staff plan to collaborate with the Orange County Cancer Coalition, providers, health networks, and community-based organizations to ensure that funds are utilized equitably to address disparities and build sustained capacity in the cancer screening and treatment community infrastructure.

[1] https://www.science.org/doi/10.1126/science.abd3377

Five-Year Hospital Quality Program

CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play a critical role in the delivery of care to members. For many years, CalOptima Health has been providing quality incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. CalOptima Health has established a Hospital Quality Program for its contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures serve to:

- Support hospital quality standards for Orange County in support of CalOptima Health's mission
- Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts
- Recognize hospitals demonstrating quality performance
- Provide comparative information on CalOptima Health hospital performance
- Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members

The program launches January 1, 2023, and extends through December 31, 2027. It includes two initiatives: Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

This initiative will include the following principles:

1. Leverage publicly available, industry-standard measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Group including:
    a. CMS Quality
    b. CMS Patient Experience
    c. Leapfrog Hospital and Surgery Center Rating
    d. Leapfrog Hospital Safety Grade
2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems-exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
    a. Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare
    b. Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating
    c. Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital
    d. Surgery Center Rating will not qualify for incentive payments
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of a budget for a five-year period from 2023–2027 to fund the hospital incentive pool. The amount that each hospital may earn will be based on their proportion of services provided to CalOptima Health members, i.e., proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Incentive awards will be based on performance compared with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

~~CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments to eligible hospitals.~~

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~~CalOptima Health Program~~ ~~Structure~~Program Structure~~s~~

"Better. Together." Is CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's single largest health insurer, we provide coverage through three major programs:

Medi-Cal

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Health Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that ~~went into effect~~began in 2019.

CalOptima Health provides Enhanced Care Management (ECM) and all 14 Community Supports ~~services~~ to address social drivers of health and assist members with finding stable or safe housing, accessing healthy food, transitioning back to home or getting support in the home. ~~In 2023, we expand our Community Supports services to the 14 options listed below:~~

~~1. Housing transition navigation services~~
~~2. Housing deposits~~
~~3. Housing tenancy and sustaining services~~
~~4. Short-term post-hospitalization housing~~
~~5. Recuperative care (medical respite)~~
~~6. Respite services~~
~~7. Day habilitation programs~~
~~8. Nursing facility transition/diversion to assisted living facilities~~
~~9. Community transition services/nursing facility transition to a home~~
~~10. Personal care and homemaker services~~
~~11. Environmental accessibility adaptations (home modifications)~~
~~12. Medically tailored meals/medically supportive foods~~
~~13. Sobering centers~~
~~14. Asthma remediation~~

Certain services are not covered by CalOptima Health but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (OCHCA)

- Substance use disorder services are administered by OC HCA
- Dental services are provided through the Medi-Cal Dental Program

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs, such as seniors, people with disabilities and people with chronic conditions, CalOptima Health has developed specialized care management (CM) services. These care management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high high-risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including OCHCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

In On July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members. CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS includeincludes both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

These integrated LTSS benefits include three the following programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)
- Hospice Care

CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

- In-Home Supportive Services (IHSS): IHSS provides in-home assistance to eligible aged, blind, and disabled individuals as an alternative to out-of-home care and enables members to remain safely in their own homes.

- Nursing Facility Services for Long-Term Care: CalOptima Health LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B and Subacute levels of care.

CalOptima Health LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

- ~~Home- and~~ Community-Based Adult Services (CBAS): ~~CBAS:~~ CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.~~An outpatient, facility-based program that offers health and social services to seniors and people with disabilities.~~ CalOptima Health LTSS monitors the levels of member access to, utilization of~~,~~ and satisfaction with ~~the program~~CBAS.~~, as well as its role in diverting members from institutionalization.~~

- ~~MSSP~~Multipurpose Senior Services Program (MSSP): Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid ~~the need for~~ institutionalization. CalOptima Health LTSS monitors the level of member access to ~~the program~~MSSP as well as its role in diverting members from institutionalization.

~~Hospice Care:~~

- ~~Hospice Care Program supports terminally ill member with a life expectancy of 6 months or less with services focused mailing on pain and symptom management.~~

OneCare (HMO D-SNP)

Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for them to get the health care they need. Since 2005, CalOptima Health has been offering OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OneCare has extensive experience serving the complex needs of ~~the~~ frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must be age 21 or older, live in Orange County and be eligible for both Medicare and Medi-Cal. Enrollment in OneCare is voluntary and by member choice.

Scope of Services

OneCare provides ~~a~~ comprehensive ~~scope of~~ services for dual eligible members enrolled in Medi-Cal and Medicare Parts A~~, and~~ B~~,~~ and D. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures, including Part C, Part D~~,~~ and CMS Star measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, OneCare members are eligible for ~~enhanced~~ supplemental benefits~~services~~, such as gym memberships.

Program of All-Inclusive Care for the Elderly (PACE)

CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

PACE combines health care and adult day care for people with multiple chronic conditions. These can be offered in the member's home, in the community or at the CalOptima Health PACE Center:

1. Routine medical care, including specialist care
2. Prescribed drugs and lab tests
3. Personal care for things like bathing, dressing and light chores
4. Recreation and social activities
5. Nutritious meals
6. Social services
7. Rides to health-related appointments, and to and from the program
8. Hospital care and emergency services

PACE maintains a separate PACE Quality Improvement Program, work plan~~,~~ and evaluation.

~~OneCare Connect~~

~~On January 1, 2023, CalOptima Health's OneCare Connect plan ended. Members were transitioned to OneCare.~~

~~CalOptima Health~~ Provider Partners

Providers have options for participating in CalOptima Health's programs to provide health care to CalOptima Health members. Providers can contract directly with CalOptima Health through CalOptima Health Direct, which consists of ~~,~~ CalOptima Health Direct-Administrative and~~/or~~ CalOptima Health Community Network (CCN). ~~and/or~~ Providers also have the option to contract directly with a CalOptima Health Health Network (HN). CalOptima Health members can choose CCN or one of ~~12~~ nine HNs representing more than ~~9~~8,0~~4~~00 providers.

CalOptima Health Direct (COD)

CalOptima Health Direct has two elements: CalOptima Health Direct-Administrative and CCN.

- ### CalOptima Health Direct-Administrative (COD-A)

  ~~CalOptima Health Direct-Administrative~~COD-A is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in OneCare), share-of-cost members, newly eligible members transitioning to a HN and members residing outside of Orange County.

- ### CalOptima Health Community Network (CCN)

  CCN doctors have an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to more than 1,23~~5~~00 Primary Care Providers (PCPs), more than 9~~7~~,09~~0~~0 specialists, 43~~4~~0 acute and rehabilitative hospitals, 52~~31~~ community health centers and ~~nearly~~ 106~~4~~0 long-term care facilities.

CalOptima Health contracts with the following HNs:

Health Network	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI Care ~~Health Network~~Medical Group	PHC	PHC-
~~AMVI/Prospect Medical Group~~	-	~~SRG~~
CHOC Health Alliance	PHC	-
Family Choice Medical Group	HMO~~PHC~~	SRG
HPN-Regal Medical Group	HMO	HMO-
~~Kaiser Permanente~~	~~HMO~~	-
Noble Mid-Orange County	SRG	SRG
Optum Care Network ~~- Arta~~	HMO~~SRG~~	HMO~~SRG~~
~~Optum Care Network - Monarch~~	~~HMO~~	~~SRG~~
~~Optum Care Network - Talbert~~	~~SRG~~	~~SRG~~
Prospect Medical Group	HMO	HMO -
United Care Medical Group	SRG	SRG

CalOptima Health contracts with vendors that provide benefits for our members. These vendors are responsible for maintaining a contracted network of providers, coordinating services, and providing direct services. They may also be delegated for plan functions.

~~Delegated~~ Vendor	Medi-Cal	OneCare
Vision Service Plan	VS	VS
MedImpact	-	PBM

HMO=Health Maintenance Organization;
PHC=Physician/Hospital Consortium;
SRG=~~Shared~~ Shared-Risk Group;
VS=Vision Service;
PBM=Pharmacy Benefit Manager

Upon successful completion of readiness reviews and audits, contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex care management
- Claims
- ~~Contracting~~
- Credentialing ~~of practitioners~~
- ~~Customer service~~

Membership Demographics

Membership Data* (as of December 31, 2022)

Total CalOptima Health Membership	Program	Members
944,975	Medi-Cal	927,086
	OneCare Connect	14,385
	OneCare (HMO D-SNP)	3,067
	Program of All-Inclusive Care for the Elderly (PACE)	437

*Based on unaudited financial reports and includes prior period adjustment. Data from prior to the OneCare Connect program end on January 1, 2023.

Membership Data* (as of September 30, 2023)

Total CalOptima Health Membership	Program	Members
979,148	Medi-Cal	960,875
	OneCare (HMO D-SNP)	17,836
	Program of All-Inclusive Care for the Elderly (PACE)	437

*Based on unaudited financial report and includes prior period adjustment

Member Demographics (as of December 31, 2022)

Member Age		Language Preference		Medi-Cal Aid Category	
0 to 5	9%	English	59%	Temporary Assistance for Needy Families	40%
6 to 18	25%	Spanish	27%	Expansion	37%
19 to 44	34%	Vietnamese	9%	Optional Targeted Low-Income Children	8%
45 to 64	20%	Other	2%	Seniors	9%
65 +	12%	Korean	1%	People With Disabilities	5%
		Farsi	1%	Long-Term Care	<1%
		Chinese	<1%	Other	<1%
		Arabic	<1%		

Member Demographics (as of September 30, 2023)

Member Age		Language Preference		Medi-Cal Aid Category	
0 to 5	8%	English	59%	Temporary Assistance for Needy Families	39%
6 to 18	24%	Spanish	27%	Expansion	38%
19 to 44	35%	Vietnamese	9%	Optional Targeted Low-Income Children	8%
45 to 64	20%	Other	2%	Seniors	9%
65 +	13%	Korean	1%	People With Disabilities	5%
		Farsi	1%	Long-Term Care	<1%
		Chinese	<1%	Other	<1%
		Arabic	<1%		

Membership Data* (as of November 30, 2023)

Total CalOptima Health Membership

963,968

Program	Members
Medi-Cal	945,874
OneCare (HMO D-SNP)	17,648
Program of All -Inclusive Care for the Elderly (PACE)	446

*Based on unaudited financial report and includes prior period adjustment

Membership Demographics (as of November 30, 2023)

Member Age		Language Preference		Medi-Cal Aid Category	
0 to 5	8%	English	58%	Temporary Assistance for Needy Families	39%
6 to 18	25%	Spanish	27%	Expansion	37%
19 to 44	34%	Vietnamese	9%	Optional Targeted Low-Income Children	8%
45 to 64	20%	Other	2%	Seniors	10%
65+	13%	Korean	1%	People With Disabilities	5%
		Farsi	1%	Long-Term Care	<1%
		Chinese	<1%	Other	<1%
		Arabic	<1%		

Quality Improvement and Health Equity Transformation Program (QIHETP)

CalOptima Health's Quality Improvement and Health Equity Transformation ~~(QI)~~ Program (QIHETP) encompasses all clinical care, health and wellness services, and quality of service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all ~~our~~ members.

CalOptima Health developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and subacute care to long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, special health care needs and chronic illnesses.

CalOptima Health's ~~Quality Improvement Program~~QIHETP includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

CalOptima Health is committed to promoting diversity in practices throughout the organization, including ~~HR~~ Human Resources best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.



Quality Improvement and Health Equity Transformation Program (QIHETP) Purpose

The purpose of the CalOptima Health ~~QI Program~~QIHETP is to establish objective methods for systematically evaluating and improving the quality of care provided to members. ~~through CalOptima Health CCN and COD-A, as well as our contracted HNs.~~ Through the QIHETP, ~~QI Program~~ and in collaboration with providers and community partners, CalOptima Health strives to continuously improve the structure, processes, and outcomes of the health care delivery system to serve ~~our~~ members. We aim to identify health inequities and to develop structures and processes to reduce disparities, ensuring that all members receive equitable and timely access to care.

CalOptima Health applies the principles of continuous quality improvement (CQI) to all aspects of service delivery system through analysis, evaluation, and systematic enhancements of the following:

- Quantitative and qualitative data collection and data-driven decision-making;
- Up-to-date evidence-based practice guidelines;
- Feedback provided by ~~M~~members and ~~Network P~~providers in the design, planning, and implementation of ~~its~~ CQI activities;
- And other issues identified by CalOptima Health or its regulators.

The CalOptima Health QIHETP ~~QI Program~~ incorporates the ~~continuous QI~~CQI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima Health's multiple customers and stakeholders (members, health care providers, community-based organizations, and government agencies). The ~~QI Program~~QIHETP is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima Health's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on ~~QIQIHE~~ quality improvement and health equity activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe care and experiences.

- Maintain ~~agencywide~~ organization~~-~~wide practices that support health plan and health equity accreditation by National ~~C~~Committee for Quality Assurance (NCQA) and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QIHETP~~QI Program~~'s ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess~~,~~ and improve the quality of the organization's governance, management, delivery system~~,~~ and support processes.

- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services~~,~~ and specialty providers. Recommending delivery system reform to ensure high quality and equitable health care.

- ~~Providing~~ Monitoring ~~oversight of~~ quality of care and services ~~monitors~~ from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

- Ensuring ~~certain~~ contracted facilities, as required by federal and state laws, report to OCHCA outbreaks of conditions and/or diseases, which may include but are not limited to methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, and since 2020, COVID-19.

- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers (OPs) to ~~assure~~ ensure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement and health equity culture at CalOptima Health.

- Ensure the annual review and acceptance of the UM CM Program Description, UM CM Evaluation, ~~and,~~ Population Health Programs, including the Population Health Strategy and Work Plans.

- Provide operational support and oversight to a ~~member~~ member-centric Population Health Management (PHM) Program.

In collaboration with the Compliance Audit & Oversight departments, the QIHETP ~~QI Program~~ ensures the following standards or outcomes are carried out and achieved by CalOptima Health's contracted HNs, including CCN and/or COD network providers serving CalOptima Health's various populations:

- Support the ~~agency's~~ organization's strategic quality and business goals by ~~utilizing~~ using resources appropriately, effectively, and efficiently.
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- Identify in a timely manner the important clinical and service issues facing the Medi-Cal and OneCare populations relevant to their demographics, ~~high~~ risks, disease profiles for both acute and chronic illnesses, and preventive care.
- Ensure continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities.
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- Ensure the reliability of risk prevention and risk management processes.
- Ensure compliance with regulatory agencies and accreditation standards.
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.
- Promote the effectiveness and efficiency of internal operations.
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima Health's strategic direction in support of its mission, vision and values.
- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based ~~medicine~~practice.

~~The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima Health departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.~~

Authority~~, Board of Directors' Committees and Responsibilities~~ and Accountability

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, ~~—~~which oversees the functions of the Quality Improvement and Health Equity~~I~~ Committee (QIHEC) described in CalOptima Health's state and federal contracts, ~~—~~and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QIHETP ~~Program~~ annually.

The QIHETP ~~QI Program~~ is based on ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QIHETP ~~. QI Program. Such recommendations shall be aligned~~in alignment with federal and state regulations, contractual obligations, and fiscal parameters.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI ~~Program~~HETP and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity contractual and regulatory standards ~~in this Contract~~ and the DHCS Comprehensive Quality Strategy. ~~.~~ QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource~~s~~ allocations of the QI ~~Program~~HETP and the Work P~~p~~lan of the QIHETP. ~~aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim:~~

~~**1. Enhancing patient experience**~~

~~2. Improving population health~~
~~3. Reducing per capita cost~~
~~4. Enhancing provider satisfaction~~

Member Advisory Committee

CalOptima Health is committed to ~~Member and/or Family~~ member-focused care through ~~M~~member and ~~C~~community engagement. The Member Advisory Committee (MAC) has ~~15~~ 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operations~~,~~ and evaluation of the overall ~~QI Program~~QIHETP. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- Medi-Cal beneficiaries or Authorized Family Members (~~2~~two seats)
- Member Advocate
- County of Orange Social Services Agency (OC SSA)
- OneCare Member or Authorized Family Members (~~2~~ 4four seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 1~~5~~7 positions, ~~—~~held by OC-SSA, ~~—~~is a standing seat. Each of the remaining 1~~4~~6 appointed members may serve two consecutive three-year terms.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive

term limits, along with a representative of OCHCA, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- OCHCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

- Family representatives (nine~~seven~~ seats)
  - Authorized representatives, which includes parents, foster parents~~,~~ and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
  - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
  - Current CalOptima Health members over the age of 21 who transitioned from CCS services

- Interests of children representatives (two~~four~~ seats)
  - Community-based organizations; or
  - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC quarterly meetings are open to the public.

~~CalOptima Health Officers' Role in the Quality Improvement~~ Health Equity Transformation Program ~~Organizational Structure Program~~

~~**Chief Executive Officer** (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIHEC) satisfies all remaining requirements of the QI Program~~QIHETP~~, as specified in the state and federal contracts.~~

~~**Chief Operating Officer** (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.~~

~~**Chief Medical Officer*** (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI Program~~HETP~~ and supports efforts so that the ~~QIHETP~~ QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI~~QIHE~~ activities to the Board of Directors' Quality Assurance Committee.~~

~~**Chief Compliance Officer** (CCO) is responsible for monitoring and driving interventions so that CalOptima Health and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.~~

~~**Chief Health Equity Officer (CHEO)** The CHEO co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. Provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.~~

~~**Chief Human Resources Officer** (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.~~

~~**Deputy Chief Medical Officer*** (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, Population Health Management, Pharmacy Management, LTSS and other medical management programs.~~

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. The COS is responsible for achieving operational efficiencies to support CalOptima Health's strategic plan, goals and objectives.

Chief Information Officer (CIO) provides oversight of CalOptima Health's enterprise-wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the agency's risk exposure.

Medical Director* (Behavioral Health) is the designated behavioral health care physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC) and CPRC. The Medical Director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Medical Director* (Credentialing and Peer Review) is the designated physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC). The Medical Director is also the chair of the Credentialing and Peer Review Committee (CPRC).

Medical Director* (Population Health and Equity) is the designated physician who will chair the Population Health Management Committee and is responsible for overseeing the Population Health Management (PHM) functions. The Medical Director provides direction and support to the CalOptima Health PHM staff to ensure objectives from the Population Health Management Strategy are met.

Medical Director* (Quality) is the physician designee who chairs the QIHEC and is responsible for overseeing QIQIHETP activities and quality management functions. The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QI ProgramQIHETP objectives are met..

Medical Director* (Whole Child Model) is the physician designee who chairs the Whole Child Model Clinical Advisory Committee and is responsible for overseeing QIHE activities and quality management functions related to Whole Child Model (WCM). The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives related to WCM are met.

Medical Director* (Behavioral Health) is the designated behavioral health care physician in the QI Program who serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC) and CPRC. The Medical Director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and

~~populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Medicare Stars and Quality Initiatives. and Credentialing.~~

~~**Executive Director, Population Health Management** (ED PHM) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.~~

~~**Executive Director, Behavioral Health Integration** (ED BHI) is responsible for oversight of CalOptima Health's Behavioral Health (BH) program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.~~

~~**Executive Director, Medi-Cal and CalAIM** is responsible for the implementation and oversight of CalAIM, a whole-system, person-centered delivery system reform to improve quality and care to members.~~

~~**Executive Director, Clinical Operations** (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Care Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO, DCMO and ED PHM, makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities.~~

~~**Executive Director, Medicare Programs** (ED MP) is responsible for strategic and operational oversight of Medicare programs including OneCare and PACE.~~

~~**Executive Director, Network Operations** (ED NO) leads and directs the integrated operations of the HNs and coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima Health's networks and making sure the delivery of accessible, cost-effective and quality health care services is maintained throughout the service delivery network.~~

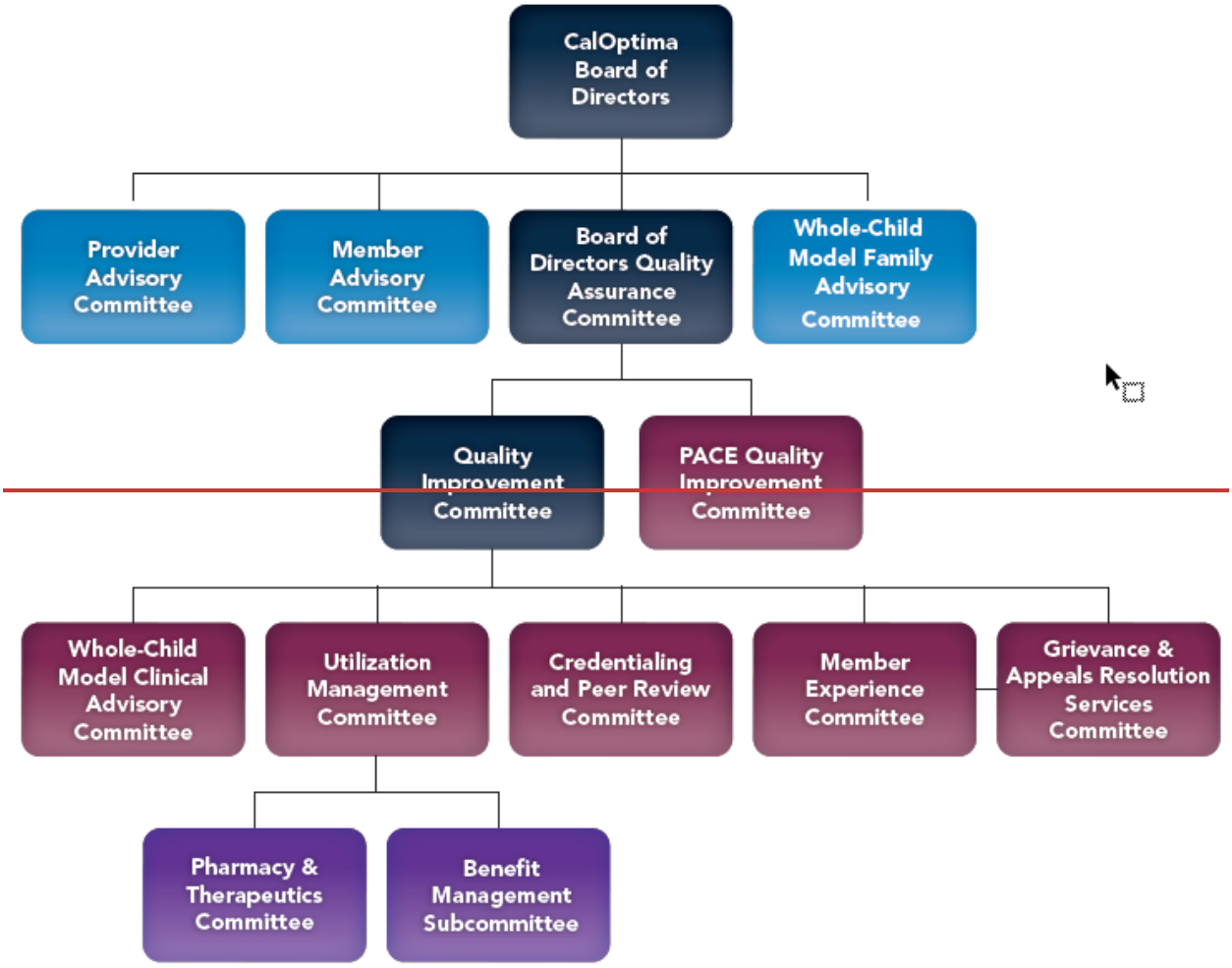
~~**Executive Director, Operations** (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.~~

~~*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox-Keene Act Section 1367.01 (c)I. Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.~~

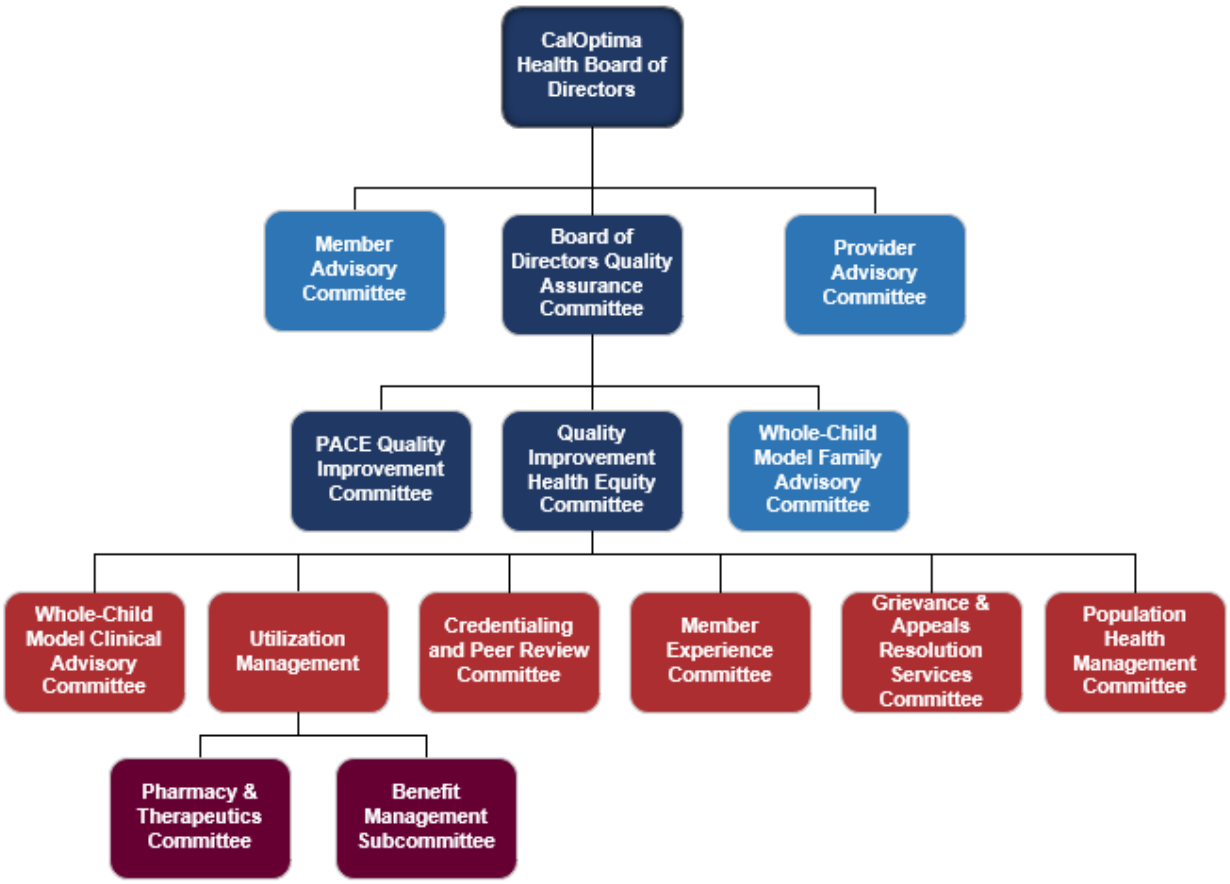
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Quality Improvement and Health Equity Transformation Program Committees Structure

Quality Improvement and Health Equity Transformation Program Committee Organization Structure — Diagram



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~~Quality Improvement Committees and Subcommittees~~

Quality Improvement ~~and~~ Health Equity Committee (~~QIC~~QIHEC)

The ~~QIC~~QIHEC is the foundation of the ~~QI Program~~QIHETP and is accountable to the QAC. The ~~QIC~~QIHEC ~~assists~~ is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee ~~in development and oversight of~~ ~~overseeing, maintaining and supporting~~ the ~~QI Program~~QIHETP and QIHETP ~~Q~~and ~~I~~ Work Plan activities.

The purpose of the ~~QIC~~QIHEC is to assure that all ~~QI~~QIHETP activities are performed, integrated~~,~~ and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the ~~QIC~~QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

The composition of the ~~QIC~~QIHEC includes ~~participating~~ a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, subcontractors, downstream subcontractors, community health workers, other non-clinical providers and members. The QIHEC participants are representative of the composition of the CalOptima Health's ~~Provider Network~~provider network and include, at a minimum, ~~Network Providers~~network providers who provide health care services to ~~M~~members affected by ~~H~~health

~~D~~disparities, Limited English Proficiency (LEP) members, ~~C~~children with ~~S~~special ~~H~~health ~~C~~care ~~N~~needs ~~(CSHCN)~~, Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. QIHEC participants are practitioners who are external to CalOptima Health, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, care review as needed, and identification of opportunities to improve care.

The ~~QIC~~QIHEC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima Health's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to ~~QI~~QIHETP ~~Projects~~projects, activities and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. ~~HEDIS~~ Performance measurement and improvement activities and interventions are reviewed, approved, processed, monitored and reported through the ~~QIC~~QIHEC.

Responsibilities of the ~~QIC~~QIHEC include:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other quality committees
- Recommend~~ing~~ policy decisions and priority alignment of the ~~QI~~QIHETP subcommittees for effective operation and achievement of objectives
- Oversee~~ing~~ the analysis and evaluation of ~~QI~~QIHETP activities
- ~~Makeing certain that there is~~Ensure practitioner participation through attendance and discussion in the planning, design, implementation~~,~~ and review of ~~QI Program~~QIHETP activities
- Identify~~ing, and~~ prioriti~~z~~e and institute~~zing~~ needed actions and interventions to improve quality
- ~~Making certain that there~~Ensure ~~is~~ appropriate follow up of quality ~~acitivities~~activities ~~as necessary~~ to determine the effectiveness of quality improvement-related actions and ~~intervention~~remediation of identified performance deficiencies.
- Monitor~~ing~~ overall quality compliance for the organization to quickly resolve deficiencies that affect members

Evaluate p

- ~~P~~ractice patterns of providers, practitioners and delegated HNs ~~are evaluated~~, ~~such as UM~~including over/under utilization of physical and behavioral health care services~~. in collaboration with Applied Behavior Analysis utilization.~~
- Recommend~~ations are made to promote~~ practices so that all members receive medical and behavioral health care that meets CalOptima Health standards.

The ~~QIC~~QIHEC oversees and coordinates member outcome-related ~~QI~~QIHE actions. Member outcome-related ~~QI~~QIHE actions consist of well-defined, planned ~~QI~~QIHE projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The ~~QIC~~QIHEC also recommends strategies for dissemination of all study results to CalOptima Health-contracted providers and practitioners, and delegated HNs.

The composition of the ~~QIC~~QIHEC is defined in the ~~QIC~~QIHEC charter and includes but is not limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- Orange County Behavioral Health Representative
- ~~CalOptima Health Chief Health Equity Officer (Chair or Designee)~~
- CalOptima Health Chief Medical Officer (Chair or Designee)
- CalOptima Health Chief Health Equity Officer (Chair or Designee)
- ~~CalOptima Health Deputy Chief Medical Officer~~
- ~~CalOptima Health Medical Directors~~
- CalOptima Health Quality Improvement Medical Director
- CalOptima Health Behavioral Health Integration Medical Director ~~(or Designee)~~
- CalOptima Health Medical Directors
- ~~CalOptima Health Executive Director, Quality~~ Improvement
- CalOptima Health Executive Director, Population Health Management
- CalOptima Health Executive Director, Behavioral Health Integration
- CalOptima Health Executive Director, Clinical Operations
- CalOptima Health Executive Director, Network Management
- CalOptima Health Executive Director, Operations

The ~~QIC~~QIHEC is supported by CalOptima Health departments including but not limited to:

- ~~Director,~~ Behavioral Health Integration
- ~~Director,~~ Care Management
- ~~Director,~~ Long-Term Services and Supports
- ~~Director,~~ Population Health Management
- ~~Director~~ Quality Analytics
- ~~Director~~ Quality Improvement
- ~~Director,~~ Utilization Management
- Director, Customer Service
- ~~Manager,~~ Cultural and Linguistic Services

Quorum

A quorum consists of a minimum of six ~~(6)~~ voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person, ~~participation~~ by telephone or ~~participation~~ by video conference.

The ~~QIC~~QIHEC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

~~QIC~~QIHEC and all ~~QI~~QIHE subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of ~~QI~~ HE proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the ~~QIC~~QIHEC and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the ~~QIC~~QIHEC meeting include but are not limited to:

- Goals and objectives outlined in the ~~QIC~~QIHEC charter
- Active discussion and analysis of quality improvement and health equity activities, outcomes, and issues
- ~~Credentialing or re-credentialing issues, as appropriate~~
- Reports from various committees and subcommittees
- Tracking and trending of quality outcomes
- Recommendations for improvement, actions~~,~~ and follow-up actions
- Monitoring of quality improvement and health equity activities of delegates
- Plans to disseminate ~~QI~~QIHE information to network providers ~~and practitioners~~
- Tracking of ~~QI~~ QIHETP Work Plan activities

All agendas, minutes, reports~~,~~ and documents presented to the ~~QIC~~QIHEC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

The ~~QIC~~QIHEC provides to the QAC quarterly written progress reports of the ~~QIC~~QIHEC that describes actions taken, ~~process~~ progress in meeting~~s~~ ~~QI Program~~QIHETP objectives, and improvements made. A written summary of the QIHEC's quarterly activities is also publicly available on the CalOptima Health website.

Under the QIIHETP, there are six ~~(6)~~ subcommittees that report, at minimum, quarterly to the QIHEC.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima Health practitioner and provider selection process and determines corrective actions, as necessary, to ensure that all practitioners and providers who serve CalOptima Health members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima Health practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima Health's

contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and physician representatives from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima Health's network. CPRC meets a minimum of six times per year and reports through the ~~QIC~~QIHEC quarterly. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the ~~optimum~~ optimal utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, BH and LTSS services for CCN and delegated HNs to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other ~~agency~~ organization standards. These clinical practice guidelines and nationally recognized ~~evidenced~~evidence-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the ~~QIC~~QIHEC. The voting member composition (including a ~~behavioral health~~BH practitioner*) and the quorum requirements of the UMC are defined in its charter.

* ~~Behavioral Health~~BH practitioner is defined as Medical Director, clinical director~~,~~ or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost-effective pharmaceutical care for all CalOptima Health members. It reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima Health members. The P&T includes practicing physicians (including both CalOptima Health employee physicians and participating provider physicians), and the membership represents a cross-section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all ~~plan~~ members. The P&T provides written decisions regarding all formulary development decisions and revisions. The P&T meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima Health staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes analyzing regulations and guidance that impacts the benefit sets and CalOptima Health's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima Health WCM program. The WCM CAC works in collaboration with county CCS, the WCM FAC and HN CCS providers. The WCM CAC meets four times a year and reports to the ~~QIC~~QIHEC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima Health. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system. NCQA's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction, and the committee's focus is to improve customer satisfaction. The MEMX committee assesses information and data directly from members, which include the annual results of CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, ~~and~~ member complaints, grievances and appeals. Then MEMX identifies opportunities to implement initiatives to improve our members' overall experience. The Access and Availability Workgroups, which report to the MEMX committee, monitor a member's ability get needed care and get care quickly, by monitoring the provider network, ~~-~~reviewing customer service metrics, and evaluating authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 202~~3~~4, the MEMX committee, which includes the Access and Availability Workgroups, will continue to meet at least quarterly and will be held accountable to meet regulatory requirements related to access and implement targeted initiatives to improve member experience and demonstrate significant improvement in ~~the MY 2022 and MY 2023~~subsequent CAHPS survey results.

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS Committee also serves to provide a mechanism to resolve provider

complaints and appeals expeditiously for all CalOptima Health providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS Committee meets at least quarterly and reports through the ~~QIC~~QIHEC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Population Health Management Committee (PHMC)

The ~~Population Health Management Committee~~PHMC provides overall direction for continuous process improvement and oversight of population health activities, monitors compliance with regulatory requirements, and ensures that population health initiatives meet the needs of CalOptima Health members. The committee ~~will~~ also ensures that all population health initiatives are performed, monitored and communicated according to the PHM Strategy and Work P~~p~~lan. The PHMC is responsible for reviewing, assessing~~,~~ and approving the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Work P~~p~~lan progress and outcomes and recommend evidence-based and/or best practice activities to improve population health outcomes and advance health equity.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima Health employees, —including contracted professionals who have access to confidential or member information, —sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

All records and proceedings of the QIHEC ~~Committee~~ and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code ~~section~~ Section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QIHEC ~~Committee~~ and the subcommittees sign a confidentiality agreement. This agreement requires ~~the~~ committee members to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any ~~QI~~QIHE reports required by law or by the state contract.

Conflict of Interest

CalOptima Health maintains a ~~Conflict of Interest~~Conflict-of-Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima Health information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers or members, except when it is determined that the financial interest does not

create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QIHE/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.
~~Quality Improvement Health Equity Strategic Priority Areas and Goals~~

20243 Quality Improvement and Health EquityI ~~Goals and Objectives~~Priority Areas and Goals

CalOptima Health's QIHEI Priority Areas and Goals ~~and Objectives~~ are aligned with CalOptima Health's ~~2022–25 Strategic Goals~~Strategic Plan and DHCS Bold Goals.

1. ~~1.~~ Maternal Health
   - ~~o~~ Close racial/ethnic disparities in well-child visits and immunizations by 50%
   - ~~o~~ Close maternity care disparity for Black and Native American persons by 50%
2. ~~2.~~ Children's Preventive Care
   - ~~o~~ Exceed the 50th percentile for all children's preventive care measures
3. ~~3.~~ Behavioral Health Care
   - ~~o~~ Improve maternal and adolescent depression screening by 50%
   - Improve follow-up for mental health and substance disorder by 50%
   - ~~o~~
4. ~~4.~~ Program Goals
   - ~~a.~~ Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS)
   - OneCare: Attain a Four-Star Rating for Medicare

~~o~~

Quality Improvement and Health Equity Transformation Program Work Plan

The QIHETP Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the ~~QIC~~QIHEC and the Board of Directors' ~~Quality Assurance Committee~~QAC. The QIHETP Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QIHETP Work Plan is monitored throughout the year. A QIHETP Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products, as needed, to capture the specific scope of the plan.

The QIHETP Work Plan is the operational and functional component of the ~~QI Program~~QIHETP and is based on CalOptima Health strategic priorities and the most recent and trended HEDIS, CAHPS, Stars and Health Outcomes Survey (HOS) scores, physician quality measures and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards, where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The ~~QI Program~~QIHETP guides the development and implementation of an annual QIHETP Work Plan, which includes but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- ~~QI Program~~QIHETP oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the ~~QI Program~~QIHETP

Priorities for QIHE activities based on CalOptima Health's organizational needs and specific needs of CalOptima Health's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on quality-of-care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QIHETP Work Plan.

The QIHETP Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the ~~QI Program~~QIHETP and applicable policies and procedures. The 2024~~3~~ QIHETP Work Plan includes all quality improvement focus areas, goals, improvement activities, progress made toward~~s~~ goals, and timeframes. Planned activities include strategies to improve access care, the delivery of services, quality of care, over and under -utilization, and member population health management. All goals will be measured and monitored in the QIHETP Work Plan, reported to ~~QIC~~QIHEC quarterly, and evaluated annually. A copy of the QIHETP Work Plan are also publicly available on the CalOptima Health website.

~~See~~ For more details on the 2024 QIHETP Work Plan see Appendix A: 2024~~3~~ QIHETP Work Plan

Quality Improvement and Health Equity Projects

QIHE Project Selection and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including but not limited to:
  - Potential quality issue (PQI) review processes
  - Provider and facility reviews
  - Preventive care audits
  - Access to care studies
  - Member experience surveys
  - HEDIS results
  - Other opportunities for improvement as identified by subcommittee's data analysis
- Measures required by regulators, such as DHCS and CMS, with a focus ~~to meet or exceed~~on meeting or exceeding the following:
  - DHCS established Minimum Performance Level (MPL) for each required Quality Performance Measure of Health Equity measures selected by DHCS.
  - Health ~~D~~disparity reduction targets for specific populations and measures as identified by DHCS.
  - Performance Improvement Projects (PIPs) required by CMS or DHCS.

The QI Project methodology described below will be used to continuously review, evaluate and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for ~~Seniors and Persons with Disabilities (~~SPD~~)~~ members
- Provisions of chronic, complex care management and care management services
- Access to and provision of preventive services

Improvements in work processes, quality of care and service are derived from all levels of the organization. For example:

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be ~~high~~ high-risk, ~~high~~ high-volume or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, management, ~~QIC~~QIHEC, UMC, etc., based upon the scope of work and impact of the effort.
- CalOptima Health collaborates with ~~its~~ delegated business partners to coordinate QI activities for all lines of business through the following:
  - Health Network Forums – Monthly
  - HN Quality Forums – Quarterly
  - Joint Operation Meetings (JOM) with Health Networks ~~–~~ – Quarterly
- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QIHE Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be used.

QI Projects shall include the following:

- Measurement of performance using objective quality indicators
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of the intervention based on the performance measures~~;~~ ~~and~~
- Planning and initiation of activities for increasing or sustaining improvement~~.~~

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5%–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima Health's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30 can be statistically significant for QI pilot projects.

The PDSA model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s) including barrier analysis
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success
11) As needed, initiate Corrective Action Plan(s), which ~~many~~may include enhanced monitoring and/or re-measurement activities.

Types of QIHE Projects

CalOptima Health implements several types of improvement projects, including QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by ~~QIC~~QIHEC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement
Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima Health may choose to continue the project or pursue another topic.

Documentation of QIHE Projects

Documentation of all aspects of each QIHE Project is required. Documentation includes but is not limited to:

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure

- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Communication of QIHE Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QIHETP Work Plan or calendar. The QIHE subcommittees will report their summarized information to the ~~QIC~~QIHEC at least quarterly in order to facilitate communication along the continuum of care. The ~~QIC~~QIHEC reports activities to the QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima Health's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the ~~QIC~~QIHEC and its subcommittees
- HN Forums, Medical Directors' Meetings, Quality Forums and other ongoing ad hoc meetings
- MAC, PAC and WCM FAC

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Quality Improvement and Health Equity ~~Annual~~ Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's QIHETP are reviewed and evaluated annually by the QIHEC and QAC, and approved by the Board of Directors, as reflected in the QIHETP Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QIHETP Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

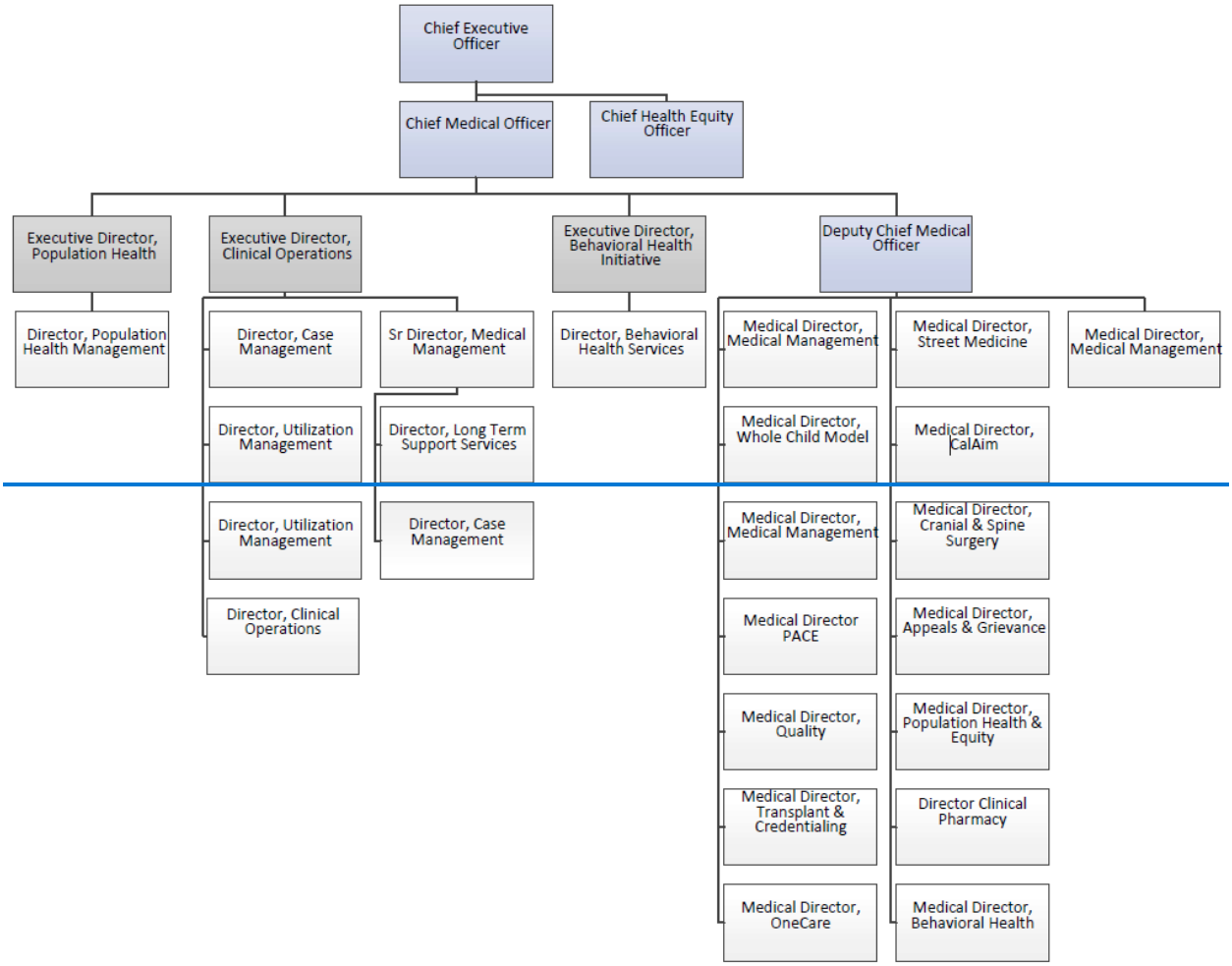
- A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QIHETP Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of QIHE activities, including QIPs, PIPs, PDSAs and CCIPs.
- An ~~evaluation~~evaluation of the effectiveness of member satisfaction surveys and initiatives.
- A report to the QIHEC and QAC summarizing all quality measures and identifying significant trends.
- A critical review of the organizational resources involved in the QIHETP through the CalOptima Health strategic planning ~~process~~process.
- Recommended changes included in the revised QIHETP Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

A copy of the QIHETP Evaluation is also publicly available on the CalOptima Health website.

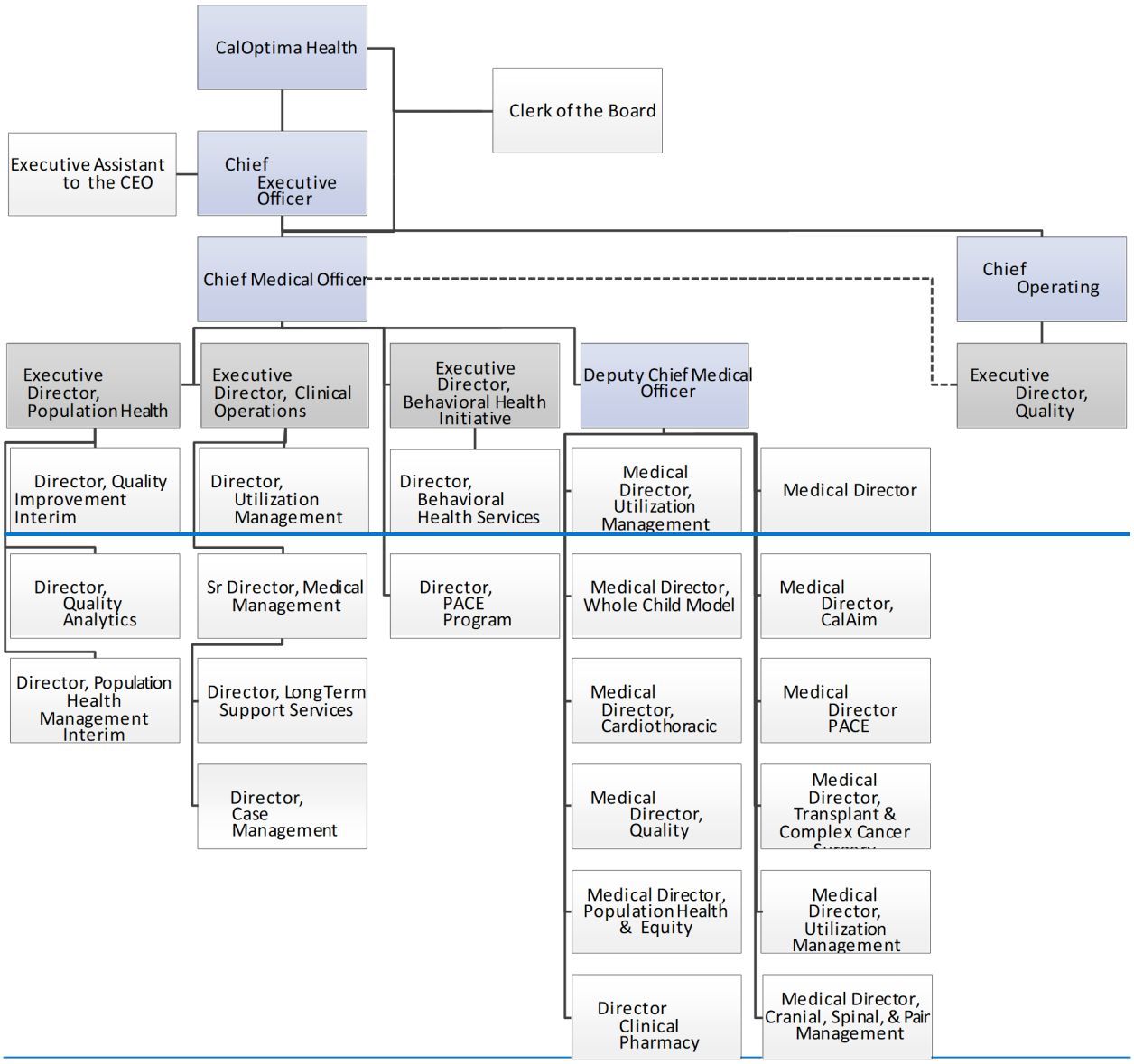
Quality Improvement and Health Equity Transformation Program Organizational Structure

Quality Program Organizational Chart~~Structure~~ — Diagram

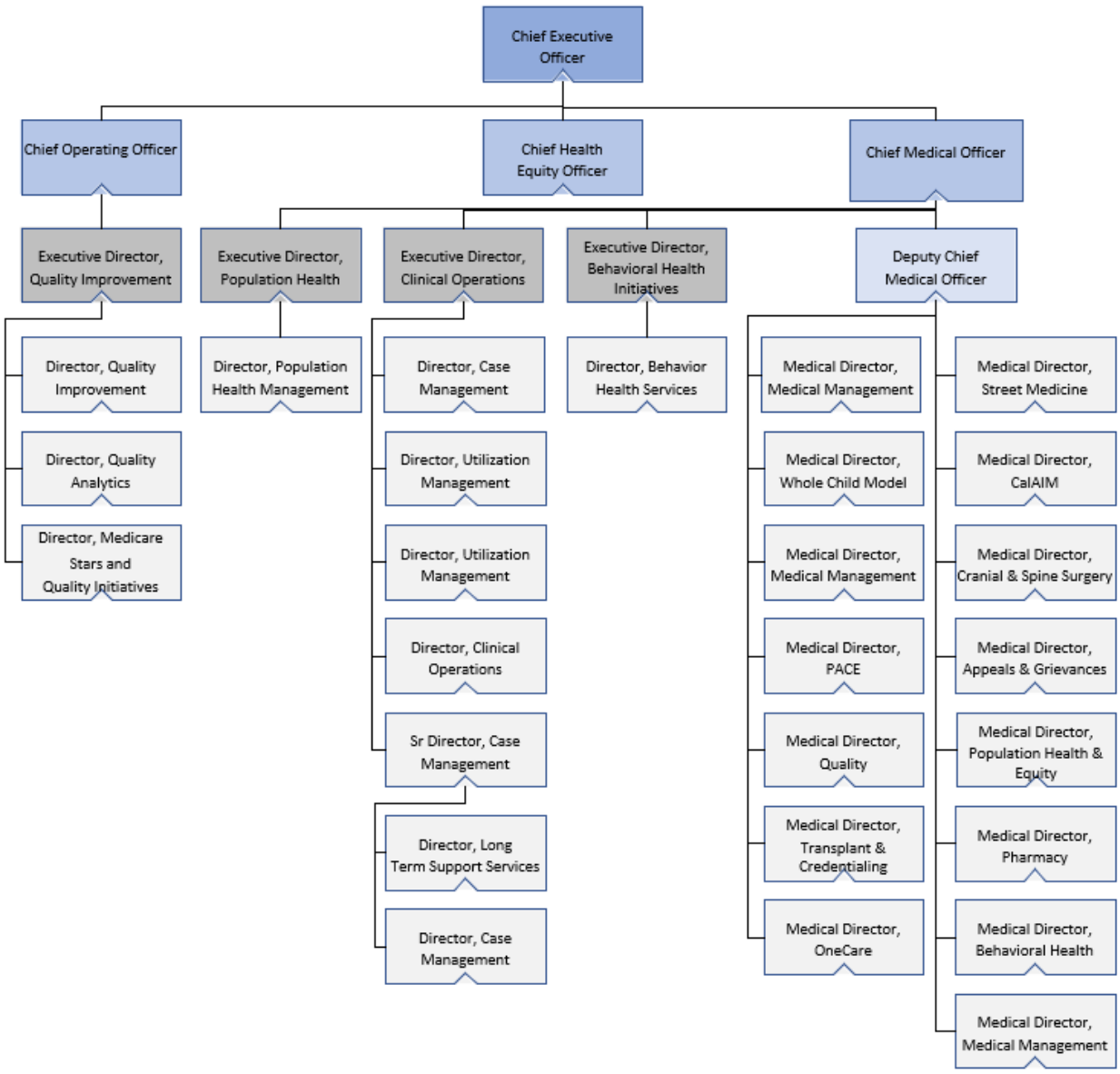
As of ~~December~~December~~,~~ ~~February~~ 2023



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Quality Improvement and Health Equity Transformation Program Organizational Structure

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima Health departments, support the organization's mission and strategic goals.~~,~~ These areas~~and~~ oversee the processes to monitor, evaluate and implement the QIHETP~~act~~ so that members receive ~~a high level of~~on the quality of high-quality care and services ~~that members receive.~~. Below lists the QI Program's functional areas and responsibilities.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Medical Officer* (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. The CMO has overall responsibility ~~of~~for the QIHETP and supports efforts so that the QIHETP objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QIHE activities to the Board of Directors' Quality Assurance Committee.

Chief Compliance Officer (CCO) is responsible for monitoring and driving interventions so that CalOptima Health and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.

Chief Health Equity Officer (CHEO) ~~The CHEO~~ co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO p~~P~~rovides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop

efficient processes for alignment with CalOptima Health's ~~'s~~ mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Deputy Chief Medical Officer* (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, Population Health Management, Pharmacy Management, LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. The COS is responsible for achieving operational efficiencies to support CalOptima Health's strategic plan, goals and objectives.

Chief Information Officer (CIO) provides oversight of CalOptima Health's enterprise-wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the ~~agency~~organization's risk exposure.

Medical Director* (Behavioral Health) is the designated behavioral health care physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC) and CPRC. The Medical Director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Medical Director* ~~((CalAIM) Advancing Innovation in MediCal))~~(CalAIM) [California Advancing and Innovating Medi-Cal] is responsible for the clinical oversight of CalAIM initiatives that include clinical programs and related services, such as ~~e~~Enhanced ~~c~~Care ~~m~~Management, ~~c~~Community ~~s~~Supports and justice--involved services.

Medical Director* (Credentialing and Peer Review) is the designated physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC). The Medical Director is also the chair of the Credentialing and Peer Review Committee (CPRC).

Medical Director* (OneCare) is responsible for ~~serving the~~ oversight of the senior members in OneCare, working on quality improvements to raise CalOptima Health's Star rating and collaborating with others on behalf of members via the interdisciplinary care teams.

Medical Director* (Population Health and Equity) is the designated physician who ~~will~~ chairs the Population Health Management Committee and is responsible for overseeing the Population Health Management (PHM) functions. The Medical Director provides direction and support to the CalOptima Health PHM staff to ensure objectives from the Population Health Management Strategy are met.

Medical Director* (Quality Improvement) is the physician designee who chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Medical Director* (Street Medicine) is responsible for the clinical oversight of the street medicine initiative that includes patient medical assessments and management, urgent care medical interventions, pharmacology management and utilization and the coordination of street medicine services with a ~~multi-disciplinary~~multidisciplinary team.

Medical Director* (Whole Child Model) is the physician designee who chairs the Whole Child Model Clinical Advisory Committee and is responsible for overseeing QIHE activities and quality management functions related to Whole Child Model (WCM). The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives related to WCM are met.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high--performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Population Health Management (ED PHM) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for oversight of CalOptima Health's Behavioral Health (BH) program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Medi-Cal and CalAIM is responsible for the implementation and oversight of CalAIM, a whole-system, person-centered delivery system reform to improve quality and care to members.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Care Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO, DCMO and ED PHM, makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities.

Executive Director, Medicare Programs (ED MP) is responsible for strategic and operational oversight of Medicare programs, including OneCare and PACE.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima Health's networks and making sure the delivery of accessible, cost-effective and quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox Keene Act Section 1367.01 I. Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

Quality Improvement and Health Equity Program Resources

CalOptima Health's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the ~~QI Program~~QIHETP. The resources are revisited on a regular basis to promote adequate support for CalOptima Health's ~~QI Program~~QIHETP.

The QIHE staff directly impacts and influences the QIHEC ~~Committee~~ and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima Health's CMO, ED QI and ED PHM, the following staff positions provide direct support for organizational and operational ~~QI Program~~QIHETP functions and activities:

Director, Quality Improvement
~~Responsibilities include assigned~~Responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the ~~QI Program~~QIHETP and maintain NCQA accreditation. This position ~~is~~ also supports the QIHEC, the committee responsible for oversight and implementation of the ~~QI Program~~QIHETP and QIHETP Work Plan. ~~implementation.~~

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement (PQI)
- Manager, Quality Improvement (FSR/PARS/MRR)
- Manager, Quality Improvement (Credentialing)
- Supervisor, Quality Improvement (FSR)
- Supervisor, Quality Improvement (PARS)
- QI Nurse Specialists (RN) (LVN)
- Project Manager
- Program Manager
- Credentialing Coordinators

- Program Specialists
- Program Assistants
- Outreach Specialists
- Auditor, Credentialing

Director~~s~~, Quality Analytics
~~(2)~~
Responsible for leading ~~implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products including HEDIS, member satisfaction, access and availability, and Medicare Stars.~~ collection, tracking~~,~~ and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. ~~Provides~~Conducts data ~~analytical~~analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. -Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.~~direction to support quality measurement activities for the agencywide QI Program~~QIHETP ~~by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC~~QIHEC ~~and other committees to ensure compliance with regulatory and accreditation agencies.~~

The following positions report to the Director~~s~~, Quality Analytics:
- Manager, Quality Analytics (HEDIS)
- ~~Manager, Quality Analytics (P4V)~~
- ~~Manager, Quality Analytics (Network Adequacy)~~
- Manager, Quality Analytics (Data Analytics)
- Data Analysts
- Project Managers
- HEDIS medical record review nurses
- ~~Program Coordinators~~
- ~~Program Specialists~~
- ~~Quality Analyst~~
- ~~Program Assistant~~

Director, Medicare Stars and Quality Initiatives
Responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the ~~organization-wide~~organization-wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

The ~~followin~~following~~g~~ positions report to the Director~~s~~, Medicare Stars and Quality Initiatives:~~Quality Analytics:~~

- Manager, Quality Analytics ~~Value Based Payment~~
- Manager, Quality Initiatives

- Project Managers
- Program Coordinators
- Program Specialists
- Data Analyst
- Quality Analyst
- Program Assistant

Director, Population Health Management

~~Provides direction for program development and implementation for agencywide population health initiatives. Ensures linkages supporting a whole-person perspective to health care with Care Management, UM, Pharmacy Management and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the Model of Care implementation for members. Reports program progress and effectiveness to QICQIHEC and other committees to support compliance with regulatory and accreditation agency requirements.~~

~~Director, Population Health Management (PHM) Director provides directionResponsible~~ for program development and implementation for ~~agency~~organization~~-~~wide population health initiatives while ensuring linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position oversees programs that promote health and wellness services for all CalOptima Health members. PHM services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). PHM also supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation ~~agency~~organization requirements.

The following positions report to the Director, Population Health Management:

- Population Health Management Manager (Clinical Operations)
- Population Health Management Manager (Health Education)
- Population Health Management Manager (Maternal Health)
- ~~Population Health Management Manager (Strategic Initiatives)~~
- Population Health Management Supervisors
- Program Managers and Senior Program Managers
- Health Coaches
- Registered ~~Dieticians~~Dietitians
- ~~Senior Health Educators~~
- Health Educators and Senior Health Educators
- ~~Quality Analysts~~
- Program Specialists
- Program Assistants
- Program Coordinators

Director, Behavioral Health Integration
~~Provides~~ Responsible for program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima Health members across all lines of business. The director is responsible for the management and strategic direction of the BHI department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Utilization Management
~~Assists in~~ Responsible for the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the UM committees and participates in the ~~QIC~~QIHEC and the BMSC.

Director, Clinical Pharmacy Management
~~Leads the~~Responsible for the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-related clinical affairs, and serves on the P&T and UMC. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Care Management
Responsible for Care Management, Transitions of Care, Complex Care Management and the clinical operations of Medi-Cal and OneCare. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports (LTSS)
Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Director, Medicare Programs
~~The Medical Director is a key member of t~~Responsible for the medical management team and ~~will be responsible for~~ providing physician leadership in the Medical Management division, serving as liaison to other CalOptima Health operational and support departments. The ~~incumbent~~director ~~will~~ collaborates with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including Quality, ~~Management,~~ Utilization and Care Management, Health Education/Disease Management, Long-~~-~~Term Care, Pharmacy, Behavioral Health Integration, ~~Program for All Inclusive Care for the Elderly (~~PACE~~)~~

as well as support departments, -including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

Staff Orientation, Training and Education

CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in health services. Qualifications and educational requirements are delineated in the respective position descriptions.

Each new employee is provided intensive orientation and job-specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA ~~and Privacy~~Rules and Compliance
- Disability Awareness
- Fraud, Waste and Abuse
- Compliance and Code of Conduct T~~t~~raining
- Cybersecurity Awareness
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Health Equity
- Cultural Competency~~, Reducing Bias and Promoting Inclusion Training~~
- Seniors and Persons with Disabilities Awareness training
- Trauma-Informed Care ~~training~~
- Diversity, Inclusion and Unconscious Bias

Employees, contracted providers and practitioner networks with responsibilities for OneCare are trained at least annually on the Model of Care (MOC). The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for education reimbursement for employees.

~~Quality Improvement Health Equity Annual Program Evaluation~~

~~The objectives, scope, organization and effectiveness of CalOptima Health's QI Program~~QIHETP ~~are reviewed and evaluated annually by the QIC~~QIHEC ~~and QAC, and approved by the Board of Directors, as reflected in the QIHETP Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are~~

~~incorporated into the QIHETP Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:~~

- ~~A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QIHETP Work Plan, and identification of opportunities for improvement.~~
- ~~Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.~~
- ~~An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.~~
- ~~An evaluation of the effectiveness of QIHE activities, including QIPs, PIPs, PDSAs and CCIPs.~~
- ~~An evaluation the effectiveness of member satisfaction surveys and initiatives.~~
- ~~A report to the QICQIHEC and QAC summarizing all quality measures and identifying significant trends.~~
- ~~A critical review of the organizational resources involved in the QI ProgramQIHETP through the CalOptima Health strategic planning process~~
- ~~Recommended changes included in the revised QI ProgramQIHETP Description for the subsequent year for QICQIHEC, QAC and the Board of Directors' review and approval.~~

Key Business Processes, Functions, Important Aspects of Care and Service

CalOptima Health provides comprehensive ~~acute and preventive~~[physical and behavioral health care services, which are based on the philosophy of a medical home for each member. The primary care practitioner is this medical home for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima Health model:

- Primary care, by definition, is accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services.
- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important ~~aspects of~~functional areas of care and service around which key business processes are designed include:

- Clinical care and service
- Behavioral health care
- Access and availability
- Continuity and coordination of care
- Transitions of care
- Prenatal and ~~P~~postpartum c~~C~~are

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- Preventive care, including:
  - Initial Health Appointment
  - Behavioral Assessment
  - Immunizations
  - Blood Lead Screenings
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Diagnosis, care and treatment of acute and chronic conditions
- Care management including complex care management
- ~~Drug utilization~~Prescription drug services
- Hospice ~~C~~care
- Palliative ~~C~~care
- Major ~~O~~organ t~~T~~ransplants
- Long-Term Care Services and Supports
- Enhanced Care Management
- Community Supports
- Transportation
- Health education and promotion
- ~~Over/underutilization~~
- Disease management
- Member experience
- Patient safety
- ~~Provider training~~

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Provider training
- Organizational ethics
- Effective utilization of resources including monitoring of over and under utilization
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Fraud and abuse* as it relates to quality of care

* CalOptima Health has a zero-tolerance policy for fraud and abuse, as required by applicable laws and regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima Health program.

~~Quality of Clinical Care~~

Quality Improvement

The QI department is responsible for implementation of the QIHETP, monitoring quality of care and service, ~~issues~~ and assuring ~~the~~ that credentialing standards, policies, and procedures are

implemented to provide a qualified provider network for our members. The QI department fully aligns with ~~the other areas of the QI team~~departments throughout the organization to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services. The QI department ensures that care and services are rendered appropriately and safely to all CalOptima Health members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both department-specific and ~~agencywide~~organization-wide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain ~~agencywide~~ organization-wide practices that support accreditation and meet regulatory requirements

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). As cases are presented to CPRC, the discussion of the care includes appropriate action and leveling of the care, which results in committee-wide inter-rated reliability process. The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima Health, which include but are not limited to Prior Authorization, Concurrent Review, Care Management, Legal, Compliance, Customer Service, Pharmacy or GARS, as well as from providers and other external sources.

The QI department provides training guidance for the non-clinical staff in Customer Service and GARS to assist the staff on the identification of potential quality issues. Potential quality of care grievances are reviewed by a Medical Director with clinical feedback provided to the member. Declined grievances captured by the Customer Service department are similarly reviewed by a Medical Director.

Comprehensive Credentialing Program ~~Standards~~

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima Health contracted delivery system.

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, Dos, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include but are not limited to non-physician BH practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima Health direct environments. Credentialing and recredentialing activities for CCN are performed at CalOptima Health and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima Health performs credentialing and recredentialing of OPs, including but not limited to acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

CalAIM Providers

CalOptima Health performs credentialing or vetting of CalAIM providers to ensure providers are qualified to provide ~~enhanced care management or community support services~~ Enhanced Care Management and Community Supports to our members. CalAIM providers include but are not limited to the following providers: FQHCs, street medicine providers, homeless navigation centers, transitional housing centers, CBAS centers, home health agencies, school-based clinics, community-based organizations ~~(CBOs)~~, recuperative care and respite providers, sobering centers, medical tailored meals, and personal care and homemaker services.

Use of QI Activities in the Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing process.

Monitoring for Sanctions and Complaints

CalOptima Health has adopted policies and procedures for ongoing monitoring of sanctions, which include but are not limited to state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review ~~Survey~~

CalOptima Health does not delegate PCP facility site, physical accessibility, and medical records review to contracted HMOs, PHCs and SRGs~~, with the exception of Kaiser Permanente in accordance with standards set forth by APL 22-017.~~. CalOptima Health assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima Health collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima Health completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for precontracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with APL 2~~0~~20-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review~~06~~ and CalOptima Health policies. An Initial Medical Record Review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima Health may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or CAP follow-up issues. If the provider is unable to meet the requirements through the CAP review, then the provider will be recommended for contract termination.

Physical Accessibility Review Survey for Seniors and Persons With Disabilities (SPD)

CalOptima Health conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas, including the exam room
- Restroom
- Exam table/scale

Medical Record Documentation ~~Standards~~

The medical record provides legal proof that the member received care. CalOptima Health requires that contracted delegated HNs make certain that each member's medical record is maintained in an accurate, current, detailed, organized and easily accessible manner. Medical records are reviewed for format, legal protocols and documented evidence of the provision of

preventive care and coordination and continuity of care services. All data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.)

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima Health's contracts with CMS and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law and must be maintained by the provider for a minimum of 10 years.

Corrective Action Plan(s) to Improve Quality of Care and Service

When monitoring by either CalOptima Health's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima Health's functional areas will be overseen by the QI department as overseen by and reported to ~~QIC~~QIHEC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams using continuous improvement tools (i.e., quality improvement plans or PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

National Committee for Quality Assurance (NCQA) Accreditation

CalOptima Health is a National Committee for Quality Assurance (NCQA) accredited Health Plan and achieved its initial commendable accreditation in August 2012. In July 2021, CalOptima Health completed tri-annual renewal survey for NCQA Health Plan Accreditation and received 100% of the allowable points through the document submission and file review process. From this renewal survey, CalOptima Health received Accredited Status, which is effective through July 27, 2024.

The ~~Quality Improvement~~QI ~~D~~department staff support CalOptima Health accreditation efforts by conducting the NCQA Steering Committee to provide~~r~~ all internal departments with NCQA standards and updates, survey readiness management and NCQA survey process management. CalOptima Health has acquired NCQA consulting services to support document review and survey readiness prior to submission.

CalOptima Health is seeking another renewal for Health Plan Accreditation and will be completing the submission by April 30, 2024. In addition to Health Plan Accreditation, CalOptima is also seeking Health Equity Accreditation with NCQA by ~~June 2025~~January 2026.

Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and PHM teams to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima Health members.

The QA department activities include design, implementation and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Conduct measurement analysis to evaluate goals, establish trends and identify root causes
- Establish measurement benchmarks and goals
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required
- Participate in various reviews through the ~~QI Program~~QIHETP, including but not limited to network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize HNs and providers to meet quality performance targets and deliver quality care
- Design and develop member, provider and organization-~~al~~ wide initiatives to improve - quality of care ~~to member~~

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include but are not limited to:

- Claims data
- Encounter data
- Utilization data
- Care management reports
- Pharmacy data
- Immunization registry

- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS results
- Member and provider satisfaction surveys
- Timely Access Survey
- Provider demographic information

By analyzing data that CalOptima Health currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS scores and CMS Star Ratings. This information will guide CalOptima Health and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Quality Performance Measures ~~Healthcare Effectiveness Data and Information ISet (HEDIS)~~

CalOptima Health annually collects, tracks~~,~~ and reports all quality performance measures required by CMS and DHCS, including the DHCS Medi-Cal Accountability Set (MCAS), Medicare reporting set~~,~~ and Star measures~~; according to requirements~~. Measure rates are validated by a NCQA-certified auditor and reported to NCQA, CMS, DHCS~~,~~ and other entities as required.

VALUE-~~-~~Based Payment **Program**

CalOptima Health's ~~Pay for Value~~Value-~~-~~Based Payment Performance Program ~~(P4V Program)~~ recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. ~~Health Networks (~~HNs~~)~~, including ~~CalOptima Health Community Network (~~CCN~~)~~, and HNs' ~~primary care physicians (~~PCPs~~)~~ are eligible to participate in the ~~P4V~~Value-~~-~~Based Payment P~~p~~rograms. CalOptima Health has adopted the Integrated Healthcare Association (IHA) pay-~~-~~for-~~-~~performance methodology to assess performance. Performance measures are aligned with the DHCS MCAS for Medi-Cal and a subset of CMS Star measures for OneCare.

~~Pay for Value Program~~

Five-Year Hospital Quality Program 2023-~~-~~2027

CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience~~,~~ and patient safety. Hospitals may earn annual incentives based on achievement of benchmarks.

Population Health Management

Population Health Management (PHM) aims to ensure that member care and services are delivered in a whole-person-centered, safe, timely, efficient and equitable manner across the entire health care continuum and life span. PHM integrates physical health, behavioral health, long-term support services, and complex case management to improve the coordination of care between managed care teams. PHM care coordination includes basic population health management, complex care management, enhanced care management (ECM) and transitional care services. CalOptima Health strives to provide integrated physical health, behavioral health, LTSS, care coordination and complex care management to improve coordination of care between health care departments. This PHM's streamlineddstreamlined care coordination interactions will ultimately result inare designed to optimized member care to meet their unique and comprehensive health needs. CalOptima Health's PHM strategy outlines programs that will focus on four key strategies:

At least annually, CalOptima Health engages with multidisciplinary care teams, members, community partners and stakeholders to update the Population Health Management (PHM) Strategy. The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also shares our creative upstream approach to address social determinants of health (SDOH) and close gaps in care that lead to health disparities among our members. In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by the National Accreditation of Quality Assurance (NCQA). CalOptima Health's PHM Strategy addresses the following areas of focus:

- Keeping members healthy
- Managing members with emerging risks
- Patient safety or outcomes across settings
- Managing members with multiple chronic conditions

This is achieved through functions described below in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima Health developed a comprehensive PHM Strategy that includes a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima Health's PHM Strategy aims to ensure the care and services provided to members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner.

To inform our PHM Strategy, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies. Mainly,The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima Health members. CalOptima Health's Population Needs Assessment (PNA) is used to summarize the results of an annual assessment on a variety of member data. The intent of the PNA is to review the characteristics and needs of our agency's organization's member population and relevant focus populations to support data-driven planning and decision-making. In addition, CalOptima Health uses PNA key findings to inform a comprehensive PHM Work Pplan.
Additionally, CalOptima Health's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Plans) will aid the PHM Strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities and gaps in services related to these issues.

~~In addition to utilizing member health outcomes, the PHM Strategy will engage in a member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.~~

The PHM Work Pplan ~~of action~~ addresses the unique needs and challenges of specific ethnic communities, including social drivers of health ~~which~~ that include but are not limited to economic, social~~, spiritual~~
and environmental stressors, to improve health outcomes. CalOptima Health will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services. These quality initiatives ~~that~~ can be expected to have a beneficial effect on health outcomes and member satisfaction~~. Quality initiatives that are conducted to improve quality of care and health services delivery to members~~, and may include quality improvement projects (QIPs), program improvement projects (PIPs), Plan-Do-Study-Act (PDSAs) and chronic care improvement projects (CCIPs). Quality Initiatives ~~for 2022~~ are tracked in the ~~Quality Improvement~~ and ~~Health Equity~~ QIHETP ~~QIHE~~ Work Pp ~~P~~lan and reported to the ~~Quality Improvement and Health Equity Committee (~~QIHEC~~)~~.

In ~~2023~~2024, the PHM ~~Strategy~~ Work Pplan will continue to focus on addressing health inequities and meeting member's social needs. ~~The COVID-19 pandemic brought worldwide attention to health disparities and inequity.~~ PHM identified opportunities to expand outreach and initiate new initiatives focused on advancing health equity as follows:

- Improving screening for member social needs and connections to resources through an integrated closed-loop referral platform.
    - ~~•~~ Increasing CalOptima Health's organizational health literacy through the Health Literacy for Equity project, with support from the ~~Orange County's~~ Equity in Orange County Initiative (EiOC).
- ~~Implementing new Medi-Cal benefits that cover doula and community health worker services.~~
- ~~Resuming~~ Expanding in-person group health education classes in the community to promote healthy eating and active living.
- ~~Implementing a multidisciplinary diabetes program and i~~Initiating ~~additional~~ interventions for members with hypertension ~~gestational diabetes~~ and chronic kidney disease.
- ~~Launching~~ Implementing the Comprehensive Community Cancer Screening and Support program ~~to create an ethos of cancer screening across Orange County.~~ that aims to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses.
- Collaborating with the Orange County Health Care Agency to reduce disparities in childhood blood lead and maternal depression screening rates.

Further details of the Population Health Management Program, activities and measurements can be found in the 2024 Population Health Management Strategy (Appendix B)

Health Education and Promotion

The PHM department provides program development and implementation for ~~agencywide~~ organization-wide PHM programs. PHM programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain

conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members. They are designed to achieve behavioral change and are reviewed on an annual basis. Program topics include exercise, nutrition, hyperlipidemia, hypertension, perinatal health, Shape Your Life/weight management, tobacco cessation, asthma, immunizations and well-child visits.

~~Primary~~The primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the ~~sixth-grade~~sixth grade reading level and are culturally and linguistically appropriate.

PHM supports CalOptima Health members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources

Managing Members With Emerging Risk

CalOptima Health staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach entails the formation of a partnership between the member, the health care practitioner and CalOptima Health. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, ~~coordination~~coordination and intervention. CalOptima Health assumes responsibility for the PHM program for all lines of business; however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Care Management

CalOptima Health is committed to serving the needs of all members and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is delivery of effective, quality health care to members with special health care needs across settings and at all levels of care, including but not limited to physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data, including Health Risk Assessment (HRA) for OneCare, SPD~~,~~ and WCM members

- Multiple avenues for referral to care management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt- out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidence-based guidelines distributed to providers who address chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD)
- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources
- Development of individualized care plans that include input from the member, caregiver, PCP, specialists, social worker and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing and modifying the plan of care to drive appropriate service quality, timeliness and effectiveness
- Establishing consistent provider-patient relationships
- Ongoing assessment of outcomes

CalOptima Health's Care Management (CM) program includes three care management levels that reflect the acuity of needs: complex care management, care coordination and basic care management. Members within defined ~~MOCs~~ models of care, (SPD, WCM and OneCare) are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

Health Risk Assessment (HRA) and Health Needs Assessment (HNA)

The comprehensive risk assessment facilitates care planning and offers actionable items for the ICT. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments are completed with the initial visit and then on an annual basis.

Interdisciplinary Care Team (ICT)

An ICT is linked to members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), depending on the results of the member's HRA and/or evaluation or changes in health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of the member) and PCP. For members with more needs, other disciplines are included, such as a Medical Director, specialist(s), care manager, BH specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

The ICT levels are:

- ICT for Low-Risk Members — occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic care management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an Individual Care Plan (ICP)
      - Communication with members or their representatives, vendors and medical group
      - Review and update the ICP at least annually, and when there is a change in health status
      - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk Members — occurs at the HN, or at CalOptima Health for CCN members.
  - Team Composition: member, caregiver or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory care manager, hospitalist, hospital care manager and/or discharge planners, HN UM staff, BH specialist and social worker
    - Roles and responsibilities of this team:
      - Identification and management of planned transitions
      - Care coordination or complex care management
      - Care management of high-risk members
      - Coordination of ICPs for high-risk members
      - Facilitating communication among member, PCP, specialists and vendors
      - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Individual Care Plan (ICP)

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per care management level. The ICP is updated annually and with change in condition.

Seniors and Persons with Disability (SPD)

The goal of care management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole-Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives care management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

OneCare -Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

The MOC is member-centric by design, and it monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care for OneCare. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of SDOH
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

CalOptima Health's D-SNP care management program includes but is not limited to:

- Complex care management program for a subset of members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional care management program focused on evaluating and coordinating transition needs for members who may be at risk of rehospitalization
- High-risk and high-utilization program for members who frequently use emergency department services or have frequent hospitalizations, and high-risk individuals
- Hospital care management program to coordinate care for members during an inpatient admission and discharge planning

Care ~~m~~Management P~~p~~rogram focuses on member-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Behavioral Health Integration Services

CalOptima Health is responsible for ~~provider~~providing quality behavioral health care focusing on prevention, recovery, resiliency~~,~~ and rehabilitation. As part of the QI Program with direction and guidance from the QIHEC, the BHI other supporting departments continue to monitor the behavioral health care that CalOptima Health providers our member and continue to seek ways to improve behavioral health care.

Medi-Cal Behavioral Health (BH)

CalOptima Health is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include but are not limited to individual and group psychotherapy, psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated to evaluate a mental health condition.

In addition, CalOptima Health covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima Health provides direct oversight, review and authorization of BHT services.

CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief ~~misuse~~ counseling on misuse is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

CalOptima Health members can access mental health services directly, without a physician referral, by contacting the CalOptima Health Behavioral Health Line at 1-855-877-3885. A CalOptima Health representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to BH practitioners within the CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima Health ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

CalOptima Health directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

CalOptima Health is participating in two of DHCS' incentive programs focused on improving BH care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is

designed to improve physical and BH outcomes, care delivery efficiency and member experience. CalOptima Health is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12 projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize BH services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH agencies and CalOptima Health by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

OneCare Behavioral Health

OneCare covers inpatient and outpatient behavioral health care services through a directly contracted behavioral health network. OneCare BH continues to be fully integrated within CalOptima Health internal operations. OneCare members can access mental health services by calling the CalOptima Health Behavioral Health Line. ~~Members will be connected to a CalOptima Health representative for assistance.~~

~~**CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).**~~

Utilization Management (UM)

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service, subject to medical necessity, and are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease or injury consistent with CalOptima Health medical policy and not furnished primarily for the convenience of the member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the ~~2022~~ 2024 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical

necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a Medical Director or other qualified reviewer, such as a licensed psychologist or clinical pharmacist.

Further details of the UM Program, activities and measurements can be found in the 2024~~3~~ Integrated UM and CM -Program Description.

~~Safety of Clinical Care~~

Patient Safety Program

Patient safety is very important to CalOptima Health; it aligns with CalOptima Health's mission statement: *To serve member health with excellence and dignity, respecting the value and needs of each person*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Patient safety is integrated into all components of enrollment and health care delivery and is a significant part of our quality and risk management functions. This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service
- Care provided in various health care settings
- Sentinel events
- Disease Surveillance and re~~e~~porting

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to consider the member's language comprehension, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures that outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety

- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Using FSRs, PARS and ~~medical record review~~MRR results from providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster and evacuation plan testing and annual training

- Institutional settings, including CBAS, SNF and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of influenza and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

Encounter Data Review

CalOptima Health's HNs must submit complete, timely, reasonable, and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types and data format specifications. A HN submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.

CalOptima Health annually measures a HN's compliance with performance standards with regards to the timely submission of complete and accurate encounter data, in accordance with Policy EE.1124 Health Network Encounter Data Performance Standards. CalOptima Health utilizes retrospective encounter data to conduct its evaluation. The measurement year is the twelve (12) month calendar year. CalOptima Health provides a HN with a HN Encounter Data Scorecard to report a HN's progress check score and annual score relating to the status of the HN's compliance with encounter data performance standards.

~~Emergency Department Diversion Pilot~~

~~In the effort to support hospital partners, members and reduce inappropriate Emergency Department (ED) visits, CalOptima Health implemented an ED Diversion pilot program. The program has been piloted at one hospital. We plan to expand the program to additional hospital partners in 2023.~~

~~The program has four major goals:~~

- ~~Promote communication and member access across all CalOptima Health Networks~~
- ~~Increase CalAIM Community Supports referrals~~
- ~~Increase PCP follow-up visit within 30 days of an ED visit~~
- ~~Decrease inappropriate ED utilization~~

~~This program provides referrals to CalAIM Community Supports, assists members with appointments to their PCP and specialists, refers members to Care Management, completes Prior Authorizations, and assists the member with transportation and medication issues.~~

Member Experience

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system.

~~NCQA's Health Insurance Plan Ratings measure customer satisfaction as one of the three dimensions.~~

CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members' expectations and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both Medi-Cal and ~~dual-eligible~~OneCare members. Focus is placed on coordinating efforts

intended to improve performance on CAHPS survey items for both the adult and child population.

Additionally, CalOptima Health reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for "pain points" that impact members at the plan and HN level (including CCN), where appropriate.

Grievance and Appeals

CalOptima Health has a process for reviewing member and provider complaints, grievances and appeals. Grievances and appeals are tracked and trended on a quarterly basis for timeliness of acknowledgment and resolution, issue types and by provider type. The grievance and appeals process includes a thorough investigation and evaluation to ensure timely access to care and the delivery of quality care and/or services. In this process, potential quality of care issues are identified and referred to an appropriately-licensed professional for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case. The quarterly report is presented and reviewed by the Grievance and Resolutions (GARS) Committee that reports to the QIHEC quarterly.

~~Quality of Service~~

Access to Care

~~With the rapid growth in CalOptima Health's membership, access~~Access to care is a major area of ~~concern~~ focus for the plan and hence the organization has dedicated ~~a~~ significant ~~amount of~~ resources to measuring and improving access to care.

CalOptima Health participates in the following to monitor and improve network adequacy and access to our ~~M~~members:

- Annual Network Certification (ANC) with DHCS
- Subcontracted Network Certification (SNC) with DHCS
- Network Adequacy Validation with the EQRO
- Network Adequacy Monitoring with CMS

CalOptima Health monitors the following to ensure that ~~members~~ we have robust provider networks for our members to access care and that members have timely access to care to primary and specialty healthcare providers and services:

Availability of Practitioners

- CalOptima Health monitors the availability of PCPs, specialists and BH practitioners and assesses them against established standards quarterly or when there is a significant change to the network.
- The performance standards are based on ~~state~~DHCS, CMS, NCQA and industry benchmarks.

- CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of practitioners.
- CalOptima Health uses a geo-mapping application to assess ~~the~~ geographic distribution.
- Data is tracked and trended and used to inform provider outreaching and recruiting efforts.

Appointment Access

- CalOptima Health monitors appointment access for PCPs, specialists and BH providers and assesses them against established standards at least annually.
- ~~In order to~~ To measure performance, CalOptima Health collects appointment access data from practitioner offices using a timely access survey.
- CalOptima Health also evaluates the grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps CalOptima Health identify and implement opportunities for improvement.
- Providers not meeting timely access standards are re-measured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Telephone Access

- CalOptima Health monitors access to its Customer Service ~~Department~~ department on a quarterly basis.
- ~~In order to~~To ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their primary care practitioner during business hours.
- Providers not meeting timely access standards are re-measured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural & Linguistic Services Program

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services P~~p~~rogram that integrates culturally and linguistically appropriate services at all levels of the operation. Services include but are not limited to face-to-face interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; ~~and~~ member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio; and referrals to culturally and linguistically appropriate community services programs. ~~.~~

The seven most common languages spoken for all CalOptima Health programs are: English, 5~~8~~9%; Spanish, 2~~7~~6%; Vietnamese, 9~~1~~0%; Farsi, 1%; Korean, 2~~1~~%; Chinese, less than 1%; and Arabic, less than 1%; and~~,~~ other less than 2%. CalOptima Health provides member materials as follows:

- Medi-Cal member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.

- OneCare member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- PACE participant materials are provided in three languages: English, Spanish and Vietnamese.

CalOptima Health's Cultural and Linguistic Services Program is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of our diverse population. Beginning with identification of needs through a ~~Group~~ Population Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical ~~areas~~areas~~89reas~~ areas.
- Improve cultural competency in materials and ~~communications~~communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group
-
- Implementing and maintaining annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical). ~~Providing information, training and tools to staff and practitioners to support culturally competent communication~~
-

Further details of the Culture and Linguistics program, activities and measurements can be found in the 2024 Culture and Linguistics Services Program and Work Plan.

DELEGATED AND NON-DELEGATED ACTIVITIES

While CalOptima Health is accountable for all QIHE functions, CalOptima Health does delegate responsibilities to subcontractors and downstream subcontractors and specifies these requirements in a mutually agreed upon delegation agreement. CalOptima Health evaluates the delegates ability to perform the delegated activities to ensure compliance with statutory, regulatory and accreditation requirements as part of ~~CalOptima Health has~~ an annual and ~~continuing~~ continuous monitoring process for delegation oversight. ~~to ensure compliance with statutory, regulatory and accreditation requirements.~~

Delegation Oversight

Participating entities are required to meet CalOptima Health's QI standards and to participate in CalOptima Health's ~~QI Program~~QIHETP. CalOptima Health has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate's ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Delegation Oversight Committee, reporting to the Compliance Committee.

CalOptima Health, via a mutually-agreed-upon delegation agreement document, describes the responsibilities and activities of the organization and the delegated entity.

CalOptima Health conducts oversight based on regulatory, CalOptima Health and NCQA standards and has a system to audit and monitor delegated entities' internal operations on a regular basis.

Delegation Oversight Performance Monitoring includes but is not limited to the CalOptima Health delegates and monitors the following functions:
~~following:~~

- ~~QI – Kaiser only,~~ Care Management, ~~Network Management,~~ Credentialing, Utilization Management, ~~Member Experience,~~ and Claims. ~~, Third Party Liability, Medicaid Module and Second Opinion.~~
-

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted HNs ~~with the exception of Kaiser Permanente,~~ and remain the responsibility of CalOptima Health:

- QI, as delineated in the Contract for Health Care Services
- ~~QI Program~~QIHETP for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Health Equity
- BH for Medi-Cal and OneCare
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health education, as applicable
- Grievance and appeals process for all lines of business, and peer review process on specific, referred cases
- PQI investigations
- Development of systemwide measures, thresholds and standards

- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second-level review of provider grievances
- Development of UM and Care Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

APPENDIX:

A – 20234 QIHETP WORK PLAN

B – 2024 POPULATION HEALTH MANAGEMENT STRATEGY

CB – CALOPTIMA HEALTH MEASUREMENT YEAR (MY) 2024

MEDI-CAL AND ONECARE PAY FOR VALUE PROGRAMSPAY FOR VALUE PROGRAM

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Abbreviations

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Experience~~vent~~
	ADA	Americans With Disabilities Act of 1990
	ADHD	Attention-Deficit Hyperactivity Disorder
	APL	All Plan Letter
	AUD	Alcohol Use Disorder
B		
	BHI	Behavioral Health Integration
	BHT	Behavioral Health Treatment
	BHIIP	Behavioral Health Integration Incentive Program
	BMSC	Benefit Management Subcommittee
C		
	CalAIM	California Advancing and Innovating Medi-Cal
	CAHPS	Consumer Assessment of Healthcare Providers and Systems ~~Ssurvey~~
	CAP	Corrective Action Plan
	CBAS	Community- Based Adult Services ~~centers~~
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHCN	CalOptima Health Community Network
	CHEO	Chief Health Equity Officer
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COO	Chief Operating Officer
	COPD	Chronic Obstructive Pulmonary Disease
	COS	Chief of Staff
	COD-A	CalOptima Health Direct-Administrative
	CPRC	Credentialing and Peer Review Committee
	CQS	Comprehensive Quality Strategy
	CR	Credentialing
D		
	DC	Doctor of Chiropractic Medicine
	DCMO	Deputy Chief Medical Officer
	DDS	Doctor of Dental Surgery
	DHCS	~~California~~ Department of Health Care Services
	DMHC	~~California~~ Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ED PHM	Executive Director, Population Health Management
	ED BH	Executive Director, Behavioral Health Integration
	BH	Behavioral Health
	ED CO	Executive Director, Clinical Operations
	ED MP	Executive Director, Medicare Programs

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	ED NO	Executive Director, Network Operations
	ED O	Executive Director, Operations
	ED Q	Executive Director, Quality
F		
	FDR	~~Means~~ First Tier, Downstream ~~and~~or Related Entity~~ies, as separately dined herein~~
	FSR	Facility Site Review
G		
	GARS	Grievance and Appeals Resolution Services
H		
	HEDIS	Healthcare Effectiveness Data and Information Set
	HIPAA	Health Insurance Portability and Accountability Act
	HMO	Health Maintenance Organization
	HN	Health Network
	HNA	Health Needs Assessment
	HOS	Health Outcomes Survey
	HRA	Health Risk Assessment
I		
	ICT	Interdisciplinary Care Team
	ICP	Individual~~ized~~ Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long~~-~~ Term Care
	LTSS	Long~~-~~ Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	~~Medical~~ Doctor of Medicine
	ME	Member Experience
	MED	Medicaid Module
	~~Member~~	~~Member (Global): A beneficiary enrolled in a CalOptima Health program~~
	MEMX	Member Experience Committee
	MOC	Model of Care
	MOU	Memorandum of Understanding
	MRR	Medical Record Review
	MRSA	Methicillin resistant Staphylococcus aureus
	MSSP	Multipurpose Senior Services Program
	MY	Measurement Year
	NCQA	National Committee for Quality Assurance
	NET	Network
	NF	Nursing Facility~~ies~~
O		
	OC	Orange County
	~~OCC~~	~~OneCare Connect~~
	OCHCA ~~or HCA~~	Orange Country Health Care Agency
	OP	Organizational Providers
	OC SSA or SSA	County of Orange Social Services Agency
Q		
	QAC	Quality Assurance Committee
	QI	Quality Improvement
	QIHE	Quality Improvement and Health Equity
	QIHEC	Quality Improvement and Health Equity Committee

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	QIP	Quality Improvement Project
P		
	P4V	Pay for Value
	P&T	Pharmacy & Therapeutics Committee
	PAC	Provider Advisory Committee
	PACE	Program of All-Inclusive Care for the Elderly
	PARS	Physical Accessibility Review Survey
	PBM	Pharmacy Benefit Manager
	PCC	Personal Care Coordinator
	PCP	Primary Care Practitioner/physician~~ovider~~
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician~~/~~ Hospital Consortium~~a~~
	PIP	Performance Improvement Project
	PPC	Prenatal and Postpartum Care
	PPC~~s~~	Provider~~-~~ Preventable Condition~~s~~
	PQI	Potential Quality Issue
	PSS	Perinatal Support Services
S		
	SABIRT	Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
	SBHIP	Student Behavioral Health Incentive Program
	SDOH	Social Drivers~~eterminants~~ of Health
	SNP	Special Needs Plan
	SNF	Skilled Nursing Facility
	SPD	Seniors and Persons with Disabilities
	SRG	Shared~~-~~ Risk Group
	SUD	Substance Use Disorder
T		
	TPL	Third~~-~~ Party Liability
U		
	UM	Utilization Management
	UMC	Utilization Management Committee
V		
	VS	Vision Service
	VSP	Vision Service Plan
W		
	WCM	Whole-Child Model Program
	WCM CAC	Whole-Child Model Clinical Advisory Committee
	WCM FAC	Whole-Child Model Family Advisory Committee

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2024 Quality Improvement and Health Equity Transformation Program Work Plan

Evaluation Category	Evaluation Sub-category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Report to Committee	LOB	Continue Monitoring from 2023	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 - Caution Green - On Target
Program Oversight		2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	QIHEC	MC,OC	X			
Program Oversight		2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	QIHETP and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	QIHEC	MC,OC	X			
Program Oversight		2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	UMC/QIHEC	MC,OC	X			
Program Oversight		2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	UMC/QIHEC	MC,OC	X			
Program Oversight		Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: Population Needs Assessment (PNA) Risk stratification Screening and Assessment Wellness and prevention Pediatric Risk Stratification Process (PRSP) monitoring	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of PHM	Manager of PHM/Director of Care Management	PHMC Q1 02/29/2024 Q2 05/16/2024 Q3 08/15/2024 Q4 11/21/2024	MC,OC	X			
Program Oversight		2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Manager of Customer Service	TBD	QIHEC	MC, OC	X			
Program Oversight		**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of PHM	TBD	QIHEC		**New**			
Program Oversight		**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	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Manager of Quality Improvement	Manager of Quality Improvement	QIHEC	MC,OC	X			
Program Oversight		**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.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Grievance and Appeals	Manager of GARS	QIHEC	MC,OC	X			
Program Oversight		**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health'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. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	QIHEC	MC,OC	X			
Program Oversight		**Utilization Management Committee (UMC) Oversight** - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. **P&T and BMSC** reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Utilization Management	Manager of UM	QIHEC	MC,OC	X			
Program Oversight		**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	WCM CAC report to QIHEC: Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Whole Child Model Medical Director / Director of Case Management	Program Assistant QI	QIHEC	MC,OC	X			
Program Oversight		Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Care Management	TBD	PHMC Q1 02/29/2024 Q2 05/16/2024 Q3 08/15/2024 Q4 11/21/2024		**New**			
Program Oversight		Delegation Oversight	Implement annual oversight and performance monitoring for delegated activites.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accredication standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Audit and Oversight	TBD	QIHEC		**New**			
Program Oversight		Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Director of PHM	TBD	PHMC Q1 02/29/2024 Q2 05/16/2024 Q3 08/15/2024 Q4 11/21/2024		**New**			
Program Oversight		Health Education	Implement Health Education Program	Report on the following activities: Evaluation of current utilization of health education services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Director of PHM/Manager of Health Education	TBD	PHMC Q1 02/29/2024 Q2 05/16/2024 Q3 08/15/2024 Q4 11/21/2024		**New**			
Program Oversight		Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Director of PHM	Manager of PHM	PHMC Q1 02/29/2024 Q2 05/16/2024 Q3 08/15/2024 Q4 11/21/2024	MC,OC	x			
Program Oversight		Long-Term Support Services (LTSS)	Implement LTSS	Report on the following activities: Evaluation of current utilization of LTSS Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from UMC to QIHEC Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of LTSS	TBD	UMC		**New**			

2024 Quality Improvement and Health Equity Transformation Program Work Plan

Evaluation Category	Evaluation Sub-category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Report to Committee	LOB	Continue Monitoring from 2023	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 - Caution Green - On Target
Program Oversight		National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024	Program Manger of QI	Director of Quality Improvement	QIHEC	MC	X			
Program Oversight	Chronic Conditions	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024	Director of Medicare Stars and Quality Initiatives	Manager of QA	QIHEC		X			
Program Oversight		Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024	Manager of Quality Analytics	TBD	QIHEC	MC, OC	X			
Program Oversight		Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024	Director of Quality Analytics	TBD	QIHEC	MC, OC	X			
Program Oversight		School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024	Director of Behavioral Health Integration	Project Manager BHI	QIHEC	MC	X			
Program Oversight	Adult Wellness	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024	Director of PHM	Manager of PHM	QIHEC	MC, OC	X			
Quality of Clinical Care	Adult Wellness	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	QIHEC	MC	X			
Quality of Clinical Care	Behavioral Health	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collabortively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second qualer. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC	X			
Quality of Clinical Care	Behavioral Health	Health Equity/Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	TBD	QIHEC		New			
Quality of Clinical Care	Behavioral Health	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primay Care Providers (PCP) for members in need of merabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC	X			
Quality of Clinical Care	Behavioral Health	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	TBD	QIHEC		New			
Quality of Clinical Care	Behavioral Health	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	TBD	QIHEC		New			
Quality of Clinical Care	Behavioral Health	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%, 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC	X			
Quality of Clinical Care	Behavioral Health	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collabortively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC, OC	X			
Quality of Clinical Care	Behavioral Health	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Helath community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC	X			

2024 Quality Improvement and Health Equity Transformation Program Work Plan

Evaluation Category	Evaluation Sub-category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Report to Committee	LOB	Continue Monitoring from 2023	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 - Caution Green - On Target
Quality of Clinical Care	Behavioral Health	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI *Field* Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC	X			
Quality of Clinical Care	Chronic Conditions	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	PHMC	MC,OC	X			
Quality of Clinical Care	Chronic Conditions	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	PHMC	MC,OC	X			
Quality of Clinical Care	Maternal Child Health	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 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) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	QIHEC	MC	X			
Quality of Clinical Care	Pediatric/Adolescent Wellness	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1)A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2)Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	QIHEC	MC	X			
Quality of Clinical Care	Pediatric/Adolescent Wellness	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	QIHEC	MC	X			
Quality of Clinical Care	Pediatric/Adolescent Wellness	Performance Improvement Projects (PIPs) Medi-Cal	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	QIHEC	MC,OC	X			
Quality of Clinical Care	Pediatric/Adolescent Wellness	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	QIHEC	MC	X			
Quality of Clinical Care	Quality Oversight	Encounter Data Review	Conduct regular review of encounter data submited by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 05/13/2024 Q4: 11/12/2024	Director of Finance	Manager of Finance	QIHEC	MC, OC	New			
Quality of Clinical Care	Quality Oversight	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update from CPRC to QIHEC Q1: 03/12/2024 Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director Quality Improvement	Manager Quality Improvement	CPRC		**New**			
Quality of Clinical Care	Quality Oversight	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q1: 03/12/2024 Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director Quality Improvement	Manager Quality Improvement	CPRC		**New**			
Quality of Clinical Care	Quality Oversight	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q1: 03/12/2024 Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director Quality Improvement	Manager Quality Improvement	CPRC		**New**			
Quality of Clinical Care	Quality Oversight	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Quality Improvement	Manager Quality Improvement	CPRC		**New**			

2024 Quality Improvement and Health Equity Transformation Program Work Plan

Evaluation Category	Evaluation Sub-category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Report to Committee	LOB	Continue Monitoring from 2023	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 - Caution Green - On Target
Quality of Clinical Care		Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	QIHEC	MC,OC	X			
Quality of Clinical Care		Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director Medical Management/Case Management	QI Nurse Specialist	QIHEC	OC	X			
Quality of Service	Access	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	1) Director of Provider Network 2) Director of Contracting	TBD	MEMX	MC,OC	X			
Quality of Service	Access	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely acces. 3) Continue to educate providers on timely acces standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Medicare Stars and Quality Initiatives	TBD	MEMX	MC,OC	X			
Quality of Service	Access	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC:	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst	MEMX	MC	X			
Quality of Service	Access	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Quarterly Report to QIHEC Q1 2024 Q2 2024 Q3 2024 Q4 2024	Director of PHM	Manager of PHM	QIHEC	MC	X			
Quality of Service	Access	Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards Maintain business for current programs Improve process for handling these services	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of Customer Service	Manager of Customer Service	QIHEC	MC, OC				
Quality of Service	Access	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q1: 03/12/2024 Q2: 06/11/2024	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	TBD	MEMx		**New**			
Quality of Service	Member Experience	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Medicare Stars and Quality Initiatives	Carol Matthews	MEMx/QIHEC		X			
Quality of Service	Member Experience	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of GARS	Manager of GARS	GARS	MC, OC	New			
Quality of Service		Customer Service	Implement customer service and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of Customer Service	TBD	QIHEC	MC, OC				
Safety of Clinical Care		Coordination of Care: Member movement across settings	Improve care coordination between the hospital and primary care physician (PCP) following patient discharge from an acute care setting	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Utilization Management	TBD	QIHEC		**New**			
Safety of Clinical Care		Coordination of Care: Member movement between practitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Case Management	TBD	QIHEC		**New**			
Safety of Clinical Care		Emergency Department Visits	Emergency Department Diversion Pilot Pilot has been implemented. In 2024 plan to expand the program to additional hospital partners.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q1: 03/12/ 2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of LTSS	Manager of LTSS	UMC	MC	X			
Safety of Clinical Care		Transitional Care Services (TCS)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving successful interactions for TCS high-risk members within 7 days of their discharge.	Assess and report the following activities: 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of UM, CM and LTSS	TBD	QIHEC	MC,OC	X			

2024

POPULATION HEALTH MANAGEMENT STRATEGY & WORK PLAN

Responsible Staff:

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PHM Oversight Responsibilities

INTRODUCTION

Agency Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. We believe that our members deserve the highest quality of care and service. To achieve this, CalOptima Health works in collaboration with members, providers, community stakeholders and government agencies guided by our mission and vision.

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.

Strategy Purpose

To meet the unique and comprehensive health needs of our members, CalOptima Health engaged with multidisciplinary care teams, community partners and stakeholders to co-create the Population Health Management (PHM) Strategy.

The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also shares our creative upstream approach to address social determinants of health (SDOH) and close gaps in care that lead to health disparities among our members.

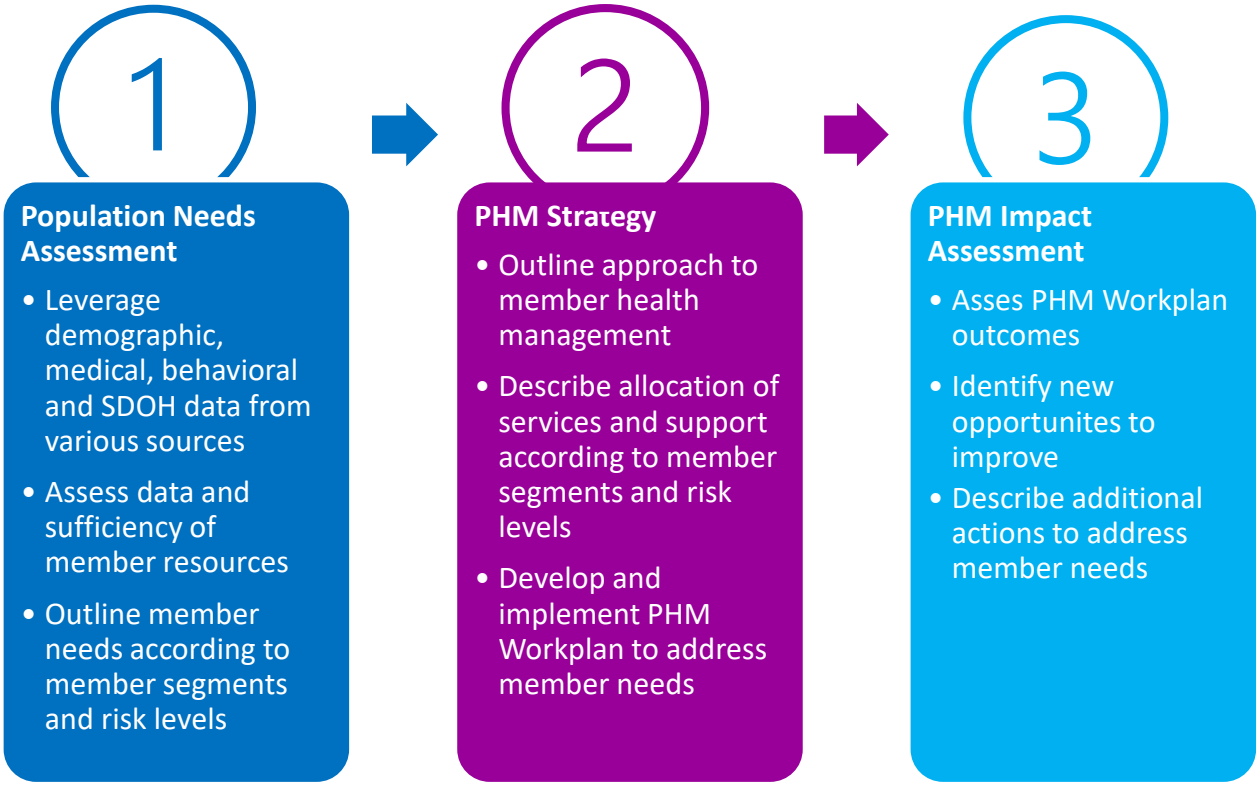
In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by the National Accreditation of Quality Assurance (NCQA).

CalOptima Health's PHM Strategy addresses the following areas of focus:

1. Keeping members healthy
2. Managing members with emerging risks
3. Member safety
4. Managing members with multiple chronic conditions

Strategic Management

To inform our PHM Strategy and programs, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies through a comprehensive PHM Workplan. The following diagram illustrates the relationship of these activities:



Population Needs Assessment

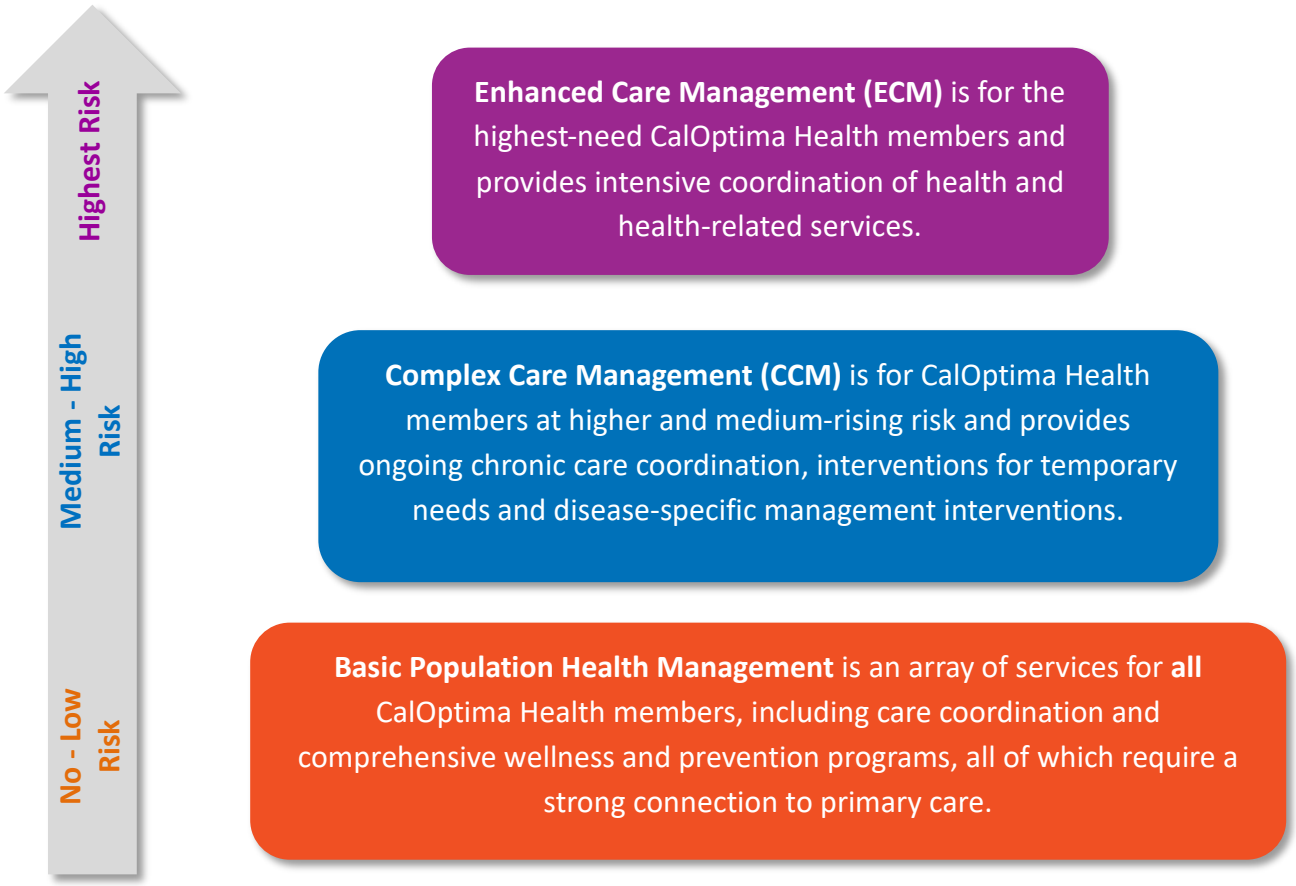
CalOptima Health's Population Needs Assessment (PNA) summarizes the results of an annual assessment on a variety of data. The intent of the PNA is to review the characteristics and needs of our agency's member population and relevant focus populations to support data-driven planning and decision-making. This report specifically focuses on CalOptima Health's:

- Overall member population, including SDOH
- Children and adolescent members ages 2–19 years old
- Members with disabilities
- Members with serious and persistent mental illness (SPMI)
- Members according to racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations

CalOptima Health uses PNA key findings to inform the PHM Strategy and Workplan which aim to address gaps in member care through intervention strategies and quality initiatives. Report findings also helped identify the need for process updates and resource allocation.

Population Segmentation and Care Coordination

CalOptima Health's PHM program aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner across the entire health care continuum and life span. The PHM program integrates physical health, behavioral health, long-term support services, care coordination and complex case management to improve coordination of care between managed care teams. The PHM program includes basic population health management, complex care management, Enhanced Care Management (ECM) and transitional care services.



PHM Strategy and Workplan

The following table provides a high-level overview of CalOptima Health's 2024 PHM Strategy and Workplan. This table shows how CalOptima Health aligns federal and state guidance with NCQA standards to guide our PHM Program efforts.

CalOptima Health 2024 PHM Workplan Overview

Area of Focus	Program/Service	Description
Keeping Members Healthy	**Blood Lead Testing in Children**	In babies and young children, whose brains are still developing, even a small amount of lead can cause learning disabilities and behavioral problems. CalOptima Health works with providers and members to ensure that all young children are tested for lead at age-appropriate intervals.
	Well-Child Visits	Well-child visits are important during the early months of a child's life to assess growth, development and identify and address any concerns early. CalOptima Health promotes preventive care for its youngest members to help them live long, happy and healthy lives.
	Health Disparity Remediation for Well-Child Visits	CalOptima Health aims to reduce the racial/ethnic disparities in well child visits in support of the statewide goals. Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate among African American child members has the potential to improve their overall health status.
	Childhood Immunizations	Childhood vaccinations are a safe and effective way to protect children from a variety of serious or potentially fatal diseases. CalOptima Health works to promote immunizations and ensure that children are healthy, growing and ready to learn.
	Comprehensive Community Cancer Screening and Support Program	CalOptima Health partnered with external stakeholders in the fight against cancer to launch this program. Together, we aim to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses through early screening.
	Bright Steps Program	CalOptima Health's prenatal and postpartum care program aims to inform and provide resources to pregnant members to help them have a healthy pregnancy, delivery and baby.
	Shape Your Life	CalOptima Health offers no-cost, in-person and virtual group classes for children ages 5 to 18 and their families. Topics include healthy eating, physical activity and other ways to build healthy habits.
Emerging Risk	**Chronic Condition Care and Self- Management Program**	CalOptima Health's programs promote self-management skills for people with chronic conditions to enable them to manage their health on a day-to-day basis and to take an active role in their health care.
Patient Safety	**CalAIM Community Supports**	California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers in accessing care. Community Supports are a core component of CalAIM.
	Street Medicine Program	CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's un-housed individuals and families through whole person care approaches and addressing social drivers of health.
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	CalOptima Health's program assesses the percentage of emergency department (ED) visits for members aged 6 and older with a principal diagnosis of alcohol and other drug abuse or dependence to ensure our members receive appropriate follow-up care.
Multiple Chronic Conditions	**Complex Case Management Program**	Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

NOTE: Please see CalOptima Health's 2024 PHM Workplan for a detailed list of programs and services, SMART objectives and related activities.

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PHM Program

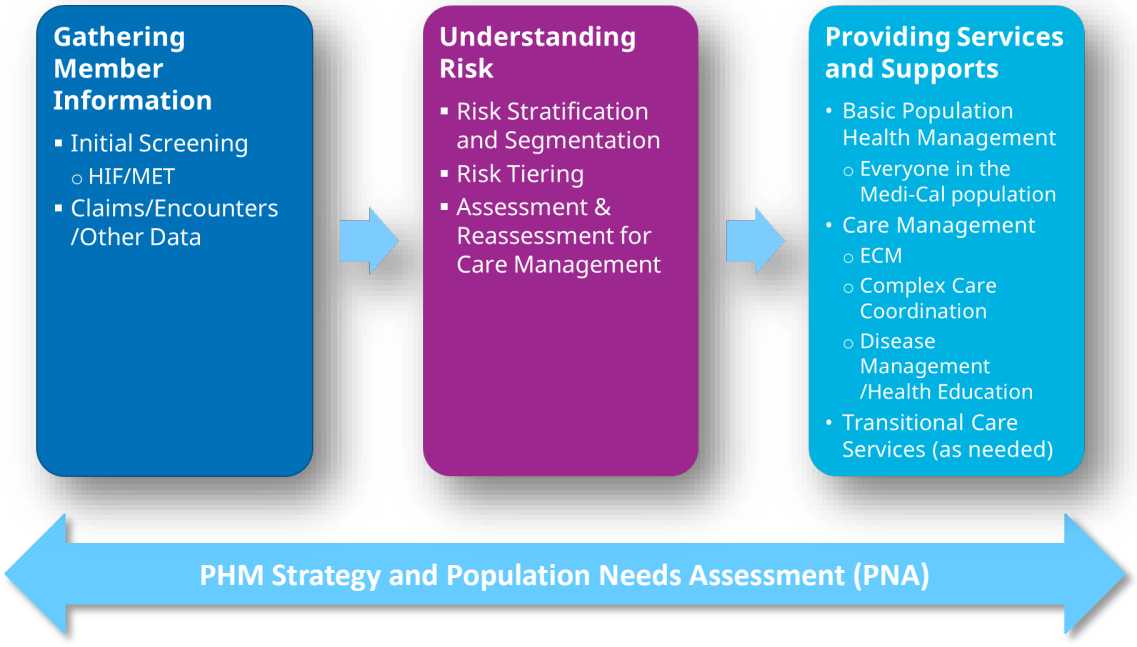
The PHM Strategy serves to guide CalOptima Health's PHM Program that aims to motivate, educate and empower members to become self-advocates in their healthcare, manage conditions, prevent acute episodes and enhance their quality of life. Our PHM Program and related services are also developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability. This is achieved by:

- Building trust and meaningful engagement with members.
- Using data-driven risk stratification and predictive analytics to address gaps in care.
- Revising and standardizing assessment processes.
- Providing care management services for all high-risk members.
- Creating robust transitional care services (TCS) to promote continuity of care and limit service disruptions.
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health.
- Implementing interventions to support health and wellness for all members.

PHM Framework

CalOptima Health adopted guiding principles of the PHM Framework to plan, implement and evaluate the PHM Program and our delivery of care. The diagram below outlines the key components used to operationalize the PHM Program, which includes:

- ***Population needs assessment and PHM Strategy*** that are used to measure health disparities and identify the health priorities and social needs of our member population, including cultural and linguistic, access and health education needs.
- ***Gathering member information*** on preferences, strengths and needs to connect every member to services at the individual level, and to allocate resources.
- ***Understanding risk*** to identifying opportunities for more efficient and effective interventions.
- ***Providing services and supports*** to address members needs across a continuum of care.



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PHM Program Coordination

CalOptima Health's PHM Program spans across several settings, providers and levels of care in an effort to meet our members' needs. To streamline PHM Program activities and avoid duplication, CalOptima Health utilizes a care management system to facilitate the coordination of care and data management for members among several care teams including:

- Behavioral Health Integration
- Case Management
- Long Term Care and Support
- Program of All-inclusive Care for the Elderly (PACE)
- Population Health Management
- Pharmacy
- Utilization Management

Through the agency's care management system, CalOptima Health can determine member eligibility for services, share data to identify and address care gaps, and coordinate care across settings. The system is available to all care team staff responsible for member care and enables them to:

- Create links between all systems that allow appropriate coordination of care and support delivered at the proper time, while minimizing duplication of effort between the coordinating teams.
- Access member records to expedite and view all relevant data in one location.
- Identifying member needs through established system logics or from providers and member self-referrals to plan an appropriate level of support whereby a staff (e.g., Personal Care Coordinator) is assigned to help the member with managing their health and social needs.
- Provide members with appropriate assessments and educational materials, derived from evidence-based tools and standardized practices.
- Create an individualized Care Plan with prioritized goals and facilitate services that minimize or eliminate barriers to care for optimal health outcomes.
- Inform Interdisciplinary Care Team (ICT) of member care needs, related activities and health goal progress.

Informing Members about PHM Programs

CalOptima Health deploys several interactive methods to inform members about PHM programs. These interactive methods are designed to share program eligibility and how to use program services. All PHM programs are voluntary. Based on members' language preferences, they are informed of various health promotion programs or how to contact care management staff via initial mailed Member Welcome Packet, member informing materials (e.g., newsletters, program/service letters, benefit manuals, etc.), CalOptima Health's member website, text messaging, personal phone outreach, robocalls and/or in person.

The following descriptions provide more details on how CalOptima Health's eligible members are informed about PHM programs:

- ***Eligibility to participate***: CalOptima Health's PHM programs are accessible to members from Medi-Cal and OneCare lines of business that meet the PHM program criteria. When a member has a referral into a PHM program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need.

- ***Use of services***: CalOptima Health provides instruction on how to use these services in multiple languages and with appropriate health literacy levels.
- ***Accepting or declining services:*** CalOptima Health honors member choice; hence, all the PHM programs are voluntary. Members can self-refer to any PHM program by contacting CalOptima Health. When CalOptima Health conducts outreach to eligible members identified through risk stratification or provider referral, members are informed that the program is voluntary, and they are able to opt-out at any time.

PHM Impact Assessment

CalOptima Health's annual PHM Impact assessment measures the effectiveness of the agency's PHM Strategy and related programs to address member care needs. Through this analysis, CalOptima Health also identifies and addresses opportunities for improvement. Specifically, the assessment focuses on the:

- Clinical impact of programs
- Cost and/or utilization impact of programs
- Member experience with programs

CalOptima Health uses key performance indicators (e.g., primary care, ambulatory care, emergency department visit, inpatient utilization) and quality measures (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®]) to assess the effectiveness of the PHM program and adjust it to meet the needs of our members. The PHM Impact findings are shared with our care management team, stakeholders and regulatory agencies at least annually.

PROMOTING HEALTH EQUITY

CalOptima Health is working to advance health equity throughout our strategic management process to ensure that PHM programs and services support our members in attaining their highest level of health. Health equity is not something that a person can do for themselves. It requires commitment from community, healthcare organizations and governments to remove obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with a living wage, quality education and housing, safe environments and health care. In response, CalOptima Health has prioritized health equity so that all members are empowered and able to access resources to be as healthy as possible, regardless of background and identity. In 2022, CalOptima Health launched an organization-wide Equity Initiative, with focus areas in:

- Health equity and SDOH
- Communications and narrative change
- Diversity, equity and inclusion for CalOptima Health workforce
- Stakeholder engagement

To meet the needs of members who are impacted by the greatest health inequities, CalOptima Health has develop a roadmap to meet the following overarching goals:

- Make an explicit commitment to advance health equity to internal and external stakeholders.
- Identify existing and needed organizational assets, resources and leadership.
- Measure health inequities and identify impactful strategies focused on SDOH.
- Implement short- and long-term strategies at the member, organizational and community level.
- Enhance data collection, shared lessons and expanded capacity.

CalOptima Health has operationalized our health equity efforts through a broad range of programs and services.

Social Determinants of Health

To guide our effort in healthy equity, CalOptima Health developed the Member Risk Dashboard to help us understand the impact that SDOH has on our members. This dashboard is informed by the Chronic Illness and Disability Payment System (CDPS) + Rx risk model which assigns a risk score to each member using diagnosis codes from claims and encounters plus pharmacy data to help assess the effective disease burden a population may face. The Member Risk Dashboard can overlay risk with several different factors (e.g., gender, ethnicity, age, health conditions, SDOH factors, etc.) to stratify and segment members. Furthermore, the SDOH data collected using diagnosis codes present on claims and encounters is categorized as follows:

- Adverse family events
- Criminal justice involved
- Housing instability
- Indications of extreme poverty
- Psychosocial circumstances

Among the different features available through this dashboard are the SDOH Profile and SDOH Comparison. The SDOH Profile provides an overview of how SDOH factors impact CalOptima Health members. The SDOH Comparison is used to compare health metrics between SDOH categories such as:

- Condition prevalence
- Hospital readmissions
- Emergency room visits
- Dental visits
- Uncontrolled A1c
- Unused authorizations

The Member Risk Dashboard serves to highlight CalOptima Health's current efforts to better identify and address the health disparities seen in our member population that are caused by SDOH. CalOptima Health plans to continue enhancing our understanding of the impact that SDOH has on our members through the expansion of data collection efforts and community engagement.

ACTIVITIES AND RESOURCES

CalOptima Health recognizes the importance of mobilizing multiple resources to support our members' health needs. At least annually, CalOptima Health conducts a strategic review of existing structures, programs, activities and resources using its PNA and dashboards. This strategic assessment helps CalOptima Health leaders set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity and proactively mitigate emerging risks. Please see the annual PNA Report for details of this review and a description of the activities and resources supported by CalOptima Health.

In addition, CalOptima Health describes activities that are designed to support the PHM Strategy, including activities not directed at individual members, in our PHM Workplan. Indirect member activities apply to multiple areas of focus to and include:

- Building partnerships with community-based organizations, local health care agencies, hospitals and clinics, universities and more to streamline efforts and leverage resources.
- Developing toolkits and resources to support health network providers and community partners.
- Conducting improvement projects (e.g., Plan, Do, Study, Act (PDSA) and Performance Improvement Projects (PIP)) to address health disparities.
- Investing in community implementation and expansion efforts to support PHM programs and services.
- Regularly sharing guidance and information relevant to members with staff, providers and stakeholders using multimodal communication strategies (e.g., newsletters, web portals, meetings, etc.)
- Exchanging data between CalOptima Health and supporting health entities (e.g., Health Network providers, local health agencies, etc.)
- Facilitating continuous education, training and professional development opportunities for staff and providers.

DELIVERY SYSTEM SUPPORTS

Providers and practitioners play an integral role in helping CalOptima Health members meet their highest level of health. Therefore, CalOptima Health works intentionally and collaboratively to support our provider and practitioner community to fulfill PHM goals. CalOptima Health offers ongoing support to providers and practitioners in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids, continuing education sessions and providing comparative quality and cost information. These supports are described below:

Information Sharing

CalOptima Health provides member-level prospective rates (or gaps in care) reports for providers on a monthly basis to support preventive care outreach and engagement. CalOptima Health will continue to improve information sharing using integrated and actionable data. Additionally, CalOptima Health facilitates ongoing collaboration and open lines of communication regarding member health outcomes through quarterly Joint Operations Meetings and quarterly Health Network Forums to discuss strategies, barriers and opportunities for improvement.

Shared Decision-Making Aids

CalOptima Health aligns decision-making aids with our clinical practice guidelines to promote shared decision making among providers and their members. These are approved by CalOptima Health's Quality Improvement Committees, posted to CalOptima Health's provider website and promoted through our providers newsletters. Shared Decision-Making Aid topics include:

- Cardiac Conditions
- Treatment for Opioid Use Disorder
- Diabetes Medication Choice
- Heart Disease
- Hypertension
- Treatment for Kidney Failure

Transformation Support

CalOptima Health's Orange County Population Health and Transition to Value-Based Care Initiative (PHVBC) aims to support participating health centers and their providers in transforming access to quality of care while strengthening the safety net system across OC. Over the course of five years, teams from local community clinics will advance their internal systems and implement projects that strengthen their population health capacities and readiness for high-quality and value-based care with the incentives provided by the $50 million PHVBC initiative. Activities will focus on advancing population and community supports (i.e., advocating for support, expanding access to coverage and quality of care) provided to disproportionately impacted communities in Orange County; ultimately, shifting from the idea that the volume of services rendered can serve as a proxy for better health outcomes to a value- and team-based model of care that focuses on the whole person.

The Institute for High Quality Care (IHCQ) will provide technical assistance throughout the initiative, and the Center for Community Health and Evaluation (CCHE) will be the initiative evaluator. Furthermore, the IHCQ will provide a variety of technical assistance to support participating teams throughout the initiative, including training, topic-specific working groups, coaching and curating best

practices and other resources. These supports will be designed and tailored on the PHVBC health centers' specific project and areas of interest and/or need.

CalOptima Health will use the provider profiles to identify practitioners, organizations or communities that do not meet accepted standards of care. Profiling can be used to evaluate both the overuse and underuse of appropriate services. This will help them transform their practices to be more quality and outcome focused. CalOptima Health will use the profiles as a mechanism to administer its financial incentives program for providers to improve quality. The incentives are designed to support practitioners with the necessary funding so they can focus more on care coordination and preventive care. It will provide clinics with the resources to bring on additional staff that can coordinate member care across the spectrum of providers. CalOptima Health will establish goals for providers that align with the quality improvement goals to focus on high priority measures.

Training on Equity, Cultural Competency, Bias, Diversity and Inclusion

CalOptima Health's Cultural Competency training is required for all health care providers and staff who care for our members. The training is available on CalOptima Health's website for providers to complete. The training provides an overview of CalOptima Health's diverse membership, helps providers identify members with potential cultural or language needs where alternate communication methods are needed, and ensures that persons interacting with CalOptima Health members understand how culture and language may influence health.

Pay for Value (P4V)

CalOptima Health's Pay for Value (P4V) program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks and CalOptima Health Community Network (CCN) PCPs are eligible to participate in the P4V programs.

The purpose of CalOptima Health's P4V program is to:

1. Recognize and reward health networks and their physicians for demonstrating quality performance;
2. Provide comparative performance information for members, providers and the public on CalOptima Health's performance; and
3. Provide industry benchmarks and data-driven feedback to health networks and physicians on their quality improvement efforts.

The Medi-Cal P4V program incentivizes performance on all HEDIS® measures that are included in the DHCS Managed Care Accountability Sets (MCAS) required to achieve a minimum performance levels (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures.

PHM Structure

PHM operations at CalOptima Health are supported by a leadership team, allied health professionals and administrative staff. PHM assumes responsibility for health education and disease management programs for all CalOptima Health members. In addition, PHM oversees the strategic management efforts including the identification the health and wellness needs of CalOptima Health members and aligning

organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. The following is a description of PHM team roles and responsibility.

Team Roles and Responsibilities

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the PHM Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members, including Population Health Management. At least quarterly, the CMO presents reports on PHM activities to the Board of Directors' Quality Assurance Committee.

Chief Health Equity Officer (CHEO) leads the development and implementation of health equity as a core competency through collaboration with leaders across CalOptima Health and serves as the voice and content expert on health equity for CalOptima Health's members, affiliates and partners, providing strategic direction around clinical interventions, benefit design, engagement strategies and participates in testing and evaluation initiatives.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Population Health Management (PHM), Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Population Health Management (ED PHM) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO) and Executive Directors from Behavioral Health, Quality, and Clinical Operations Departments, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Clinical Operations functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the Executive Director of Quality and Population Health Management.

Executive Director, Quality (ED QI) is responsible for facilitating the companywide QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Credentialing.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for the management and oversight of CalOptima's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Medical Director, Population Health Management and Equity is responsible for advancing population-wide health and well-being for CalOptima Health members by providing clinical guidance for PHM strategies and programs, conducting staff and provider trainings on relevant PHM issues, reviewing and approving health education materials, group class curricula, clinical practice guidelines, shared decision-making aids, and consulting on individual member cases within PHM programs.

Director, Population Health Management (PHM Director) is responsible for advancing population-wide health and well-being for CalOptima Health members by coordinating the development and implementation of a comprehensive population health management plan and health equity framework aligned with the organization's strategic goals. PHM Director provides oversight and supervision of staff to monitor the implement organization-wide population health initiatives amongst internal departments, contracted providers health networks and external stakeholders aligned with CalOptima's overall mission and strategic goals. The PHM Director ensures that the department meets ongoing regulatory compliance and accreditation standards. PHM Director plays a key leadership role, interacting with all levels of CalOptima staff and external stakeholders to implement programs and Quality Improvement (QI) processes that improve cost savings, quality outcomes and member and provider satisfaction.

The following staff support the implementation of strategies within the Population Health Management department:

Managers, Population Health Management (PHM Managers) in Health Education, Disease Management, Maternal Health and Strategic Initiatives:

- Assist with the development of PHM goals and program priorities.
- Analyze best practices for population management and generating ideas to improve operational efficiency within the department.
- Oversee processes to ensure all regulatory requirements are met and exceed all standards.

Supervisors, Population Health Management (PHM Supervisors) in Health Education and Disease Management:

- Provide guidance and support for the implementation of special projects and pilots, or directly handling complex PHM requests from members, providers or staff.

- Monitor staff goals and productivity.
- Ensure compliance with cultural and linguistic requirements and processes, desktop procedures, organizational policies or contractual requirements.

Program Managers, Population Health Management (PHM Program Managers) in strategic initiatives:

- Develop cross-agency workstreams to meet standards in population health as outlined by regulatory entities, strategic priorities and Board directives.
- Plan, implementing and/or evaluating new interventions, programs and interventions.
  Keep current on the local, state, and federal healthcare environment, identifying issues that may impact CalOptima's medical management programs.

Health Educator, Population Health Management (PHM HEs) team:

- Provides health education coaching to individuals or group classes using a member-centric approach.
- Prepares written materials for distribution to members in the appropriate formats and literacy levels as needed.
- Delivers health education interventions through various methods and techniques that are effective to CalOptima Health's members.

Health Coaches, Population Health Management (PHM HCs) team:

- Assesses and develops self-management plans for CalOptima Health members benefiting from chronic condition management, nutrition management and/or psychosocial support.
- Shares the member's specific self-management goals, progress and other pertinent information with their health care team to ensure consistency of member goals.
- Monitors member's health condition and self-management goal outcomes.

Registered Dietitians, Population Health Management (PHM RDs) team:

- Provides individual nutrition assessments, counseling and education by phone or in person using a patient-centered approach.
- Develops nutrition education materials to promote prevention, management of chronic illness and healthy living.
- Works closely with other departments and medical support staff to assist with member care planning.

Personal Care C*oordinators*, *Population Health Management (PHM PCCs)* team:

- Provides outreach to members to coordinate completion of trimester specific assessments including postpartum following CPSP protocols.
- Collaborates with licensed professionals in the development of an initial care plan for each member, incorporating all assessment findings.
- Facilitates warm transfers to member's assigned case manager in accordance with member needs, when appropriate. Notifies member's care team of key event triggers.

Program Coordinator, Population Health Management (PHM PC):

- Provides analytical support to Population Health Management functions, including program development, evaluation and targeted initiatives.
- Manages department calendar by updating and bringing awareness to upcoming milestones and events.
- Acts as administrative support for company-wide and department-specific projects, such as generating reports and maintaining the department's tracking logs, including, but not limited to, action items and executive briefs.

Program Specialists*, Population Health Management (PHM PS)* team:

- Participates in cross-functional teams responsible for the identification, implementation and evaluation of health education activities.
- Supports management in the development, running and evaluation of new population-based disease management programs that support department initiatives.
- Supports management by developing and/or overseeing the process of written tools for programmatic use including program plans, surveys and evaluation instruments.

PHM Oversight

CalOptima Health strives to ensure that PHM strategic management processes are co-created, monitored and evaluated with input from members, providers, stakeholders and leadership. This helps ensure that all PHM programs and services are informed by multidisciplinary experts and approved through careful leadership consideration. The following description provides a high-level summary of our PHM strategic management oversight process.

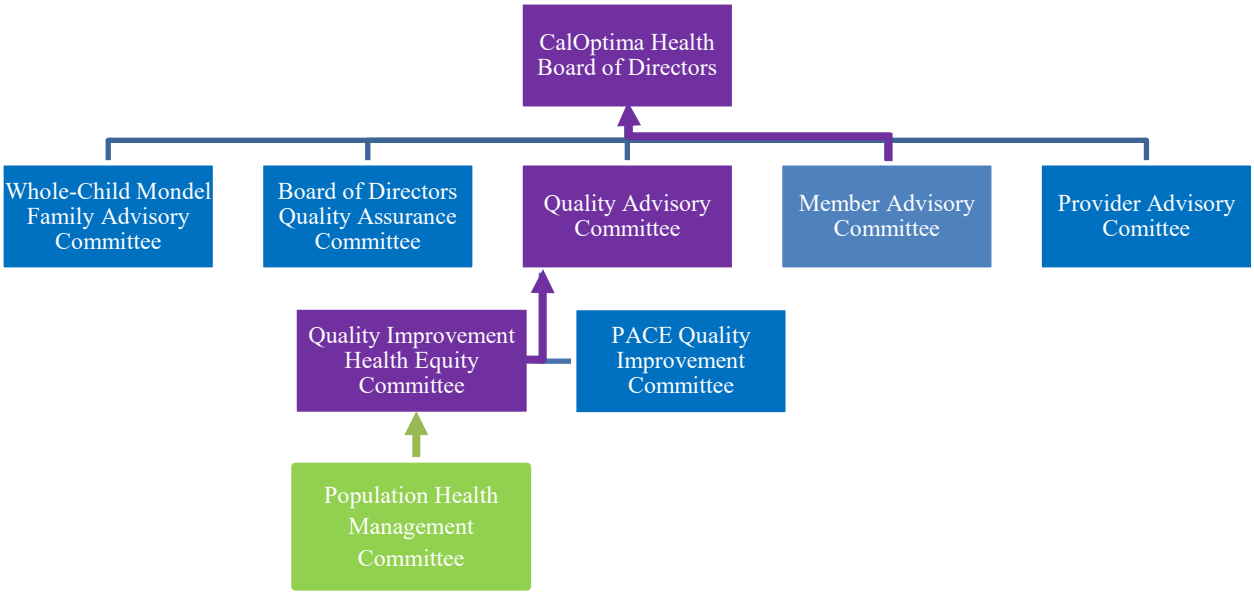
PHM Oversight Responsibilities

Dedicated staff from PHM, in collaboration with other multidisciplinary work teams throughout the agency and guidance from CalOptima Health leadership, assess service utilization patterns, disease burden and SDOH factors to identify gaps in member care. This comprehensive assessment is summarized in an annual PNA. Key findings of the PNA are shared with CalOptima Health's Member Advisory Committee, multidisciplinary care teams and stakeholders to propose new interventions to overcome member gaps in care. Proposed interventions are reviewed by Population Health Management Committee (PHMC) and documented as part of the annual PHM Strategy and Workplan proposals. The PHM Strategy and Workplan proposals are presented to the Quality Improvement Health Equity Committee (QIHEC) for approval. CalOptima Health's QIHEC reports summarize approved PHM Strategy and Workplans to the Board of Director's Quality Assurance Committee (QAC).

Committee Approval Descriptions

The diagram below illustrates the pathway of approval and oversight of the PHM Strategic Management activities along with committee descriptions.

PHM Approval Diagram



Population Health Management Committee (PHMC)

The purpose of the PHMC is to provide overall direction for continuous process improvement and oversight of the PHM Program; ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities; and monitor compliance with regulatory requirements.

Quality Improvement Health Equity Committee (QIHEC)

The purpose of the QIHEC is to assure that all quality improvement activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members.

Board of Directors' Quality Assurance Committee (QAC)

The QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations.

CalOptima Health Board of Directors

The Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima Health's state and federal contracts — and to CalOptima Health's CEO.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

MY 2024 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the Medi-Cal P4V program.

Recommended for MY 2024 Medi-Cal P4V

1. Include measures held to an MPL in the MY2024 MCAS measure set.

MY 2024 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Chlamydia Screening in Women
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Postpartum Care
Child and Adolescent Well-Care Visits	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	CAHPS- Rating of Health Plan: Adult and Child
Lead Screening in Children	CAHPS- Rating of Health Care: Adult and Child
Topical Fluoride in Children	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Getting Needed Care: Adult and Child
Asthma Medication Ratio	CAHPS- Getting Care Quickly: Adult and Child
Controlling High Blood Pressure*	CAHPS- Coordination of Care: Adult and Child
Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) lower is better*	

   - Utilize both Child and Adult CAHPS scores.
     - To calculate performance, average scores
2. Maintain program funding methodology at ten percent (10%) of professional capitation (base rate only).
3. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

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Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS measures weighted 1.0
  - CAHPS measures weighted 1.5
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

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Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on areas with the greatest opportunity for improvement and incentivizes performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

1. Utilize the following CMS Star Part C and Part D measures, measure weights, and Star thresholds as benchmarks:

Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
	Rating of Drug Plan
	Getting Needed Prescription Drugs

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS process measures weighted 1.0
  - CAHPS measures weighted 2.0
  - Outcome measures weighted 3.0
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

3. Apply a program funding methodology of $20 PMPM

2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

EFFECTIVE DATE: JANUARY 1, 2024 TO DECEMBER 31, 2024

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2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM SIGNATURE PAGE

Quality Improvement and Health Equity Committee Chairperson:

_____ _____

Richard Pitts, D.O., Ph.D. **Date**
CalOptima Health Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. **Date**

Board of Directors Chairperson:

_____ _____

Clayton M. Corwin **Date**

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CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

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 (SDOH).

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.



Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2022–2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in June 2022. Our core strategy is the "inter-agency" co-creation of services and programs, together with our delegated networks, providers and community partners, to support the mission and vision.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

CalOptima Health aligns our strategic plan with the priorities of our federal and state regulators.

Centers for Medicare & Medicaid Services (CMS) National Quality Strategy

The CMS national quality strategy aims to set and raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity and accessibility for all individuals, especially for people in historically underserved and under-resourced communities. The strategy focuses on a person-centric approach from birth to end of life as individuals journey across the continuum of care, from home or community-based settings to hospital to post-acute care, and across payer types, including Traditional Medicare, Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP) and Marketplace coverage.

Quality Mission: To achieve optimal health and well-being for all individuals.

Quality Vision: As a trusted partner, shape a resilient, high-value American health care system to achieve high-quality, safe, equitable and accessible care for all.

CMS National Quality Strategy has four priority areas, each with two goals.

1. Outcomes and Alignment
    a. Outcomes: Improve quality and health outcomes across the care journey.
    b. Alignment: Align and coordinate across programs and settings.
2. Equity and Engagement
    a. Advance health equity and whole-person care.
    b. Engage individuals and communities to become partners in their care.
3. Safety and Resiliency
    a. Safety: Achieve zero preventable harm.
    b. Resiliency: Enable a responsive and resilient health care system to improve quality.
4. Interoperability and Scientific Advancement
    a. Interoperability: Accelerate and support the transition to a digital and data-driven health care system.
    b. Scientific Advancement: Transform health care using science, analytics and technology.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 CQS lays out DHCS' quality and health equity strategy that leverages a whole-system, person-centered, and population health approach to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and emphasize DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

CQS outlines specific clinical goals across the Medi-Cal program. Centered on specific clinical focus areas, the CQS introduces DHCS' Bold Goals: 50x2025 initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025.

Bold Goals: 50x2025:

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow-up for mental health and substance disorder by 50%
- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

DHCS recognizes that inequities are embedded within our health care system. DHCS has developed a Health Equity Framework to identify, catalog and eliminate health disparities through:

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

SDOH are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptima Health's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive readiness assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.



Program Structure

"Better. Together." Is CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's single largest health insurer, we provide coverage through three major programs:

Medi-Cal

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Health Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019.

CalOptima Health provides Enhanced Care Management (ECM) and all 14 Community Supports to address social drivers of health and assist members with finding stable or safe housing, accessing healthy food, transitioning back to home or getting support in the home.

Certain services are not covered by CalOptima Health but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (OCHCA)
- Substance use disorder services are administered by OCHCA
- Dental services are provided through the Medi-Cal Dental Program

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs, such as seniors, people with disabilities and people with chronic conditions, CalOptima Health has developed specialized care management (CM) services. These care management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high-risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with

certain community agencies, including OCHCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

On July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members. CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS includes both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

These integrated LTSS benefits include the following programs:

- In-Home Supportive Services (IHSS): IHSS provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care and enables members to remain safely in their own homes.

- Nursing Facility Services for Long-Term Care: CalOptima Health LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B and Subacute levels of care. CalOptima Health LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

- Community-Based Adult Services (CBAS): CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CalOptima Health LTSS monitors the levels of member access to, utilization of and satisfaction with CBAS.

- Multipurpose Senior Services Program (MSSP): Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid institutionalization. CalOptima Health LTSS monitors the level of member access to MSSP as well as its role in diverting members from institutionalization.

OneCare (HMO D-SNP)

Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for them to get the health care they need. Since 2005, CalOptima Health has been offering OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OneCare has extensive experience serving the complex needs of frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must be age 21 or older, live in Orange County and be eligible for both Medicare and Medi-Cal. Enrollment in OneCare is voluntary and by member choice.

Scope of Services

OneCare provides comprehensive services for dual eligible members enrolled in Medi-Cal and Medicare Parts A, B and D. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures, including Part C, Part D and CMS Star measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, OneCare members are eligible for supplemental benefits, such as gym memberships.

Program of All-Inclusive Care for the Elderly (PACE)

CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

PACE combines health care and adult day care for people with multiple chronic conditions. These can be offered in the member's home, in the community or at the CalOptima Health PACE Center:

1. Routine medical care, including specialist care
2. Prescribed drugs and lab tests
3. Personal care for things like bathing, dressing and light chores
4. Recreation and social activities
5. Nutritious meals
6. Social services
7. Rides to health-related appointments, and to and from the program
8. Hospital care and emergency services

PACE maintains a separate PACE Quality Improvement Program, work plan and evaluation.

Provider Partners

Providers have options for participating in CalOptima Health's programs to provide health care to CalOptima Health members. Providers can contract directly with CalOptima Health through CalOptima Health Direct, which consists of CalOptima Health Direct-Administrative and CalOptima Health Community Network (CCN). Providers also have the option to contract directly with a CalOptima Health Health Network (HN). CalOptima Health members can choose CCN or one of nine HNs representing more than 8,000 providers.

CalOptima Health Direct (COD)

CalOptima Health Direct has two elements: CalOptima Health Direct-Administrative and CCN.

CalOptima Health Direct-Administrative (COD-A)

COD-A is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in OneCare), share-of-cost members, newly eligible members transitioning to a HN and members residing outside of Orange County.

CalOptima Health Community Network (CCN)

CCN doctors have an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to more than 1,200 Primary Care Providers (PCPs), more than 9,000 specialists, 43 acute and rehabilitative hospitals, 52 community health centers and 106 long-term care facilities.

CalOptima Health contracts with the following HNs:

Health Network	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI Care Medical Group	PHC	PHC
CHOC Health Alliance	PHC	-
Family Choice Medical Group	HMO	SRG
HPN-Regal Medical Group	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Optum Care Network	HMO	HMO
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG

CalOptima Health contracts with vendors that provide benefits for our members. These vendors are responsible for maintaining a contracted network of providers, coordinating services and providing direct services. They may also be delegated for plan functions.

Vendor	Medi-Cal	OneCare
Vision Service Plan	VS	VS
MedImpact	-	PBM

HMO=Health Maintenance Organization; PHC=Physician/Hospital Consortium; SRG=Shared-Risk Group; VS=Vision Service; PBM=Pharmacy Benefit Manager

Upon successful completion of readiness reviews and audits, contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex care management
- Claims
- Credentialing

Membership Demographics

Membership Data* (as of November 30, 2023)

Total CalOptima Health Membership

963,968

Program	Members
Medi-Cal	945,874
OneCare (HMO D-SNP)	17,648
Program of All -Inclusive Care for the Elderly (PACE)	446

*Based on unaudited financial report and includes prior period adjustment

Membership Demographics (as of November 30, 2023)

Member Age

0 to 5	8%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65+	13%

Language Preference

English	58%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category

Temporary Assistance for Needy Families	39%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Quality Improvement and Health Equity Transformation Program (QIHETP)

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and quality of service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members.

CalOptima Health developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and subacute care to long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, special health care needs and chronic illnesses.

CalOptima Health's QIHETP includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

CalOptima Health is committed to promoting diversity in practices throughout the organization, including Human Resources best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.

Quality Improvement and Health Equity Transformation Program (QIHETP) Purpose

The purpose of the CalOptima Health QIHETP is to establish objective methods for systematically evaluating and improving the quality of care provided to members. Through the QIHETP, and in collaboration with providers and community partners, CalOptima Health strives to continuously improve the structure, processes and outcomes of the health care delivery system to serve members. We aim to identify health inequities and to develop structures and processes to reduce disparities, ensuring that all members receive equitable and timely access to care.

CalOptima Health applies the principles of continuous quality improvement (CQI) to all aspects of service delivery system through analysis, evaluation and systematic enhancements of the following:

- Quantitative and qualitative data collection and data-driven decision-making
- Up-to-date evidence-based practice guidelines
- Feedback provided by members and providers in the design, planning and implementation of CQI activities
- And other issues identified by CalOptima Health or its regulators

The CalOptima Health QIHETP incorporates the CQI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima Health's multiple customers and

stakeholders (members, health care providers, community-based organizations and government agencies). The QIHETP is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima Health's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on quality improvement and health equity activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe care and experiences.

- Maintain organizationwide practices that support health plan and health equity accreditation by National Committee for Quality Assurance (NCQA) and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QIHETP's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess and improve the quality of the organization's governance, management, delivery system and support processes.

- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers. Recommending delivery system reform to ensure high quality and equitable health care.

- Monitoring quality of care and services from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

- Ensuring contracted facilities, as required by federal and state laws, report to OCHCA outbreaks of conditions and/or diseases, which may include but are not limited to methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, and since 2020, COVID-19.

- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers (OPs) to ensure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement and health equity culture at CalOptima Health.

- Ensure the annual review and acceptance of the UM CM Program Description, UM CM Evaluation Population Health Programs, including the Population Health Strategy and Work Plans.

- Provide operational support and oversight to a member-centric Population Health Management (PHM) Program.

In collaboration with the Compliance Audit & Oversight departments, the QIHETP ensures the following standards or outcomes are carried out and achieved by CalOptima Health's contracted HNs, including CCN and/or COD network providers serving CalOptima Health's various populations:

- Support the organization's strategic quality and business goals by using resources appropriately, effectively and efficiently.
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- Identify in a timely manner the important clinical and service issues facing the Medi-Cal and OneCare populations relevant to their demographics, risks, disease profiles for both acute and chronic illnesses, and preventive care.
- Ensure continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities.
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- Ensure the reliability of risk prevention and risk management processes.
- Ensure compliance with regulatory agencies and accreditation standards.
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.
- Promote the effectiveness and efficiency of internal operations.
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima Health's strategic direction in support of its mission, vision and values.
- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based practice.

Authority and Accountability

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement and Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QIHETP annually.

The QIHETP is based on ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QIHETP in alignment with federal and state regulations, contractual obligations, and fiscal parameters.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity contractual and regulatory standards and the DHCS Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Member Advisory Committee

CalOptima Health is committed to member-focused care through member and community engagement. The Member Advisory Committee (MAC) has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on

community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- Medi-Cal beneficiaries or Authorized Family Members (two seats)
- Member Advocate
- County of Orange Social Services Agency (OC SSA)
- OneCare Member or Authorized Family Members (four seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 17 positions, held by OCSSA, is a standing seat. Each of the remaining 16 appointed members may serve two consecutive three-year terms.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OCHCA, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- OCHCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

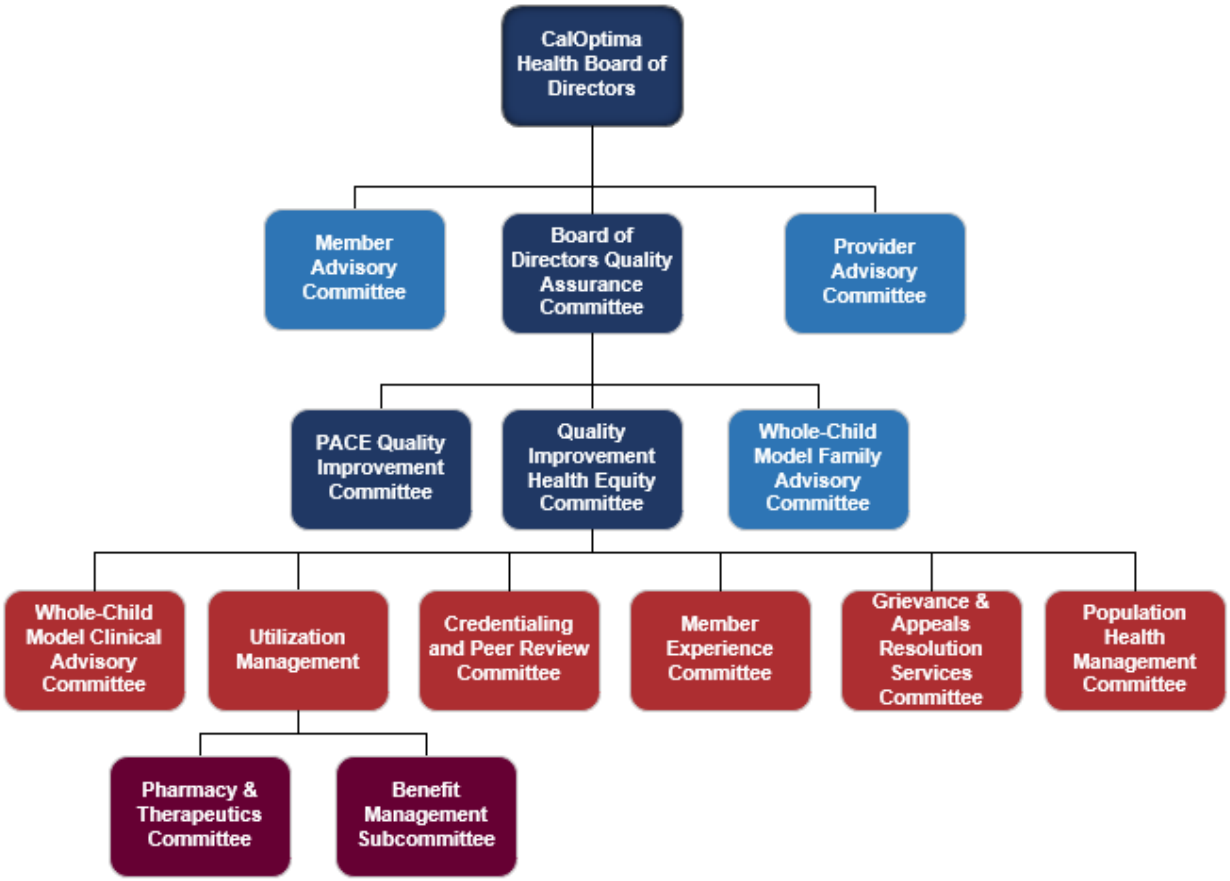
- Family representatives (nine seats)
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
    - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
    - Current CalOptima Health members over the age of 21 who transitioned from CCS services

- Interests of children representatives (two seats)
    - Community-based organizations; or
    - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC quarterly meetings are open to the public.

Quality Improvement and Health Equity Transformation Program Committee Structure

Quality Improvement and Health Equity Transformation Program Committee Organization Structure — Diagram



Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to assure that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

The composition of the QIHEC includes a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, subcontractors, downstream

subcontractors, community health workers, other non-clinical providers and members. The QIHEC participants are representative of the composition of the CalOptima Health's provider network and include, at a minimum, network providers who provide health care services to members affected by health disparities, Limited English Proficiency (LEP) members, children with special health care needs, Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. QIHEC participants are practitioners who are external to CalOptima Health, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, care review as needed, and identification of opportunities to improve care.

The QIHEC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima Health's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QIHETP projects, activities and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. Performance measurement and improvement activities and interventions are reviewed, approved, processed, monitored and reported through the QIHEC.

Responsibilities of the QIHEC include:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other quality committees
- Recommend policy decisions and priority alignment of the QIHETP subcommittees for effective operation and achievement of objectives
- Oversee the analysis and evaluation of QIHETP activities
- Ensure practitioner participation through attendance and discussion in the planning, design, implementation and review of QIHETP activities
- Identify, prioritize and institute needed actions and interventions to improve quality
- Ensure appropriate follow up of quality activities to determine the effectiveness of quality improvement-related actions and remediation of identified performance deficiencies.
- Monitor overall quality compliance for the organization to quickly resolve deficiencies that affect members
- Evaluate practice patterns of providers, practitioners and delegated HNs, including over/under utilization of physical and behavioral health care services
- Recommend practices so that all members receive medical and behavioral health care that meets CalOptima Health standards.

The QIHEC oversees and coordinates member outcome-related QIHE actions. Member outcome-related QIHE actions consist of well-defined, planned QIHE projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services. The QIHEC also recommends strategies for dissemination of all study results to CalOptima Health-contracted providers and practitioners, and delegated HNs.

The composition of the QIHEC is defined in the QIHEC charter and includes but is not limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- Orange County Behavioral Health Representative
- CalOptima Health Chief Medical Officer (Chair or Designee)
- CalOptima Health Chief Health Equity Officer (Chair or Designee)
- CalOptima Health Deputy Chief Medical Officer
- CalOptima Health Quality Improvement Medical Director
- CalOptima Health Behavioral Health Integration Medical Director
- CalOptima Health Medical Directors
- CalOptima Health Executive Director, Quality Improvement
- CalOptima Health Executive Director, Population Health Management
- CalOptima Health Executive Director, Behavioral Health Integration
- CalOptima Health Executive Director, Clinical Operations
- CalOptima Health Executive Director, Network Management
- CalOptima Health Executive Director, Operations

The QIHEC is supported by CalOptima Health departments including but not limited to:

- Behavioral Health Integration
- Care Management
- Long-Term Services and Supports
- Population Health Management
- Quality Analytics
- Quality Improvement
- Utilization Management
- Director, Customer Service
- Cultural and Linguistic Services

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person, by telephone or by video conference.

The QIHEC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

QIHEC and all QIHE subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of HE proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the QIHEC and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIHEC meeting include but are not limited to:

- Goals and objectives outlined in the QIHEC charter
- Active discussion and analysis of quality improvement and health equity activities, outcomes, and issues
- Reports from various committees and subcommittees
- Tracking and trending of quality outcomes
- Recommendations for improvement, actions and follow-up actions
- Monitoring of quality improvement and health equity activities of delegates
- Plans to disseminate QIHE information to network providers
- Tracking of QIHETP Work Plan activities

All agendas, minutes, reports and documents presented to the QIHEC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

The QIHEC provides to the QAC quarterly written progress reports of the QIHEC that describes actions taken, progress in meeting QIHETP objectives, and improvements made. A written summary of the QIHEC's quarterly activities is also publicly available on the CalOptima Health website.

Under the QIIHETP, there are six subcommittees that report, at minimum, quarterly to the QIHEC.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima Health practitioner and provider selection process and determines corrective actions, as necessary, to ensure that all practitioners and providers who serve CalOptima Health members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima Health practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima Health's contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and physician representatives from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima Health's network. CPRC meets a minimum of six times per year and reports through the QIHEC quarterly. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimal utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the

UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, BH and LTSS services for CCN and delegated HNs to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other organization standards. These clinical practice guidelines and nationally recognized evidence-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIHEC. The voting member composition (including a BH practitioner*) and the quorum requirements of the UMC are defined in its charter.

* BH practitioner is defined as Medical Director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost-effective pharmaceutical care for all CalOptima Health members. It reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima Health members. The P&T includes practicing physicians (including both CalOptima Health employee physicians and participating provider physicians), and the membership represents a cross-section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all members. The P&T provides written decisions regarding all formulary development decisions and revisions. The P&T meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima Health staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes analyzing regulations and guidance that impacts the benefit sets and CalOptima Health's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima Health WCM program. The WCM CAC works in collaboration with county CCS, the WCM FAC and HN CCS providers. The WCM CAC meets four times a year and reports to the QIHEC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima Health. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system. NCQA's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction, and the committee's focus is to improve customer satisfaction. The MEMX committee assesses information and data directly from members, which include the annual results of CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, member complaints, grievances and appeals. Then MEMX identifies opportunities to implement initiatives to improve our members' overall experience. The Access and Availability Workgroups, which report to the MEMX committee, monitor a member's ability get needed care and get care quickly, by monitoring the provider network, reviewing customer service metrics, and evaluating authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 2024, the MEMX committee, which includes the Access and Availability Workgroups, will continue to meet at least quarterly and will be held accountable to meet regulatory requirements related to access and implement targeted initiatives to improve member experience and demonstrate significant improvement in subsequent CAHPS survey results.

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS Committee also serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima Health providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS Committee meets at least quarterly and reports through the QIHEC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Population Health Management Committee (PHMC)

The PHMC provides overall direction for continuous process improvement and oversight of population health activities, monitors compliance with regulatory requirements, and ensures that population health initiatives meet the needs of CalOptima Health members. The committee also ensures that all population health initiatives are performed, monitored and communicated

according to the PHM Strategy and Work Plan. The PHMC is responsible for reviewing, assessing and approving the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Work Plan progress and outcomes and recommend evidence-based and/or best practice activities to improve population health outcomes and advance health equity.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima Health employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

All records and proceedings of the QIHEC and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code Section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QIHEC and the subcommittees sign a confidentiality agreement. This agreement requires committee members to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QIHE reports required by law or by the state contract.

Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima Health information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QIHE/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

2024 Quality Improvement and Health Equity Priority Areas and Goals

CalOptima Health's QIHE Priority Areas and Goals are aligned with CalOptima Health's Strategic Plan and DHCS Bold Goals.

1. Maternal Health

    - Close racial/ethnic disparities in well-child visits and immunizations by 50%
    - Close maternity care disparity for Black and Native American persons by 50%

2. Children's Preventive Care
    - Exceed the 50th percentile for all children's preventive care measures

3. Behavioral Health Care
    - Improve maternal and adolescent depression screening by 50%
    - Improve follow-up for mental health and substance disorder by 50%

4. Program Goals
    - Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS)
    - OneCare: Attain a Four-Star Rating for Medicare

Quality Improvement and Health Equity Transformation Program Work Plan

The QIHETP Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The QIHETP Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QIHETP Work Plan is monitored throughout the year. A QIHETP Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products, as needed, to capture the specific scope of the plan.

The QIHETP Work Plan is the operational and functional component of the QIHETP and is based on CalOptima Health strategic priorities and the most recent and trended HEDIS, CAHPS, Stars and Health Outcomes Survey (HOS) scores, physician quality measures and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards, where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QIHETP guides the development and implementation of an annual QIHETP Work Plan, which includes but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service

- Member experience
- QIHETP oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QIHETP

Priorities for QIHE activities based on CalOptima Health's organizational needs and specific needs of CalOptima Health's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on quality-of-care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QIHETP Work Plan.

The QIHETP Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QIHETP and applicable policies and procedures. The 2024 QIHETP Work Plan includes all quality improvement focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve access care, the delivery of services, quality of care, over and under utilization, and member population health management. All goals will be measured and monitored in the QIHETP Work Plan, reported to QIHEC quarterly, and evaluated annually. A copy of the QIHETP Work Plan are also publicly available on the CalOptima Health website.

For more details on the 2024 QIHETP Work Plan see Appendix A: 2024 QIHETP Work Plan

Quality Improvement and Health Equity Projects

QIHE Project Selection and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including but not limited to:
  - Potential quality issue (PQI) review processes
  - Provider and facility reviews
  - Preventive care audits
  - Access to care studies
  - Member experience surveys
  - HEDIS results
  - Other opportunities for improvement as identified by subcommittee's data analysis
- Measures required by regulators, such as DHCS and CMS, with a focus on meeting or exceeding the following:
  - DHCS established Minimum Performance Level (MPL) for each required Quality Performance Measure of Health Equity measures selected by DHCS.
  - Health disparity reduction targets for specific populations and measures as identified by DHCS.

- Performance Improvement Projects (PIPs) required by CMS or DHCS.

The QI Project methodology described below will be used to continuously review, evaluate and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD members
- Provisions of chronic, complex care management and care management services
- Access to and provision of preventive services

Improvements in work processes, quality of care and service are derived from all levels of the organization. For example:

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high-risk, high-volume or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, management, QIHEC, UMC, etc., based upon the scope of work and impact of the effort.
- CalOptima Health collaborates with delegated business partners to coordinate QI activities for all lines of business through the following:
  - Health Network Forums – Monthly
  - HN Quality Forums – Quarterly
  - Joint Operation Meetings (JOM) with Health Networks – Quarterly
- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QIHE Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be used.

QI Projects shall include the following:

- Measurement of performance using objective quality indicators
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of the intervention based on the performance measures
- Planning and initiation of activities for increasing or sustaining improvement

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5%–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima Health's previous year's score. Also, smaller sample size

may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30 can be statistically significant for QI pilot projects.

The PDSA model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s) including barrier analysis
4) Develop an action plan
Do 5) Communicate change plan
6) Implement change plan
Study 7) Review and evaluate result of change
8) Communicate progress
Act 9) Reflect and act on learning
10) Standardize process and celebrate success
11) As needed, initiate Corrective Action Plan(s), which may include enhanced monitoring and/or re-measurement activities.

Types of QIHE Projects

CalOptima Health implements several types of improvement projects, including QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIHEC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima Health may choose to continue the project or pursue another topic.

Documentation of QIHE Projects

Documentation of all aspects of each QIHE Project is required. Documentation includes but is not limited to:

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Communication of QIHE Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QIHETP Work Plan or calendar. The QIHE subcommittees will report their summarized information to the QIHEC at least quarterly in order to facilitate communication along the continuum of care. The QIHEC reports activities to the QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima Health's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the QIHEC and its subcommittees
- HN Forums, Medical Directors' Meetings, Quality Forums and other ongoing ad hoc meetings
- MAC, PAC and WCM FAC

Quality Improvement and Health Equity Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's QIHETP are reviewed and evaluated annually by the QIHEC and QAC, and approved by the Board of Directors, as reflected in the QIHETP Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QIHETP Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

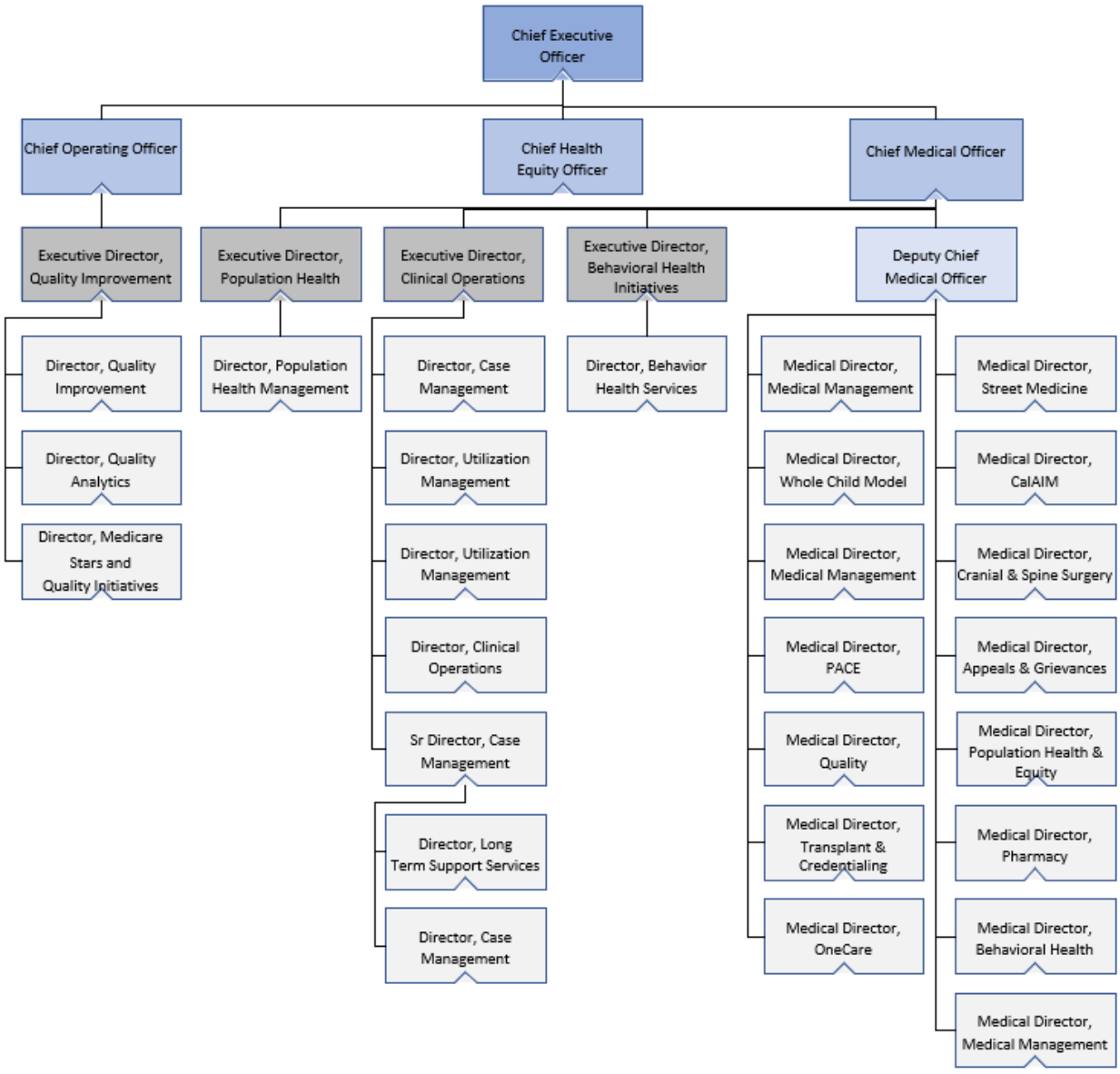
- A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QIHETP Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of QIHE activities, including QIPs, PIPs, PDSAs and CCIPs.
- An evaluation of the effectiveness of member satisfaction surveys and initiatives.
- A report to the QIHEC and QAC summarizing all quality measures and identifying significant trends.
- A critical review of the organizational resources involved in the QIHETP through the CalOptima Health strategic planning process.
- Recommended changes included in the revised QIHETP Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

A copy of the QIHETP Evaluation is also publicly available on the CalOptima Health website.

Quality Improvement and Health Equity Transformation Program Organizational Structure

Quality Program Organizational Chart — Diagram

As of December 2023



Quality Improvement and Health Equity Transformation Program Organizational Structure

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima Health departments, support the organization's mission and strategic goals. These areas oversee the processes to monitor, evaluate and implement the QIHETP so that members receive high-quality care and services. Below lists the QI Program's functional areas and responsibilities.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Medical Officer* (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. The CMO has overall responsibility for the QIHETP and supports efforts so that the QIHETP objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QIHE activities to the Board of Directors' Quality Assurance Committee.

Chief Compliance Officer (CCO) is responsible for monitoring and driving interventions so that CalOptima Health and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Deputy Chief Medical Officer* (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, Population Health Management, Pharmacy Management, LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. The COS is

responsible for achieving operational efficiencies to support CalOptima Health's strategic plan, goals and objectives.

Chief Information Officer (CIO) provides oversight of CalOptima Health's enterprisewide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the organization's risk exposure.

Medical Director* (Behavioral Health) is the designated behavioral health care physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC) and CPRC. The Medical Director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Medical Director* (CalAIM) [California Advancing and Innovating Medi-Cal] is responsible for the clinical oversight of CalAIM initiatives that include clinical programs and related services, such as Enhanced Care Management, Community Supports and justice-involved services.

Medical Director* (Credentialing and Peer Review) is the designated physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC). The Medical Director is also the chair of the Credentialing and Peer Review Committee (CPRC).

Medical Director* (OneCare) is responsible for oversight of the senior members in OneCare, working on quality improvements to raise CalOptima Health's Star rating and collaborating with others on behalf of members via the interdisciplinary care teams.

Medical Director* (Population Health and Equity) is the designated physician who chairs the Population Health Management Committee and is responsible for overseeing the Population Health Management (PHM) functions. The Medical Director provides direction and support to the CalOptima Health PHM staff to ensure objectives from the Population Health Management Strategy are met.

Medical Director* (Quality Improvement) is the physician designee who chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Medical Director* (Street Medicine) is responsible for the clinical oversight of the street medicine initiative that includes patient medical assessments and management, urgent care medical interventions, pharmacology management and utilization and the coordination of street medicine services with a multidisciplinary team.

Medical Director* (Whole Child Model) is the physician designee who chairs the Whole Child Model Clinical Advisory Committee and is responsible for overseeing QIHE activities and quality management functions related to Whole Child Model (WCM). The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives related to WCM are met.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Population Health Management (ED PHM) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for oversight of CalOptima Health's Behavioral Health (BH) program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Medi-Cal and CalAIM is responsible for the implementation and oversight of CalAIM, a whole-system, person-centered delivery system reform to improve quality and care to members.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Care Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO, DCMO and ED PHM, makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities.

Executive Director, Medicare Programs (ED MP) is responsible for strategic and operational oversight of Medicare programs, including OneCare and PACE.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima Health's networks and making sure the delivery of accessible, cost-effective and quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox Keene Act Section 1367.01 I. Ongoing monitoring is

performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

Quality Improvement and Health Equity Program Resources

CalOptima Health's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the QIHETP. The resources are revisited on a regular basis to promote adequate support for CalOptima Health's QIHETP.

The QIHE staff directly impacts and influences the QIHEC and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima Health's CMO, ED QI and ED PHM, the following staff positions provide direct support for organizational and operational QIHETP functions and activities:

Director, Quality Improvement
Responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement (PQI)
- Manager, Quality Improvement (FSR/PARS/MRR)
- Manager, Quality Improvement (Credentialing)
- Supervisor, Quality Improvement (FSR)
- Supervisor, Quality Improvement (PARS)
- QI Nurse Specialists (RN) (LVN)
- Project Manager
- Program Manager
- Credentialing Coordinators
- Program Specialists
- Program Assistants
- Outreach Specialists
- Auditor, Credentialing

Director, Quality Analytics
Responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)

- Manager, Quality Analytics (Data Analytics)
- Data Analysts
- Project Managers
- HEDIS medical record review nurses

Director, Medicare Stars and Quality Initiatives
Responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the organizationwide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

The following positions report to the Director, Medicare Stars and Quality Initiatives:
- Manager, Quality Analytics
- Manager, Quality Initiatives
- Project Managers
- Program Coordinators
- Program Specialists
- Data Analyst
- Quality Analyst
- Program Assistant

Director, Population Health Management
Responsible for program development and implementation for organizationwide population health initiatives while ensuring linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position oversees programs that promote health and wellness services for all CalOptima Health members. PHM services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). PHM also supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation organization requirements.

The following positions report to the Director, Population Health Management:
- Population Health Management Manager (Clinical Operations)
- Population Health Management Manager (Health Education)
- Population Health Management Manager (Maternal Health)
- Population Health Management Manager (Strategic Initiatives)
- Population Health Management Supervisors
- Program Managers and Senior Program Managers
- Health Coaches
- Registered Dietitians
- Health Educators and Senior Health Educators
- Program Specialists

- Program Assistants
- Program Coordinators

Director, Behavioral Health Integration
Responsible for program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima Health members across all lines of business. The director is responsible for the management and strategic direction of the BHI department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Utilization Management
Responsible for the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the UM committees and participates in the QIHEC and the BMSC.

Director, Clinical Pharmacy Management
Responsible for the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-related clinical affairs, and serves on the P&T and UMC. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Care Management
Responsible for Care Management, Transitions of Care, Complex Care Management and the clinical operations of Medi-Cal and OneCare. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports (LTSS)
Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Director, Medicare Programs
Responsible for the medical management team and providing physician leadership in the Medical Management division, serving as liaison to other CalOptima Health operational and support departments. The director collaborates with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including Quality, Utilization and Care Management, Health Education/Disease Management, Long-Term Care, Pharmacy, Behavioral Health Integration, PACE as well as support departments, including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

Staff Orientation, Training and Education

CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in health services. Qualifications and educational requirements are delineated in the respective position descriptions.

Each new employee is provided intensive orientation and job-specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA Rules and Compliance
- Disability Awareness Fraud, Waste and Abuse
- Compliance and Code of Conduct Training
- Cybersecurity Awareness
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Health Equity
- Cultural Competency
- Seniors and Persons with Disabilities Awareness training
- Trauma-Informed Care
- Diversity, Inclusion and Unconscious Bias

Employees, contracted providers and practitioner networks with responsibilities for OneCare are trained at least annually on the Model of Care (MOC). The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for education reimbursement for employees.

Key Business Processes, Functions, Important Aspects of Care and Service

CalOptima Health provides comprehensive physical and behavioral health care services, which are based on the philosophy of a medical home for each member. The primary care practitioner is this medical home for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima Health model:

- Primary care, by definition, is accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services.
- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important functional areas of care and service around which key business processes are designed include:

- Clinical care and service
- Behavioral health care
- Access and availability
- Continuity and coordination of care
- Transitions of care
- Prenatal and postpartum care
- Preventive care, including:
  - Initial Health Appointment
  - Behavioral Assessment
  - Immunizations
  - Blood Lead Screenings
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Diagnosis, care and treatment of acute and chronic conditions
- Care management including complex care management
- Prescription drug services
- Hospice care
- Palliative care
- Major organ transplants
- Long-Term Care Services and Supports
- Enhanced Care Management
- Community Supports
- Transportation
- Health education and promotion
- Disease management
- Member experience
- Patient safety

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Provider training
- Organizational ethics
- Effective utilization of resources including monitoring of over and under utilization
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Fraud and abuse* as it relates to quality of care

* CalOptima Health has a zero-tolerance policy for fraud and abuse, as required by applicable laws and regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima Health program.

Quality Improvement

The QI department is responsible for implementation of the QIHETP, monitoring quality of care and service, and assuring that credentialing standards, policies, and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with departments throughout the organization to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services. The QI department ensures that care and services are rendered appropriately and safely to all CalOptima Health members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both department-specific and organizationwide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain organizationwide practices that support accreditation and meet regulatory requirements

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). As cases are presented to CPRC, the discussion of the care includes appropriate action and leveling of the care, which results in committee-wide inter-rated reliability process. The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima Health, which include but are not limited to Prior Authorization, Concurrent Review, Care Management, Legal, Compliance, Customer Service, Pharmacy or GARS, as well as from providers and other external sources.

The QI department provides training guidance for the non-clinical staff in Customer Service and GARS to assist the staff on the identification of potential quality issues. Potential quality of care

grievances are reviewed by a Medical Director with clinical feedback provided to the member. Declined grievances captured by the Customer Service department are similarly reviewed by a Medical Director.

Comprehensive Credentialing Program

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima Health contracted delivery system.

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, Dos, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include but are not limited to non-physician BH practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima Health direct environments. Credentialing and recredentialing activities for CCN are performed at CalOptima Health and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima Health performs credentialing and recredentialing of OPs, including but not limited to acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

CalAIM Providers

CalOptima Health performs credentialing or vetting of CalAIM providers to ensure providers are qualified to provide Enhanced Care Management and Community Supports to our members. CalAIM providers include but are not limited to the following providers: FQHCs, street medicine providers, homeless navigation centers, transitional housing centers, CBAS centers, home health agencies, school-based clinics, community-based organizations, recuperative care and respite providers, sobering centers, medical tailored meals, and personal care and homemaker services.

Use of QI Activities in the Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing process.

Monitoring for Sanctions and Complaints

CalOptima Health has adopted policies and procedures for ongoing monitoring of sanctions, which include but are not limited to state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review

CalOptima Health does not delegate PCP facility site, physical accessibility, and medical records review to contracted HMOs, PHCs and SRGs. CalOptima Health assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima Health collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima Health completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for precontracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and CalOptima Health policies. An Initial Medical Record Review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima Health may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or CAP follow-up issues. If the provider is unable to meet the requirements through the CAP review, then the provider will be recommended for contract termination.

Physical Accessibility Review Survey for Seniors and Persons With Disabilities (SPD)

CalOptima Health conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas, including the exam room
- Restroom
- Exam table/scale

Medical Record Documentation

The medical record provides legal proof that the member received care. CalOptima Health requires that contracted delegated HNs make certain that each member's medical record is maintained in an accurate, current, detailed, organized and easily accessible manner. Medical

records are reviewed for format, legal protocols and documented evidence of the provision of preventive care and coordination and continuity of care services. All data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.)

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima Health's contracts with CMS and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law and must be maintained by the provider for a minimum of 10 years.

Corrective Action Plan(s) to Improve Quality of Care and Service

When monitoring by either CalOptima Health's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima Health's functional areas will be overseen by the QI department as overseen by and reported to QIHEC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams using continuous improvement tools (i.e., quality improvement plans or PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

National Committee for Quality Assurance (NCQA) Accreditation

CalOptima Health is a National Committee for Quality Assurance (NCQA) accredited Health Plan and achieved its initial commendable accreditation in August 2012. In July 2021, CalOptima Health completed triannual renewal survey for NCQA Health Plan Accreditation and received 100% of the allowable points through the document submission and file review process. From this renewal survey, CalOptima Health received Accredited Status, which is effective through July 27, 2024.

The QI department staff support CalOptima Health accreditation efforts by conducting the NCQA Steering Committee to provide all internal departments with NCQA standards and

updates, survey readiness management and NCQA survey process management. CalOptima Health has acquired NCQA consulting services to support document review and survey readiness prior to submission.

CalOptima Health is seeking another renewal for Health Plan Accreditation and will be completing the submission by April 30, 2024. In addition to Health Plan Accreditation, CalOptima is also seeking Health Equity Accreditation with NCQA by January 2026.

Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and PHM teams to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima Health members.

The QA department activities include design, implementation and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Conduct measurement analysis to evaluate goals, establish trends and identify root causes
- Establish measurement benchmarks and goals
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QIHETP, including but not limited to network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize HNs and providers to meet quality performance targets and deliver quality care
  Design and develop member, provider and organization-wide initiatives to improve - quality of care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include but are not limited to:

- Claims data
- Encounter data
- Utilization data
- Care management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS results

- Member and provider satisfaction surveys
- Timely Access Survey
- Provider demographic information

By analyzing data that CalOptima Health currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS scores and CMS Star Ratings. This information will guide CalOptima Health and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Quality Performance Measures

CalOptima Health annually collects, tracks and reports all quality performance measures required by CMS and DHCS, including the DHCS Medi-Cal Accountability Set (MCAS), Medicare reporting set and Star measures. Measure rates are validated by a NCQA-certified auditor and reported to NCQA, CMS, DHCS and other entities as required.

VALUE-Based Payment **Program**

CalOptima Health's Value-Based Payment Performance Program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. HNs, including CCN, and HNs' PCPs are eligible to participate in the Value-Based Payment Programs. CalOptima Health has adopted the Integrated Healthcare Association (IHA) pay-for-performance methodology to assess performance. Performance measures are aligned with the DHCS MCAS for Medi-Cal and a subset of CMS Star measures for OneCare.

Five-Year Hospital Quality Program 2023–2027

CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience and patient safety. Hospitals may earn annual incentives based on achievement of benchmarks.

Population Health Management

Population Health Management (PHM) aims to ensure that member care and services are delivered in a whole-person-centered, safe, timely, efficient and equitable manner across the entire health care continuum and life span. PHM integrates physical health, behavioral health, long-term support services and complex case management to improve the coordination of care between managed care teams. PHM care coordination includes basic population health management, complex care management, enhanced care management (ECM) and transitional care services. PHM's streamlined care coordination interactions are designed to optimize member care to meet their unique and comprehensive health needs.

At least annually, CalOptima Health engages with multidisciplinary care teams, members, community partners and stakeholders to update the PHM Strategy. The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the

continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also shares our creative upstream approach to address SDOH and close gaps in care that lead to health disparities among our members. In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by NCQA. CalOptima Health's PHM Strategy addresses the following areas of focus:

- Keeping members healthy
- Managing members with emerging risks
- Patient safety or outcomes across settings
- Managing members with multiple chronic conditions

To inform our PHM Strategy, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies. Mainly CalOptima Health's Population Needs Assessment (PNA) is used to summarize the results of an annual assessment on a variety of member data. The intent of the PNA is to review the characteristics and needs of our organization's member population and relevant focus populations to support data-driven planning and decision-making. In addition, CalOptima Health uses PNA key findings to inform a comprehensive PHM Work Plan.

The PHM Work Plan addresses the unique needs and challenges of specific ethnic communities, including social drivers of health that include but are not limited to economic, social and environmental stressors, to improve health outcomes. CalOptima Health will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services. These quality initiatives can be expected to have a beneficial effect on health outcomes and member satisfaction, and may include quality improvement projects (QIPs), program improvement projects (PIPs), Plan-Do-Study-Act (PDSAs) and chronic care improvement projects (CCIPs). Quality Initiatives are tracked in the QIHETP Work Plan and reported to the QIHEC.

In 2024, the PHM Work Plan will continue to focus on addressing health inequities and meeting member's social needs. PHM identified opportunities to expand outreach and initiate new initiatives focused on advancing health equity as follows:

- Improving screening for member social needs and connections to resources through an integrated closed-loop referral platform.
- Increasing CalOptima Health's organizational health literacy through the Health Literacy for Equity project, with support from the Equity in Orange County Initiative (EiOC).
- Expanding in-person group health education classes in the community to promote healthy eating and active living.
- Initiating interventions for members with hypertension and chronic kidney disease.
- Implementing the Comprehensive Community Cancer Screening and Support program that aims to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses.
- Collaborating with the Orange County Health Care Agency to reduce disparities in childhood blood lead and maternal depression screening rates.

Further details of the Population Health Management Program, activities and measurements can be found in the 2024 Population Health Management Strategy (Appendix B)

Health Education and Promotion

The PHM department provides program development and implementation for organizationwide PHM programs. PHM programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members. They are designed to achieve behavioral change and are reviewed on an annual basis. Program topics include exercise, nutrition, hyperlipidemia, hypertension, perinatal health, Shape Your Life/weight management, tobacco cessation, asthma, immunizations and well-child visits.

The primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth grade reading level and are culturally and linguistically appropriate.

PHM supports CalOptima Health members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources

Managing Members With Emerging Risk

CalOptima Health staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach entails the formation of a partnership between the member, the health care practitioner and CalOptima Health. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima Health assumes responsibility for the PHM program for all lines of business; however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Care Management

CalOptima Health is committed to serving the needs of all members and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is delivery of effective, quality health care to members with special health care needs across settings and at all levels of care, including but not limited to physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data, including Health Risk Assessment (HRA) for OneCare, SPD and WCM members
- Multiple avenues for referral to care management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidence-based guidelines distributed to providers who address chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD)
- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources
- Development of individualized care plans that include input from the member, caregiver, PCP, specialists, social worker and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing and modifying the plan of care to drive appropriate service quality, timeliness and effectiveness
- Establishing consistent provider-patient relationships
- Ongoing assessment of outcomes

CalOptima Health's Care Management (CM) program includes three care management levels that reflect the acuity of needs: complex care management, care coordination and basic care management. Members within defined models of care, (SPD, WCM and OneCare) are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

Health Risk Assessment (HRA) and Health Needs Assessment (HNA)

The comprehensive risk assessment facilitates care planning and offers actionable items for the ICT. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments are completed with the initial visit and then on an annual basis.

Interdisciplinary Care Team (ICT)

An ICT is linked to members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), depending on the results of the member's HRA and/or evaluation or changes in health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of the member) and PCP. For members with more needs, other disciplines are included, such as a Medical Director, specialist(s), care manager, BH specialist, pharmacist, social worker, dietitian

and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

The ICT levels are:

- ICT for Low-Risk Members occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic care management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an Individual Care Plan (ICP)
      - Communication with members or their representatives, vendors and medical group
      - Review and update the ICP at least annually, and when there is a change in health status
      - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk Members occurs at the HN, or at CalOptima Health for CCN members.
  - Team Composition: member, caregiver or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory care manager, hospitalist, hospital care manager and/or discharge planners, HN UM staff, BH specialist and social worker
    - Roles and responsibilities of this team:
      - Identification and management of planned transitions
      - Care coordination or complex care management
      - Care management of high-risk members
      - Coordination of ICPs for high-risk members
      - Facilitating communication among member, PCP, specialists and vendors
      - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Individual Care Plan (ICP)

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per care management level. The ICP is updated annually and with change in condition.

Seniors and Persons with Disability (SPD)

The goal of care management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole-Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives care management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

OneCare Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

The MOC is member-centric by design, and it monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care for OneCare. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of SDOH
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

CalOptima Health's D-SNP care management program includes but is not limited to:

- Complex care management program for a subset of members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional care management program focused on evaluating and coordinating transition needs for members who may be at risk of rehospitalization
- High-risk and high-utilization program for members who frequently use emergency department services or have frequent hospitalizations, and high-risk individuals
- Hospital care management program to coordinate care for members during an inpatient admission and discharge planning

Care Management Program focuses on member-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Behavioral Health Integration Services

CalOptima Health is responsible for providing quality behavioral health care focusing on prevention, recovery, resiliency and rehabilitation. As part of the QI Program with direction and guidance from the QIHEC, the BHI other supporting departments continue to monitor the behavioral health care that CalOptima Health providers our member and continue to seek ways to improve behavioral health care.

Medi-Cal Behavioral Health (BH)

CalOptima Health is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include but are not limited to individual and group psychotherapy, psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated to evaluate a mental health condition.

In addition, CalOptima Health covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima Health provides direct oversight, review and authorization of BHT services.

CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief counseling on misuse is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

CalOptima Health members can access mental health services directly, without a physician referral, by contacting the CalOptima Health Behavioral Health Line at 1-855-877-3885. A CalOptima Health representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to BH practitioners within the CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima Health ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

CalOptima Health directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

CalOptima Health is participating in two of DHCS' incentive programs focused on improving BH care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and BH outcomes, care delivery efficiency and member experience. CalOptima Health is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12 projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize BH services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH agencies and CalOptima Health by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

OneCare Behavioral Health

OneCare covers inpatient and outpatient behavioral health care services through a directly contracted behavioral health network. OneCare BH continues to be fully integrated within CalOptima Health internal operations. OneCare members can access mental health services by calling the CalOptima Health Behavioral Health Line.

Utilization Management (UM)

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service, subject to medical necessity, and are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease or injury consistent with CalOptima Health medical policy and not furnished primarily for the convenience of the member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2024 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a Medical Director or other qualified reviewer, such as a licensed psychologist or clinical pharmacist.

Further details of the UM Program, activities and measurements can be found in the 2024 Integrated UM and CM Program Description.

Patient Safety Program

Patient safety is very important to CalOptima Health; it aligns with CalOptima Health's mission statement: *To serve member health with excellence and dignity, respecting the value and needs of each person*. By encouraging members and families to play an active role in making their care

safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Patient safety is integrated into all components of enrollment and health care delivery and is a significant part of our quality and risk management functions. This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service
- Care provided in various health care settings
- Sentinel events
- Disease Surveillance and reporting

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to consider the member's language comprehension, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures that outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Using FSRs, PARS and MRR results from providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training

- Preventative maintenance contracts to promote keeping equipment in good working order
- Fire, disaster and evacuation plan testing and annual training

- Institutional settings, including CBAS, SNF and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of influenza and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

Encounter Data Review

CalOptima Health's HNs must submit complete, timely, reasonable, and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types and data format specifications. A HN submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.

CalOptima Health annually measures a HN's compliance with performance standards with regards to the timely submission of complete and accurate encounter data, in accordance with Policy EE.1124 Health Network Encounter Data Performance Standards. CalOptima Health utilizes retrospective encounter data to conduct its evaluation. The measurement year is the twelve (12) month calendar year. CalOptima Health provides a HN with a HN Encounter Data Scorecard to report a HN's progress check score and annual score relating to the status of the HN's compliance with encounter data performance standards.

Member Experience

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system. CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members' expectations and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both Medi-Cal and OneCare members. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child population.

Additionally, CalOptima Health reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for "pain points" that impact members at the plan and HN level (including CCN), where appropriate.

Grievance and Appeals

CalOptima Health has a process for reviewing member and provider complaints, grievances and appeals. Grievances and appeals are tracked and trended on a quarterly basis for timeliness of

acknowledgment and resolution, issue types and by provider type. The grievance and appeals process includes a thorough investigation and evaluation to ensure timely access to care and the delivery of quality care and/or services. In this process, potential quality of care issues are identified and referred to an appropriately-licensed professional for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case. The quarterly report is presented and reviewed by the Grievance and Resolutions (GARS) Committee that reports to the QIHEC quarterly.

Access to Care

Access to care is a major area of focus for the plan and hence the organization has dedicated significant resources to measuring and improving access to care.

CalOptima Health participates in the following to monitor and improve network adequacy and access to our members:

- Annual Network Certification (ANC) with DHCS
- Subcontracted Network Certification (SNC) with DHCS
- Network Adequacy Validation with the EQRO
- Network Adequacy Monitoring with CMS

CalOptima Health monitors the following to ensure that we have robust provider networks for our members to access care and that members have timely access to care to primary and specialty healthcare providers and services:

Availability of Practitioners

- CalOptima Health monitors the availability of PCPs, specialists and BH practitioners and assesses them against established standards quarterly or when there is a significant change to the network.
- The performance standards are based on DHCS, CMS, NCQA and industry benchmarks.
- CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of practitioners.
- CalOptima Health uses a geo-mapping application to assess geographic distribution.
- Data is tracked and trended and used to inform provider outreaching and recruiting efforts.

Appointment Access

- CalOptima Health monitors appointment access for PCPs, specialists and BH providers and assesses them against established standards at least annually.
- To measure performance, CalOptima Health collects appointment access data from practitioner offices using a timely access survey.
- CalOptima Health also evaluates the grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps CalOptima Health identify and implement opportunities for improvement.
- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Telephone Access

- CalOptima Health monitors access to its Customer Service department on a quarterly basis.
- To ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their primary care practitioner during business hours.
- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural & Linguistic Services Program

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program that integrates culturally and linguistically appropriate services at all levels of the operation. Services include but are not limited to face-to-face interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio; and referrals to culturally and linguistically appropriate community services programs.

The seven most common languages spoken for all CalOptima Health programs are: English, 58%; Spanish, 27%; Vietnamese, 9%; Farsi, 1%; Korean, 2%; Chinese, less than 1%; and Arabic, less than 1%; and other less than 2%. CalOptima Health provides member materials as follows:

- Medi-Cal member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- OneCare member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- PACE participant materials are provided in three languages: English, Spanish and Vietnamese.

CalOptima Health's Cultural and Linguistic Services Program is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of our diverse population. Beginning with identification of needs through a Population Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group
- Implementing and maintaining annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical).

Further details of the Culture and Linguistics program, activities and measurements can be found in the 2024 Culture and Linguistics Services Program and Work Plan.

Delegated And Non-Delegated Activities

While CalOptima Health is accountable for all QIHE functions, CalOptima Health does delegate responsibilities to subcontractors and downstream subcontractors and specifies these requirements in a mutually agreed upon delegation agreement. CalOptima Health evaluates the delegates ability to perform the delegated activities to ensure compliance with statutory, regulatory and accreditation requirements as part of an annual and continuous monitoring process for delegation oversight.

Delegation Oversight

Participating entities are required to meet CalOptima Health's QI standards and to participate in CalOptima Health's QIHETP. CalOptima Health has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate's ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Delegation Oversight Committee, reporting to the Compliance Committee.

CalOptima Health, via a mutually-agreed-upon delegation agreement document, describes the responsibilities and activities of the organization and the delegated entity.

CalOptima Health conducts oversight based on regulatory, CalOptima Health and NCQA standards and has a system to audit and monitor delegated entities' internal operations on a regular basis.

Delegation Oversight Performance Monitoring includes but is not limited to the CalOptima Health delegates and monitors the following functions:

- Care Management, Credentialing, Utilization Management, and Claims.

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted HNs and remain the responsibility of CalOptima Health:

- QI, as delineated in the Contract for Health Care Services
- QIHETP for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Health Equity
- BH for Medi-Cal and OneCare
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health education, as applicable
- Grievance and appeals process for all lines of business, and peer review process on specific, referred cases
- PQI investigations
- Development of systemwide measures, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second-level review of provider grievances
- Development of UM and Care Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

APPENDIX:

A – 2024 QIHETP WORK PLAN

B – 2024 POPULATION HEALTH MANAGEMENT STRATEGY

C – CALOPTIMA HEALTH MEASUREMENT YEAR (MY) 2024 MEDI-CAL AND ONECARE PAY FOR VALUE PROGRAMS

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Abbreviations

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Experience
	ADA	Americans With Disabilities Act of 1990
	ADHD	Attention-Deficit Hyperactivity Disorder
	APL	All Plan Letter
	AUD	Alcohol Use Disorder
B		
	BHI	Behavioral Health Integration
	BHT	Behavioral Health Treatment
	BHIIP	Behavioral Health Integration Incentive Program
	BMSC	Benefit Management Subcommittee
C		
	CalAIM	California Advancing and Innovating Medi-Cal
	CAHPS	Consumer Assessment of Healthcare Providers and Systems
	CAP	Corrective Action Plan
	CBAS	Community Based Adult Services
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHCN	CalOptima Health Community Network
	CHEO	Chief Health Equity Officer
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COO	Chief Operating Officer
	COPD	Chronic Obstructive Pulmonary Disease
	COS	Chief of Staff
	COD-A	CalOptima Health Direct-Administrative
	CPRC	Credentialing and Peer Review Committee
	CQS	Comprehensive Quality Strategy
	CR	Credentialing
D		
	DC	Doctor of Chiropractic Medicine
	DCMO	Deputy Chief Medical Officer
	DDS	Doctor of Dental Surgery
	DHCS	Department of Health Care Services
	DMHC	Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ED PHM	Executive Director, Population Health Management
	ED BH	Executive Director, Behavioral Health Integration
	BH	Behavioral Health
	ED CO	Executive Director, Clinical Operations
	ED MP	Executive Director, Medicare Programs

	ED NO	Executive Director, Network Operations
	ED O	Executive Director, Operations
	ED Q	Executive Director, Quality
F		
	FDR	First Tier, Downstream or Related Entity
	FSR	Facility Site Review
G		
	GARS	Grievance and Appeals Resolution Services
H		
	HEDIS	Healthcare Effectiveness Data and Information Set
	HIPAA	Health Insurance Portability and Accountability Act
	HMO	Health Maintenance Organization
	HN	Health Network
	HNA	Health Needs Assessment
	HOS	Health Outcomes Survey
	HRA	Health Risk Assessment
I		
	ICT	Interdisciplinary Care Team
	ICP	Individual Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long Term Care
	LTSS	Long Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	Doctor of Medicine
	ME	Member Experience
	MED	Medicaid Module
	MEMX	Member Experience Committee
	MOC	Model of Care
	MOU	Memorandum of Understanding
	MRR	Medical Record Review
	MRSA	Methicillin resistant Staphylococcus aureus
	MSSP	Multipurpose Senior Services Program
	MY	Measurement Year
	NCQA	National Committee for Quality Assurance
	NET	Network
	NF	Nursing Facility
O		
	OC	Orange County
	OCHCA	Orange Country Health Care Agency
	OP	Organizational Providers
	OC SSA or SSA	County of Orange Social Services Agency
Q		
	QAC	Quality Assurance Committee
	QI	Quality Improvement
	QIHE	Quality Improvement and Health Equity
	QIHEC	Quality Improvement and Health Equity Committee
	QIP	Quality Improvement Project
P		

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	P4V	Pay for Value
	P&T	Pharmacy & Therapeutics Committee
	PAC	Provider Advisory Committee
	PACE	Program of All-Inclusive Care for the Elderly
	PARS	Physical Accessibility Review Survey
	PBM	Pharmacy Benefit Manager
	PCC	Personal Care Coordinator
	PCP	Primary Care Practitioner/physician
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician Hospital Consortium
	PIP	Performance Improvement Project
	PPC	Prenatal and Postpartum Care
	PPC	Provider Preventable Condition
	PQI	Potential Quality Issue
	PSS	Perinatal Support Services
S		
	SABIRT	Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
	SBHIP	Student Behavioral Health Incentive Program
	SDOH	Social Drivers of Health
	SNP	Special Needs Plan
	SNF	Skilled Nursing Facility
	SPD	Seniors and Persons with Disabilities
	SRG	Shared Risk Group
	SUD	Substance Use Disorder
T		
	TPL	Third Party Liability
U		
	UM	Utilization Management
	UMC	Utilization Management Committee
V		
	VS	Vision Service
	VSP	Vision Service Plan
W		
	WCM	Whole-Child Model Program
	WCM CAC	Whole-Child Model Clinical Advisory Committee
	WCM FAC	Whole-Child Model Family Advisory Committee

2024 Quality Improvement and Health Equity Transformation Program Work Plan

Evaluation Category	Evaluation Sub-category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Report to Committee	LOB	Continue Monitoring from 2023	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 - Caution Green - On Target
Program Oversight		2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	QIHEC	MC,OC	X			
Program Oversight		2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	QIHETP and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	QIHEC	MC,OC	X			
Program Oversight		2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	UMC/QIHEC	MC,OC	X			
Program Oversight		2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	UMC/QIHEC	MC,OC	X			
Program Oversight		Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: Population Needs Assessment (PNA) Risk stratification Screening and Assessment Wellness and prevention Pediatric Risk Stratification Process (PRSP) monitoring	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of PHM	Manager of PHM/Director of Care Management	PHMC Q1 02/29/2024 Q2 05/16/2024 Q3 08/15/2024 Q4 11/21/2024	MC,OC	X			
Program Oversight		2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Manager of Customer Service	TBD	QIHEC	MC, OC	X			
Program Oversight		**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of PHM	TBD	QIHEC		**New**			
Program Oversight		**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	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Manager of Quality Improvement	Manager of Quality Improvement	QIHEC	MC,OC	X			
Program Oversight		**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.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Grievance and Appeals	Manager of GARS	QIHEC	MC,OC	X			
Program Oversight		**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health'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. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	QIHEC	MC,OC	X			
Program Oversight		**Utilization Management Committee (UMC) Oversight** - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. **P&T and BMSC** reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Utilization Management	Manager of UM	QIHEC	MC,OC	X			
Program Oversight		**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	WCM CAC report to QIHEC: Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Whole Child Model Medical Director / Director of Case Management	Program Assistant QI	QIHEC	MC,OC	X			
Program Oversight		Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Care Management	TBD	PHMC Q1 02/29/2024 Q2 05/16/2024 Q3 08/15/2024 Q4 11/21/2024		**New**			
Program Oversight		Delegation Oversight	Implement annual oversight and performance monitoring for delegated activites.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accredication standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Audit and Oversight	TBD	QIHEC		**New**			
Program Oversight		Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Director of PHM	TBD	PHMC Q1 02/29/2024 Q2 05/16/2024 Q3 08/15/2024 Q4 11/21/2024		**New**			
Program Oversight		Health Education	Implement Health Education Program	Report on the following activities: Evaluation of current utilization of health education services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Director of PHM/Manager of Health Education	TBD	PHMC Q1 02/29/2024 Q2 05/16/2024 Q3 08/15/2024 Q4 11/21/2024		**New**			
Program Oversight		Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q1 03/12/2024 Q2 06/1 1/2024 Q3 09/10/2024 Q4 12/10/2024	Director of PHM	Manager of PHM	PHMC Q1 02/29/2024 Q2 05/16/2024 Q3 08/15/2024 Q4 11/21/2024	MC,OC	x			
Program Oversight		Long-Term Support Services (LTSS)	Implement LTSS	Report on the following activities: Evaluation of current utilization of LTSS Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from UMC to QIHEC Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of LTSS	TBD	UMC		**New**			

2024 Quality Improvement and Health Equity Transformation Program Work Plan

Evaluation Category	Evaluation Sub-category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Report to Committee	LOB	Continue Monitoring from 2023	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 - Caution Green - On Target
Program Oversight		National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024	Program Manger of QI	Director of Quality Improvement	QIHEC	MC	X			
Program Oversight	Chronic Conditions	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024	Director of Medicare Stars and Quality Initiatives	Manager of QA	QIHEC		X			
Program Oversight		Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024	Manager of Quality Analytics	TBD	QIHEC	MC, OC	X			
Program Oversight		Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024	Director of Quality Analytics	TBD	QIHEC	MC, OC	X			
Program Oversight		School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024	Director of Behavioral Health Integration	Project Manager BHI	QIHEC	MC	X			
Program Oversight	Adult Wellness	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q1: 01/09/2024 Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024	Director of PHM	Manager of PHM	QIHEC	MC, OC	X			
Quality of Clinical Care	Adult Wellness	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	QIHEC	MC	X			
Quality of Clinical Care	Behavioral Health	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collabortively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second qualer. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC	X			
Quality of Clinical Care	Behavioral Health	Health Equity/Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	TBD	QIHEC		New			
Quality of Clinical Care	Behavioral Health	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primay Care Providers (PCP) for members in need of merabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC	X			
Quality of Clinical Care	Behavioral Health	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	TBD	QIHEC		New			
Quality of Clinical Care	Behavioral Health	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	TBD	QIHEC		New			
Quality of Clinical Care	Behavioral Health	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%, 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC	X			
Quality of Clinical Care	Behavioral Health	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collabortively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC, OC	X			
Quality of Clinical Care	Behavioral Health	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Helath community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC	X			

2024 Quality Improvement and Health Equity Transformation Program Work Plan

Evaluation Category	Evaluation Sub-category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Report to Committee	LOB	Continue Monitoring from 2023	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 - Caution Green - On Target
Quality of Clinical Care	Behavioral Health	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI *Field* Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	QIHEC	MC	X			
Quality of Clinical Care	Chronic Conditions	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	PHMC	MC,OC	X			
Quality of Clinical Care	Chronic Conditions	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	PHMC	MC,OC	X			
Quality of Clinical Care	Maternal Child Health	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 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) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	QIHEC	MC	X			
Quality of Clinical Care	Pediatric/Adolescent Wellness	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1)A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2)Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	QIHEC	MC	X			
Quality of Clinical Care	Pediatric/Adolescent Wellness	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	QIHEC	MC	X			
Quality of Clinical Care	Pediatric/Adolescent Wellness	Performance Improvement Projects (PIPs) Medi-Cal	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	QIHEC	MC,OC	X			
Quality of Clinical Care	Pediatric/Adolescent Wellness	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	QIHEC	MC	X			
Quality of Clinical Care	Quality Oversight	Encounter Data Review	Conduct regular review of encounter data submited by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 05/13/2024 Q4: 11/12/2024	Director of Finance	Manager of Finance	QIHEC	MC, OC	New			
Quality of Clinical Care	Quality Oversight	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update from CPRC to QIHEC Q1: 03/12/2024 Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director Quality Improvement	Manager Quality Improvement	CPRC		**New**			
Quality of Clinical Care	Quality Oversight	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q1: 03/12/2024 Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director Quality Improvement	Manager Quality Improvement	CPRC		**New**			
Quality of Clinical Care	Quality Oversight	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q1: 03/12/2024 Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director Quality Improvement	Manager Quality Improvement	CPRC		**New**			
Quality of Clinical Care	Quality Oversight	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Quality Improvement	Manager Quality Improvement	CPRC		**New**			

2024 Quality Improvement and Health Equity Transformation Program Work Plan

Evaluation Category	Evaluation Sub-category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Report to Committee	LOB	Continue Monitoring from 2023	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 - Caution Green - On Target
Quality of Clinical Care		Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	QIHEC	MC,OC	X			
Quality of Clinical Care		Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director Medical Management/Case Management	QI Nurse Specialist	QIHEC	OC	X			
Quality of Service	Access	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	1) Director of Provider Network 2) Director of Contracting	TBD	MEMX	MC,OC	X			
Quality of Service	Access	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely acces. 3) Continue to educate providers on timely acces standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Medicare Stars and Quality Initiatives	TBD	MEMX	MC,OC	X			
Quality of Service	Access	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC:	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst	MEMX	MC	X			
Quality of Service	Access	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Quarterly Report to QIHEC Q1 2024 Q2 2024 Q3 2024 Q4 2024	Director of PHM	Manager of PHM	QIHEC	MC	X			
Quality of Service	Access	Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards Maintain business for current programs Improve process for handling these services	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of Customer Service	Manager of Customer Service	QIHEC	MC, OC				
Quality of Service	Access	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q1: 03/12/2024 Q2: 06/11/2024	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	TBD	MEMx		**New**			
Quality of Service	Member Experience	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q1: 03/12/2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of Medicare Stars and Quality Initiatives	Carol Matthews	MEMx/QIHEC		X			
Quality of Service	Member Experience	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of GARS	Manager of GARS	GARS	MC, OC	New			
Quality of Service		Customer Service	Implement customer service and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of Customer Service	TBD	QIHEC	MC, OC				
Safety of Clinical Care		Coordination of Care: Member movement across settings	Improve care coordination between the hospital and primary care physician (PCP) following patient discharge from an acute care setting	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Utilization Management	TBD	QIHEC		**New**			
Safety of Clinical Care		Coordination of Care: Member movement between practitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of Case Management	TBD	QIHEC		**New**			
Safety of Clinical Care		Emergency Department Visits	Emergency Department Diversion Pilot Pilot has been implemented. In 2024 plan to expand the program to additional hospital partners.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q1: 03/12/ 2024 Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024	Director of LTSS	Manager of LTSS	UMC	MC	X			
Safety of Clinical Care		Transitional Care Services (TCS)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving successful interactions for TCS high-risk members within 7 days of their discharge.	Assess and report the following activities: 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (01/14/2025)	Director of UM, CM and LTSS	TBD	QIHEC	MC,OC	X			

2024

POPULATION HEALTH MANAGEMENT STRATEGY & WORK PLAN

Responsible Staff:

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INTRODUCTION

Agency Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. We believe that our members deserve the highest quality of care and service. To achieve this, CalOptima Health works in collaboration with members, providers, community stakeholders and government agencies guided by our mission and vision.

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.

Strategy Purpose

To meet the unique and comprehensive health needs of our members, CalOptima Health engaged with multidisciplinary care teams, community partners and stakeholders to co-create the Population Health Management (PHM) Strategy.

The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also shares our creative upstream approach to address social determinants of health (SDOH) and close gaps in care that lead to health disparities among our members.

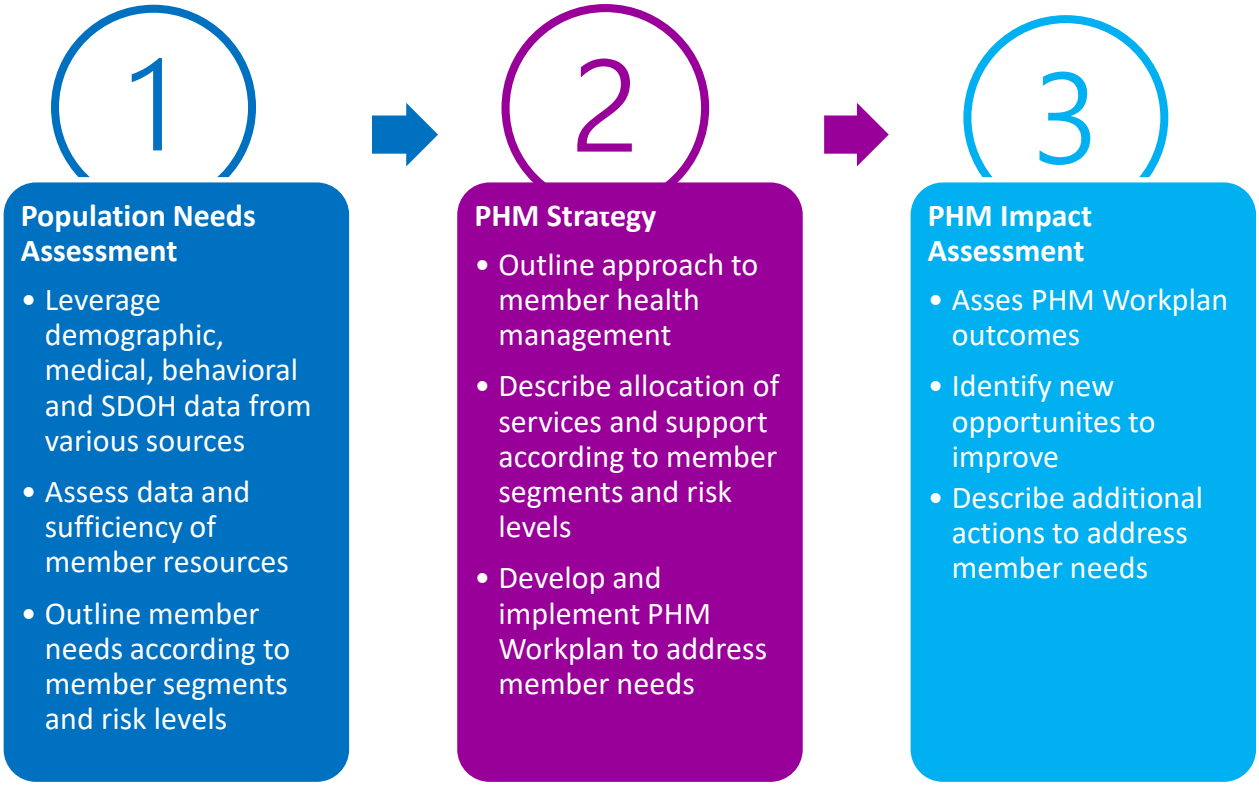
In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by the National Accreditation of Quality Assurance (NCQA).

CalOptima Health's PHM Strategy addresses the following areas of focus:

1. Keeping members healthy
2. Managing members with emerging risks
3. Member safety
4. Managing members with multiple chronic conditions

Strategic Management

To inform our PHM Strategy and programs, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies through a comprehensive PHM Workplan. The following diagram illustrates the relationship of these activities:



Population Needs Assessment

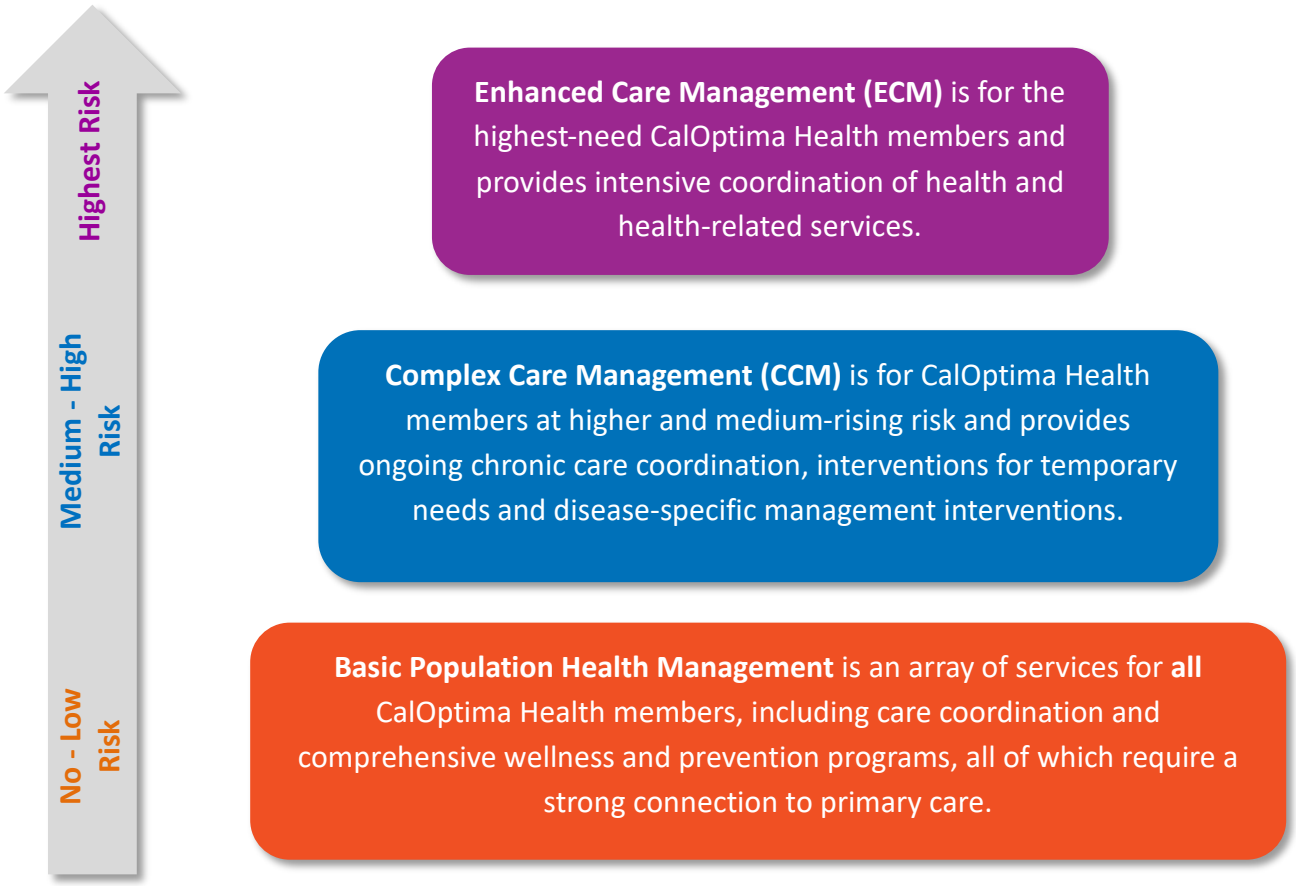
CalOptima Health's Population Needs Assessment (PNA) summarizes the results of an annual assessment on a variety of data. The intent of the PNA is to review the characteristics and needs of our agency's member population and relevant focus populations to support data-driven planning and decision-making. This report specifically focuses on CalOptima Health's:

- Overall member population, including SDOH
- Children and adolescent members ages 2–19 years old
- Members with disabilities
- Members with serious and persistent mental illness (SPMI)
- Members according to racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations

CalOptima Health uses PNA key findings to inform the PHM Strategy and Workplan which aim to address gaps in member care through intervention strategies and quality initiatives. Report findings also helped identify the need for process updates and resource allocation.

Population Segmentation and Care Coordination

CalOptima Health's PHM program aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner across the entire health care continuum and life span. The PHM program integrates physical health, behavioral health, long-term support services, care coordination and complex case management to improve coordination of care between managed care teams. The PHM program includes basic population health management, complex care management, Enhanced Care Management (ECM) and transitional care services.



PHM Strategy and Workplan

The following table provides a high-level overview of CalOptima Health's 2024 PHM Strategy and Workplan. This table shows how CalOptima Health aligns federal and state guidance with NCQA standards to guide our PHM Program efforts.

CalOptima Health 2024 PHM Workplan Overview

Area of Focus	Program/Service	Description
Keeping Members Healthy	**Blood Lead Testing in Children**	In babies and young children, whose brains are still developing, even a small amount of lead can cause learning disabilities and behavioral problems. CalOptima Health works with providers and members to ensure that all young children are tested for lead at age-appropriate intervals.
	Well-Child Visits	Well-child visits are important during the early months of a child's life to assess growth, development and identify and address any concerns early. CalOptima Health promotes preventive care for its youngest members to help them live long, happy and healthy lives.
	Health Disparity Remediation for Well-Child Visits	CalOptima Health aims to reduce the racial/ethnic disparities in well child visits in support of the statewide goals. Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate among African American child members has the potential to improve their overall health status.
	Childhood Immunizations	Childhood vaccinations are a safe and effective way to protect children from a variety of serious or potentially fatal diseases. CalOptima Health works to promote immunizations and ensure that children are healthy, growing and ready to learn.
	Comprehensive Community Cancer Screening and Support Program	CalOptima Health partnered with external stakeholders in the fight against cancer to launch this program. Together, we aim to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses through early screening.
	Bright Steps Program	CalOptima Health's prenatal and postpartum care program aims to inform and provide resources to pregnant members to help them have a healthy pregnancy, delivery and baby.
	Shape Your Life	CalOptima Health offers no-cost, in-person and virtual group classes for children ages 5 to 18 and their families. Topics include healthy eating, physical activity and other ways to build healthy habits.
Emerging Risk	**Chronic Condition Care and Self- Management Program**	CalOptima Health's programs promote self-management skills for people with chronic conditions to enable them to manage their health on a day-to-day basis and to take an active role in their health care.
Patient Safety	**CalAIM Community Supports**	California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers in accessing care. Community Supports are a core component of CalAIM.
	Street Medicine Program	CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's un-housed individuals and families through whole person care approaches and addressing social drivers of health.
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	CalOptima Health's program assesses the percentage of emergency department (ED) visits for members aged 6 and older with a principal diagnosis of alcohol and other drug abuse or dependence to ensure our members receive appropriate follow-up care.
Multiple Chronic Conditions	**Complex Case Management Program**	Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

NOTE: Please see CalOptima Health's 2024 PHM Workplan for a detailed list of programs and services, SMART objectives and related activities.

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PHM Program

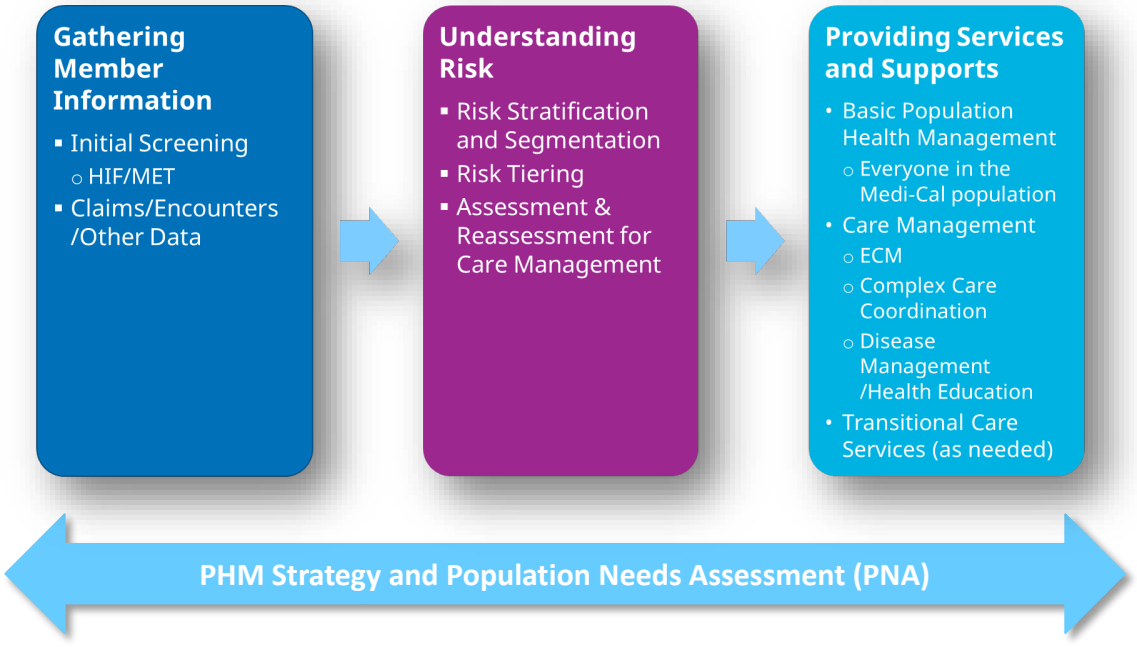
The PHM Strategy serves to guide CalOptima Health's PHM Program that aims to motivate, educate and empower members to become self-advocates in their healthcare, manage conditions, prevent acute episodes and enhance their quality of life. Our PHM Program and related services are also developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability. This is achieved by:

- Building trust and meaningful engagement with members.
- Using data-driven risk stratification and predictive analytics to address gaps in care.
- Revising and standardizing assessment processes.
- Providing care management services for all high-risk members.
- Creating robust transitional care services (TCS) to promote continuity of care and limit service disruptions.
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health.
- Implementing interventions to support health and wellness for all members.

PHM Framework

CalOptima Health adopted guiding principles of the PHM Framework to plan, implement and evaluate the PHM Program and our delivery of care. The diagram below outlines the key components used to operationalize the PHM Program, which includes:

- ***Population needs assessment and PHM Strategy*** that are used to measure health disparities and identify the health priorities and social needs of our member population, including cultural and linguistic, access and health education needs.
- ***Gathering member information*** on preferences, strengths and needs to connect every member to services at the individual level, and to allocate resources.
- ***Understanding risk*** to identifying opportunities for more efficient and effective interventions.
- ***Providing services and supports*** to address members needs across a continuum of care.



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PHM Program Coordination

CalOptima Health's PHM Program spans across several settings, providers and levels of care in an effort to meet our members' needs. To streamline PHM Program activities and avoid duplication, CalOptima Health utilizes a care management system to facilitate the coordination of care and data management for members among several care teams including:

- Behavioral Health Integration
- Case Management
- Long Term Care and Support
- Program of All-inclusive Care for the Elderly (PACE)
- Population Health Management
- Pharmacy
- Utilization Management

Through the agency's care management system, CalOptima Health can determine member eligibility for services, share data to identify and address care gaps, and coordinate care across settings. The system is available to all care team staff responsible for member care and enables them to:

- Create links between all systems that allow appropriate coordination of care and support delivered at the proper time, while minimizing duplication of effort between the coordinating teams.
- Access member records to expedite and view all relevant data in one location.
- Identifying member needs through established system logics or from providers and member self-referrals to plan an appropriate level of support whereby a staff (e.g., Personal Care Coordinator) is assigned to help the member with managing their health and social needs.
- Provide members with appropriate assessments and educational materials, derived from evidence-based tools and standardized practices.
- Create an individualized Care Plan with prioritized goals and facilitate services that minimize or eliminate barriers to care for optimal health outcomes.
- Inform Interdisciplinary Care Team (ICT) of member care needs, related activities and health goal progress.

Informing Members about PHM Programs

CalOptima Health deploys several interactive methods to inform members about PHM programs. These interactive methods are designed to share program eligibility and how to use program services. All PHM programs are voluntary. Based on members' language preferences, they are informed of various health promotion programs or how to contact care management staff via initial mailed Member Welcome Packet, member informing materials (e.g., newsletters, program/service letters, benefit manuals, etc.), CalOptima Health's member website, text messaging, personal phone outreach, robocalls and/or in person.

The following descriptions provide more details on how CalOptima Health's eligible members are informed about PHM programs:

- ***Eligibility to participate***: CalOptima Health's PHM programs are accessible to members from Medi-Cal and OneCare lines of business that meet the PHM program criteria. When a member has a referral into a PHM program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need.

- ***Use of services***: CalOptima Health provides instruction on how to use these services in multiple languages and with appropriate health literacy levels.
- ***Accepting or declining services:*** CalOptima Health honors member choice; hence, all the PHM programs are voluntary. Members can self-refer to any PHM program by contacting CalOptima Health. When CalOptima Health conducts outreach to eligible members identified through risk stratification or provider referral, members are informed that the program is voluntary, and they are able to opt-out at any time.

PHM Impact Assessment

CalOptima Health's annual PHM Impact assessment measures the effectiveness of the agency's PHM Strategy and related programs to address member care needs. Through this analysis, CalOptima Health also identifies and addresses opportunities for improvement. Specifically, the assessment focuses on the:

- Clinical impact of programs
- Cost and/or utilization impact of programs
- Member experience with programs

CalOptima Health uses key performance indicators (e.g., primary care, ambulatory care, emergency department visit, inpatient utilization) and quality measures (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®]) to assess the effectiveness of the PHM program and adjust it to meet the needs of our members. The PHM Impact findings are shared with our care management team, stakeholders and regulatory agencies at least annually.

PROMOTING HEALTH EQUITY

CalOptima Health is working to advance health equity throughout our strategic management process to ensure that PHM programs and services support our members in attaining their highest level of health. Health equity is not something that a person can do for themselves. It requires commitment from community, healthcare organizations and governments to remove obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with a living wage, quality education and housing, safe environments and health care. In response, CalOptima Health has prioritized health equity so that all members are empowered and able to access resources to be as healthy as possible, regardless of background and identity. In 2022, CalOptima Health launched an organization-wide Equity Initiative, with focus areas in:

- Health equity and SDOH
- Communications and narrative change
- Diversity, equity and inclusion for CalOptima Health workforce
- Stakeholder engagement

To meet the needs of members who are impacted by the greatest health inequities, CalOptima Health has develop a roadmap to meet the following overarching goals:

- Make an explicit commitment to advance health equity to internal and external stakeholders.
- Identify existing and needed organizational assets, resources and leadership.
- Measure health inequities and identify impactful strategies focused on SDOH.
- Implement short- and long-term strategies at the member, organizational and community level.
- Enhance data collection, shared lessons and expanded capacity.

CalOptima Health has operationalized our health equity efforts through a broad range of programs and services.

Social Determinants of Health

To guide our effort in healthy equity, CalOptima Health developed the Member Risk Dashboard to help us understand the impact that SDOH has on our members. This dashboard is informed by the Chronic Illness and Disability Payment System (CDPS) + Rx risk model which assigns a risk score to each member using diagnosis codes from claims and encounters plus pharmacy data to help assess the effective disease burden a population may face. The Member Risk Dashboard can overlay risk with several different factors (e.g., gender, ethnicity, age, health conditions, SDOH factors, etc.) to stratify and segment members. Furthermore, the SDOH data collected using diagnosis codes present on claims and encounters is categorized as follows:

- Adverse family events
- Criminal justice involved
- Housing instability
- Indications of extreme poverty
- Psychosocial circumstances

Among the different features available through this dashboard are the SDOH Profile and SDOH Comparison. The SDOH Profile provides an overview of how SDOH factors impact CalOptima Health members. The SDOH Comparison is used to compare health metrics between SDOH categories such as:

- Condition prevalence
- Hospital readmissions
- Emergency room visits
- Dental visits
- Uncontrolled A1c
- Unused authorizations

The Member Risk Dashboard serves to highlight CalOptima Health's current efforts to better identify and address the health disparities seen in our member population that are caused by SDOH. CalOptima Health plans to continue enhancing our understanding of the impact that SDOH has on our members through the expansion of data collection efforts and community engagement.

ACTIVITIES AND RESOURCES

CalOptima Health recognizes the importance of mobilizing multiple resources to support our members' health needs. At least annually, CalOptima Health conducts a strategic review of existing structures, programs, activities and resources using its PNA and dashboards. This strategic assessment helps CalOptima Health leaders set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity and proactively mitigate emerging risks. Please see the annual PNA Report for details of this review and a description of the activities and resources supported by CalOptima Health.

In addition, CalOptima Health describes activities that are designed to support the PHM Strategy, including activities not directed at individual members, in our PHM Workplan. Indirect member activities apply to multiple areas of focus to and include:

- Building partnerships with community-based organizations, local health care agencies, hospitals and clinics, universities and more to streamline efforts and leverage resources.
- Developing toolkits and resources to support health network providers and community partners.
- Conducting improvement projects (e.g., Plan, Do, Study, Act (PDSA) and Performance Improvement Projects (PIP)) to address health disparities.
- Investing in community implementation and expansion efforts to support PHM programs and services.
- Regularly sharing guidance and information relevant to members with staff, providers and stakeholders using multimodal communication strategies (e.g., newsletters, web portals, meetings, etc.)
- Exchanging data between CalOptima Health and supporting health entities (e.g., Health Network providers, local health agencies, etc.)
- Facilitating continuous education, training and professional development opportunities for staff and providers.

DELIVERY SYSTEM SUPPORTS

Providers and practitioners play an integral role in helping CalOptima Health members meet their highest level of health. Therefore, CalOptima Health works intentionally and collaboratively to support our provider and practitioner community to fulfill PHM goals. CalOptima Health offers ongoing support to providers and practitioners in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids, continuing education sessions and providing comparative quality and cost information. These supports are described below:

Information Sharing

CalOptima Health provides member-level prospective rates (or gaps in care) reports for providers on a monthly basis to support preventive care outreach and engagement. CalOptima Health will continue to improve information sharing using integrated and actionable data. Additionally, CalOptima Health facilitates ongoing collaboration and open lines of communication regarding member health outcomes through quarterly Joint Operations Meetings and quarterly Health Network Forums to discuss strategies, barriers and opportunities for improvement.

Shared Decision-Making Aids

CalOptima Health aligns decision-making aids with our clinical practice guidelines to promote shared decision making among providers and their members. These are approved by CalOptima Health's Quality Improvement Committees, posted to CalOptima Health's provider website and promoted through our providers newsletters. Shared Decision-Making Aid topics include:

- Cardiac Conditions
- Treatment for Opioid Use Disorder
- Diabetes Medication Choice
- Heart Disease
- Hypertension
- Treatment for Kidney Failure

Transformation Support

CalOptima Health's Orange County Population Health and Transition to Value-Based Care Initiative (PHVBC) aims to support participating health centers and their providers in transforming access to quality of care while strengthening the safety net system across OC. Over the course of five years, teams from local community clinics will advance their internal systems and implement projects that strengthen their population health capacities and readiness for high-quality and value-based care with the incentives provided by the $50 million PHVBC initiative. Activities will focus on advancing population and community supports (i.e., advocating for support, expanding access to coverage and quality of care) provided to disproportionately impacted communities in Orange County; ultimately, shifting from the idea that the volume of services rendered can serve as a proxy for better health outcomes to a value- and team-based model of care that focuses on the whole person.

The Institute for High Quality Care (IHCQ) will provide technical assistance throughout the initiative, and the Center for Community Health and Evaluation (CCHE) will be the initiative evaluator. Furthermore, the IHCQ will provide a variety of technical assistance to support participating teams throughout the initiative, including training, topic-specific working groups, coaching and curating best

practices and other resources. These supports will be designed and tailored on the PHVBC health centers' specific project and areas of interest and/or need.

CalOptima Health will use the provider profiles to identify practitioners, organizations or communities that do not meet accepted standards of care. Profiling can be used to evaluate both the overuse and underuse of appropriate services. This will help them transform their practices to be more quality and outcome focused. CalOptima Health will use the profiles as a mechanism to administer its financial incentives program for providers to improve quality. The incentives are designed to support practitioners with the necessary funding so they can focus more on care coordination and preventive care. It will provide clinics with the resources to bring on additional staff that can coordinate member care across the spectrum of providers. CalOptima Health will establish goals for providers that align with the quality improvement goals to focus on high priority measures.

Training on Equity, Cultural Competency, Bias, Diversity and Inclusion

CalOptima Health's Cultural Competency training is required for all health care providers and staff who care for our members. The training is available on CalOptima Health's website for providers to complete. The training provides an overview of CalOptima Health's diverse membership, helps providers identify members with potential cultural or language needs where alternate communication methods are needed, and ensures that persons interacting with CalOptima Health members understand how culture and language may influence health.

Pay for Value (P4V)

CalOptima Health's Pay for Value (P4V) program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks and CalOptima Health Community Network (CCN) PCPs are eligible to participate in the P4V programs.

The purpose of CalOptima Health's P4V program is to:

1. Recognize and reward health networks and their physicians for demonstrating quality performance;
2. Provide comparative performance information for members, providers and the public on CalOptima Health's performance; and
3. Provide industry benchmarks and data-driven feedback to health networks and physicians on their quality improvement efforts.

The Medi-Cal P4V program incentivizes performance on all HEDIS® measures that are included in the DHCS Managed Care Accountability Sets (MCAS) required to achieve a minimum performance levels (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures.

PHM Structure

PHM operations at CalOptima Health are supported by a leadership team, allied health professionals and administrative staff. PHM assumes responsibility for health education and disease management programs for all CalOptima Health members. In addition, PHM oversees the strategic management efforts including the identification the health and wellness needs of CalOptima Health members and aligning

organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. The following is a description of PHM team roles and responsibility.

Team Roles and Responsibilities

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the PHM Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members, including Population Health Management. At least quarterly, the CMO presents reports on PHM activities to the Board of Directors' Quality Assurance Committee.

Chief Health Equity Officer (CHEO) leads the development and implementation of health equity as a core competency through collaboration with leaders across CalOptima Health and serves as the voice and content expert on health equity for CalOptima Health's members, affiliates and partners, providing strategic direction around clinical interventions, benefit design, engagement strategies and participates in testing and evaluation initiatives.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Population Health Management (PHM), Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Population Health Management (ED PHM) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO) and Executive Directors from Behavioral Health, Quality, and Clinical Operations Departments, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Clinical Operations functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the Executive Director of Quality and Population Health Management.

Executive Director, Quality (ED QI) is responsible for facilitating the companywide QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Credentialing.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for the management and oversight of CalOptima's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Medical Director, Population Health Management and Equity is responsible for advancing population-wide health and well-being for CalOptima Health members by providing clinical guidance for PHM strategies and programs, conducting staff and provider trainings on relevant PHM issues, reviewing and approving health education materials, group class curricula, clinical practice guidelines, shared decision-making aids, and consulting on individual member cases within PHM programs.

Director, Population Health Management (PHM Director) is responsible for advancing population-wide health and well-being for CalOptima Health members by coordinating the development and implementation of a comprehensive population health management plan and health equity framework aligned with the organization's strategic goals. PHM Director provides oversight and supervision of staff to monitor the implement organization-wide population health initiatives amongst internal departments, contracted providers health networks and external stakeholders aligned with CalOptima's overall mission and strategic goals. The PHM Director ensures that the department meets ongoing regulatory compliance and accreditation standards. PHM Director plays a key leadership role, interacting with all levels of CalOptima staff and external stakeholders to implement programs and Quality Improvement (QI) processes that improve cost savings, quality outcomes and member and provider satisfaction.

The following staff support the implementation of strategies within the Population Health Management department:

Managers, Population Health Management (PHM Managers) in Health Education, Disease Management, Maternal Health and Strategic Initiatives:

- Assist with the development of PHM goals and program priorities.
- Analyze best practices for population management and generating ideas to improve operational efficiency within the department.
- Oversee processes to ensure all regulatory requirements are met and exceed all standards.

Supervisors, Population Health Management (PHM Supervisors) in Health Education and Disease Management:

- Provide guidance and support for the implementation of special projects and pilots, or directly handling complex PHM requests from members, providers or staff.

- Monitor staff goals and productivity.
- Ensure compliance with cultural and linguistic requirements and processes, desktop procedures, organizational policies or contractual requirements.

Program Managers, Population Health Management (PHM Program Managers) in strategic initiatives:

- Develop cross-agency workstreams to meet standards in population health as outlined by regulatory entities, strategic priorities and Board directives.
- Plan, implementing and/or evaluating new interventions, programs and interventions.
  Keep current on the local, state, and federal healthcare environment, identifying issues that may impact CalOptima's medical management programs.

Health Educator, Population Health Management (PHM HEs) team:

- Provides health education coaching to individuals or group classes using a member-centric approach.
- Prepares written materials for distribution to members in the appropriate formats and literacy levels as needed.
- Delivers health education interventions through various methods and techniques that are effective to CalOptima Health's members.

Health Coaches, Population Health Management (PHM HCs) team:

- Assesses and develops self-management plans for CalOptima Health members benefiting from chronic condition management, nutrition management and/or psychosocial support.
- Shares the member's specific self-management goals, progress and other pertinent information with their health care team to ensure consistency of member goals.
- Monitors member's health condition and self-management goal outcomes.

Registered Dietitians, Population Health Management (PHM RDs) team:

- Provides individual nutrition assessments, counseling and education by phone or in person using a patient-centered approach.
- Develops nutrition education materials to promote prevention, management of chronic illness and healthy living.
- Works closely with other departments and medical support staff to assist with member care planning.

Personal Care C*oordinators*, *Population Health Management (PHM PCCs)* team:

- Provides outreach to members to coordinate completion of trimester specific assessments including postpartum following CPSP protocols.
- Collaborates with licensed professionals in the development of an initial care plan for each member, incorporating all assessment findings.
- Facilitates warm transfers to member's assigned case manager in accordance with member needs, when appropriate. Notifies member's care team of key event triggers.

Program Coordinator, Population Health Management (PHM PC):

- Provides analytical support to Population Health Management functions, including program development, evaluation and targeted initiatives.
- Manages department calendar by updating and bringing awareness to upcoming milestones and events.
- Acts as administrative support for company-wide and department-specific projects, such as generating reports and maintaining the department's tracking logs, including, but not limited to, action items and executive briefs.

Program Specialists*, Population Health Management (PHM PS)* team:

- Participates in cross-functional teams responsible for the identification, implementation and evaluation of health education activities.
- Supports management in the development, running and evaluation of new population-based disease management programs that support department initiatives.
- Supports management by developing and/or overseeing the process of written tools for programmatic use including program plans, surveys and evaluation instruments.

PHM Oversight

CalOptima Health strives to ensure that PHM strategic management processes are co-created, monitored and evaluated with input from members, providers, stakeholders and leadership. This helps ensure that all PHM programs and services are informed by multidisciplinary experts and approved through careful leadership consideration. The following description provides a high-level summary of our PHM strategic management oversight process.

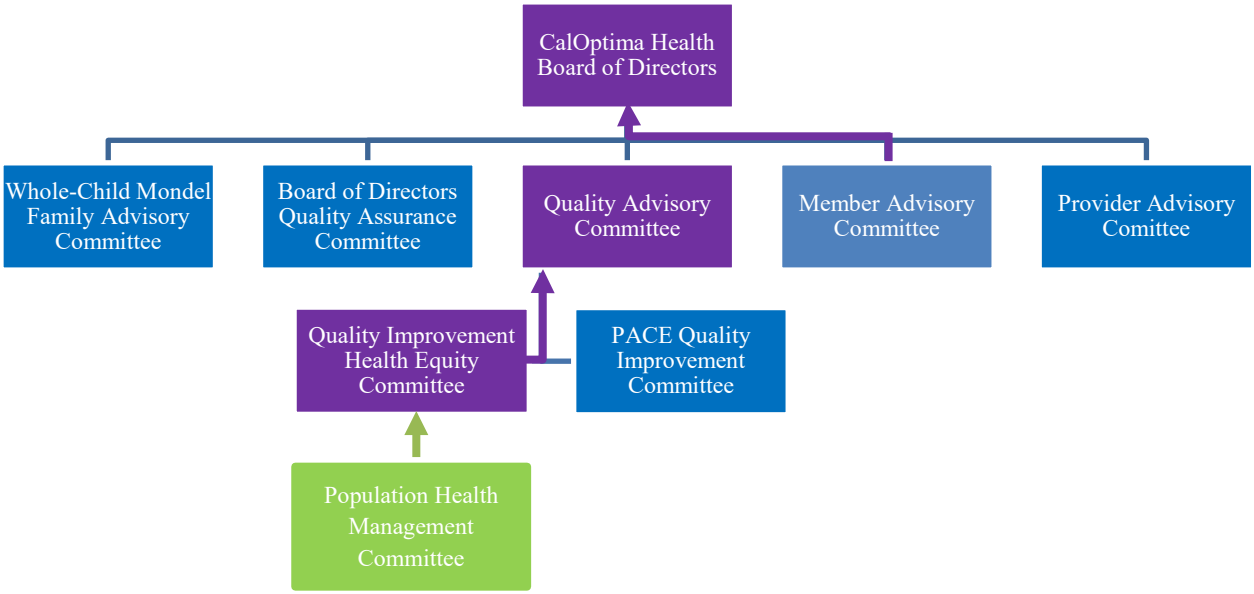
PHM Oversight Responsibilities

Dedicated staff from PHM, in collaboration with other multidisciplinary work teams throughout the agency and guidance from CalOptima Health leadership, assess service utilization patterns, disease burden and SDOH factors to identify gaps in member care. This comprehensive assessment is summarized in an annual PNA. Key findings of the PNA are shared with CalOptima Health's Member Advisory Committee, multidisciplinary care teams and stakeholders to propose new interventions to overcome member gaps in care. Proposed interventions are reviewed by Population Health Management Committee (PHMC) and documented as part of the annual PHM Strategy and Workplan proposals. The PHM Strategy and Workplan proposals are presented to the Quality Improvement Health Equity Committee (QIHEC) for approval. CalOptima Health's QIHEC reports summarize approved PHM Strategy and Workplans to the Board of Director's Quality Assurance Committee (QAC).

Committee Approval Descriptions

The diagram below illustrates the pathway of approval and oversight of the PHM Strategic Management activities along with committee descriptions.

PHM Approval Diagram



Population Health Management Committee (PHMC)

The purpose of the PHMC is to provide overall direction for continuous process improvement and oversight of the PHM Program; ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities; and monitor compliance with regulatory requirements.

Quality Improvement Health Equity Committee (QIHEC)

The purpose of the QIHEC is to assure that all quality improvement activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members.

Board of Directors' Quality Assurance Committee (QAC)

The QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations.

CalOptima Health Board of Directors

The Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima Health's state and federal contracts — and to CalOptima Health's CEO.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

MY 2024 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the Medi-Cal P4V program.

Recommended for MY 2024 Medi-Cal P4V

1. Include measures held to an MPL in the MY2024 MCAS measure set.

MY 2024 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Chlamydia Screening in Women
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Postpartum Care
Child and Adolescent Well-Care Visits	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	CAHPS- Rating of Health Plan: Adult and Child
Lead Screening in Children	CAHPS- Rating of Health Care: Adult and Child
Topical Fluoride in Children	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Getting Needed Care: Adult and Child
Asthma Medication Ratio	CAHPS- Getting Care Quickly: Adult and Child
Controlling High Blood Pressure*	CAHPS- Coordination of Care: Adult and Child
Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) lower is better*	

   - Utilize both Child and Adult CAHPS scores.
     - To calculate performance, average scores
2. Maintain program funding methodology at ten percent (10%) of professional capitation (base rate only).
3. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

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Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS measures weighted 1.0
  - CAHPS measures weighted 1.5
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

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Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on areas with the greatest opportunity for improvement and incentivizes performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

1. Utilize the following CMS Star Part C and Part D measures, measure weights, and Star thresholds as benchmarks:

Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
	Rating of Drug Plan
	Getting Needed Prescription Drugs

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS process measures weighted 1.0
  - CAHPS measures weighted 2.0
  - Outcome measures weighted 3.0
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

3. Apply a program funding methodology of $20 PMPM

2023 Quality Improvement Program Evaluation, 2024 Quality Improvement and Health Equity Transformation Program and Work Plan

Quality Assurance Committee Meeting

March 13, 2024

Linda Lee, Executive Director, Quality Improvement

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.

2023 Quality Improvement (QI) Program Evaluation

Board of Directors Quality Assurance Committee

March 13, 2024

Linda Lee, Executive Director, Quality Improvement

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CalOptima Health

Quality Improvement (QI) Evaluation

- Annually, CalOptima Health evaluates the effectiveness of the QI Program:
  - Achievements from the previous year
  - Program structure
  - Responsibility and success of QI initiatives
  - Identification of new initiatives

QI Evaluation: 2023 QI Program Achievements

- **September 2023:** For the ninth year in a row, our Medi-Cal plan was among the top plans in California, according to the NCQA's[1] Medicaid Health Plan Ratings 2023.
  - CalOptima Health earned 4 stars out of 5 stars.
- **November 2023:** Two community-based organizations honored CalOptima Health's work serving vulnerable populations.
  - Community Action Partnership of Orange County presented CalOptima Health with its Community Hero Award for our work on housing and food security.
  - The Eli Home presented its Humanitarian Award for our contribution to serving abused and unhoused children and families.

NCQA[1] - National Committee for Quality Assurance

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QI Evaluation: 2023 QI Program Achievements Cont.

- **December 2023:** CalOptima Health was honored twice by the Orange County Business Council's Turning Red Tape Into Red Carpet Awards.
  - We received a nomination for Public-Private Partnership with Chrysalis on a workforce development program.
  - CEO Michael Hunn was nominated for Leadership in Public Service.
- Throughout the year, our executives were honored for their successful leadership at CalOptima Health.
  - Richard Pitts, D.O., Ph.D., Chief Medical Officer, was named a Health Care Hero by the Community Health Initiative of Orange County.
  - Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, was honored by the Los Angeles Times as an OC Visionary and for the OC Inspirational Women Awards.
  - Carmen Katsarov, Executive Director, Behavioral Health Integration, was appointed to Gov. Gavin Newsom's Behavioral Health Task Force.

QI Evaluation: Review of 2023 Priority Goals

Priority Goals	Accomplishments
1. Develop CalOptima Health's Health Equity Framework	• CalOptima Health developed a Health Equity Framework that begins with assessing organizational readiness and includes several milestones to implement interventions, plan activities, and track progress.
2. Improve quality of care and member experience by attaining an NCQA[1] Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare.	• Received a rating of 4 out of 5 in the NCQA's[1] Medicaid Health Plan Ratings in 2023 (9th year in a row) • Received a 3.0 Star Overall Rating for Medicare (OneCare)

NCQA[1] - National Committee for Quality Assurance

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QI Evaluation: Review of 2023 Priority Goals

Priority Goals	Accomplishments

3. Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare, and Hospital Quality.	• Pay for Value:
	  • Generated monthly Prospective Rate reports for Health Networks (HNs) and CalOptima Health Community Network (CCN) Clinics
	  • Shared Health Network Report Cards with HNs
	  • Issued payment checks in Q4 2023
	  • Adopted the Integrated Healthcare Association (IHA) pay for performance methodology (aligns with DHCS[1] MCAS[2] for Medi-Cal and CMS[3] Star measures for OneCare).
	• Hospital Quality Program
	  • Developed and distributed to each contracted hospital baseline scorecards indicating hospital performance for MY 2022.

DHCS[1] – Department of Health Care Services
MCAS[2] – Managed Care Accountability Sets
CMS[3] – Centers for Medicare and Medicaid

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2023 QI Evaluation Highlights: Program Structure and Oversight

- The QIHEC met 12 times in 2023
  - Six subcommittees met at least quarterly in 2023
- Integrated health equity and population health management
  - Changed from Quality Improve Committee to Quality Improvement Health Equity Committee (QIHEC)
  - Change from Quality Improvement Program to Quality Improvement and Health Equity Transformation Program (QIHETP)
  - Hired a new Chief Health Equity Officer (CHEO), who co-chairs the QIHEC
  - Created a new subcommittee, the Population Health Management Committee, to oversee and guide the Population Health Management (PHM) Strategy activities and PHM Workplan.
- Expansion to 15 Medical Directors to support a Medical Model
- Care Management System Transition from Guiding Care to Jiva

2023 QI Evaluation Highlights: Program Initiatives

- COVID-19 Vaccination Incentive Program (VIP) met goal with a 70.28% vaccination rate for members 18 years of age or older (Goal = 70%)
- Through the Student Behavioral Health Incentive Program (SBHIIP), CalOptima Health has built strong partnerships with Orange County Department of Education (OCDE) Leadership from 29 school districts to increase BH screenings and referrals and provider better care for our members.
- Launched an Enhanced Care Management (ECM) Academy to add new ECM providers and implemented a Street Medicine Program as part of CalAIM.

2023 QI Evaluation Highlights: Performance Outcomes

- Medi-Cal
  - CalOptima Health met 14 of the 15 MCAS[1] measures held to the MPL[2]
  - Lead Screening in Children (LSC) is a new measure for MPL and did not meet the MPL
- OneCare
  - 9 of the 13 Star measures achieved a 3.0 Star or higher rating
  - The following measures reported a 2.0 Star rating
    - Transitions of Care
    - Follow-up After Emergency Visit for People with Multiple High Risk Chronic Conditions
    - Statin Therapy for Patients with Cardiovascular Disease
    - Annual Flu Vaccinations

MCAS[1] – Medi-Cal Managed Care Accountability Set; goal is 50th percentile
MPL[2] – Minimum Performance Level

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2023 QI Evaluation Highlights: Member Experience

- Member Experience (CAHPS[1]) Surveys were fielded at both the plan and network level in 2023
  - NCQA[2] Health Plan Rating for Patient Experience at 2-Stars (Medi-Cal)
  - CMS[3] Star Rating (OneCare)
    - Rating of Health Plan at 2-Stars
    - Rating of Health Care Quality 3-Stars (from a 1-Star)
- CalOptima Health submitted all deliverables to DHCS for Annual Network Certification (ANC) and Subcontracted Network Certification (SNC).
  - Met all network certification requirements for ANC.
  - Area of focus: Timely Access (appointment availability) and network adequacy at the health network level.

CAHPS[1] - Consumer Assessment of Healthcare Providers and Systems
NCQA[2] - National Committee for Quality Assurance
CMS[3] – Centers for Medicare and Medicaid

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2023 QI Evaluation Highlights: Patient Safety

- Launched a Transitions of Care (TCS) Program
  - TCS Case Management staff outreach to TCS High Risk members to ensure member needs are met post-hospitalization
  - Focus to reduce plan all cause readmissions (PCR)
    - Follow-up visit with PCP within 30-days after hospital discharge for:
      - Medication review
      - Resolution of discharge summary follow-up items.
  - TCS Program met goal (Q3 2023) with a PCR of 18.39% (Goal – 25%; lower is better)

2023 QI Evaluation: Recommendations for 2024

- Collaborate with external stakeholders and partners in comprehensive assessments of members.
- Enhance member and provider data collection to ensure the practitioner network can meet cultural and linguistic needs of our members.
- Incorporate feedback provided by members and network providers in the design, planning, and implementation of its continuous quality improvement (CQI) activities, focusing on access to care.
- Incorporate social determinants of health (SDOH) factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
- Strategize and streamline member outreach by using multiple modes of communication via contracted external vendors, including through website, direct mailings, email, interactive voice response (IVR) calls, mobile texting, targeted social media campaigns and robocall technology.

2024 Quality Improvement and Health Equity Transformation Program (QIHETP) Description

Board of Directors Quality Assurance Committee
March 13, 2024

Linda Lee, Executive Director, Quality Improvement

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2024 Quality Improvement and Health Equity Transformation Program (QIHETP) Process

- Based upon the evaluation of the previous year, the QIHETP is revised and updated for the following year.
- The QIHETP provides a formal process to systematically monitor and objectively evaluate, track, and trend quality, efficiency, and effectiveness.
- The QIHE Annual Workplan provides the detail of how CalOptima will design, implement and measure the initiatives outlined in the QIHETP.

2024 QIHETP Description

- QIHETP describes the following:
  - Program Structure
  - Scope of services for each line of business
  - Provider network and partners
  - Quality and safety of clinical care, and organizational services provided to our members
  - QIHE Annual Workplan (Appendix)
  - Population Health Management Strategy (Appendix)
  - Pay for Value (P4V) Program (Appendix)

2024 QIHETP Description(cont.)

- The QIHETP aligns with:
  - CalOptima Health's five Strategic Priorities and Objectives:
    - Organizational and Leadership Development
    - Overcoming Health Disparities
    - Finance and Resource Allocation
    - Accountabilities and Results Tracking
    - Future Growth
  - The priorities of our state and federal regulators:
    - Center for Medicare and Medicaid Services (CMS) National Quality Strategy
    - Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)
  - CalOptima Health's Health Equity Framework

2024 QIHETP Description:
2024 QIHETP Priority Areas and Goals

Priority Area	Goals
Maternal Health	○ Close racial/ethnic disparities in well-child visits and immunizations by 50% ○ Close maternity care disparity for Black and Native American persons by 50%
Children's Preventive Care	○ Exceed the 50th percentile for all children's preventive care measures
Behavioral Health Care	○ Improve maternal and adolescent depression screening by 50% ○ Improve follow-up for mental health substance disorder by 50%
Program Goals	○ Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS) ○ OneCare: Attain a Four-Star Rating for Medicare

2024 QIHETP Description and Revision Highlights

- Incorporated a health equity focus into the QI Program, now named Quality Improvement and Health Equity Transformation Program (QIHETP)
- Updated the priority areas and goals
- Updated sections in the QIHETP to reflect current operational processes and workflows
  - NCQA Accreditation
  - Grievance and Appeals
  - Encounter Data Review

2024 QIHETP Description and Revision Highlights

- Updated the QIHE Program Staffing and Resources to reflect current organizational structure
  - Added a Chief Health Equity Officer
  - Added Medical Directors to support a Medical Model
  - Added Director, Medicare Stars and Quality Initiatives
  - Added Director, Medicare Programs
- Updated the QIHE Committee Structure
  - Added the Population Health Management Committee
- Removed programs that were concluded in 2023
- Updated sections in the QIHETP to reflect current operational processes and workflows

2024 Annual Work Plan Focus Areas

- Preventive measures and screenings identified in the DHCS Quality Strategy (Bold Goals)
- Social Determinants of Health (SDoH) factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
- Quality initiatives to improve member experience, focused on increasing member access to care.

2024 QI Annual Work Plan Revisions: Program Structure and Oversight

Change	Programs
Revised	○ Incorporated health equity into the Quality Improvement (QI) Program; now called Quality Improvement and Health Equity Transformation Program (QIHEC) ○ Utilization Management Program Description changed to Utilization Management Case Management Program Description
Added	○ Cultural and Linguistic Program and Workplan ○ Population Health Management Committee ○ Care Management Program ○ Delegation Oversight ○ Disease Management Program ○ Health Education ○ Long-Term Support Services (LTSS)
Removed	○ CalAIM – Monitored under Utilization Management Committee (UMC)

2024 QI Annual Work Plan Revisions : Quality of Clinical Care

Change	Programs
Added	○ Coordination of Care: Member movement across settings and between practitioners ○ Facility Site Reviews (FSRs) include Medical Record Reviews (MRRs) and Physical Accessibility Reviews (PARs) ○ Continuity and Coordination of Care Between Medical Care and Behavioral Health Provider Credentialing ○ Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) ○ Encounter Data Review
Removed	○ COVID-19 Vaccination and Communication Strategy – Program Ended ○ Implement multi-disciplinary approach to improving diabetes care for CCN Latino Members Pilot - Program Ended ○ Depression Remission or Response/Screening and Follow-up for Adolescents and Adults

2024 QI Annual Work Plan Revisions : Quality of Service and Safety of Clinical Care

Change	Programs
Revised	○ Transitional Care Services (TCS) goal revised
Added	○ Grievances and Appeals Resolution Services ○ Annual Network Certification (ANC) ○ Subcontracted Network Certification (SNC) ○ Cultural and Linguistic and Language Accessibility
Removed	○ Provider Data Improvement – monitored until SNC ○ STARS Measures Improvement – monitored under Quality Performance ○ Reporting Communicable Diseases – On-going provider education

Questions



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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 13, 2024
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

4. Recommend that the Board of Directors Approve the 2023 CalOptima Health Utilization Management Program Evaluation and the 2024 CalOptima Health Integrated Utilization Management/Case Management Program Description

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director, Utilization Management, (657) 900-1013

Recommended Actions

- Recommend Board of Directors' approval of the 2023 CalOptima Health Utilization Management Program Evaluation, and
- Recommend Board of Directors' approval of the 2024 CalOptima Health Integrated Utilization Management and Case Management Program Description.

Background

CalOptima Health's Utilization Management (UM) Program describes how medically necessary and quality health care services are delivered to members in a coordinated, comprehensive, and culturally competent manner. The program ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, and does not encourage decisions that result in underutilization.

CalOptima Health's UM Program is reviewed and evaluated annually and approved by the Board of Directors. The UM Program defines the structure within which UM activities are conducted and establishes processes for systematically coordinating, managing, and monitoring these processes to achieve positive member outcomes.

CalOptima Health's UM Program achievements in 2023 included:

- Improved reporting/workflows to prioritize treatment authorization to exceed required turnaround times;
- Provider portal enhancements to automation and capabilities;
- Design, configuration, and preparation for the new medical management clinical documentation platform, Jiva, for implementation in February 2024;
- Continuity of care protocol refinements;
- Transplant and transitional care services program enhancements;
- Pediatric inpatient rounds and coordination of California Children's Services eligibility needs;
- Launch of care coordination workgroups to include, Brain/Spine/Pain, Bed Day Reduction Strategy, and Inpatient Utilization Strategy.

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In 2022, the CalOptima Health UM leadership worked with the enterprise analytics team to develop real time reporting capabilities and implemented internal structural changes to improve the timeliness and operational effectiveness of the UM Program. These structural changes continue to be reviewed and enhanced to allow for continued inventory management oversight. Additional improvements included the addition of four (4) Medical Director leaders and filling several vacant key roles. Process improvements such as improved workflows, standardized templates, and improved real time reporting all contributed to UM Program enhancements during 2023.

Discussion

CalOptima Health's 2024 Integrated UM and Case Management (CM) Program Description includes the following departments quality, pharmacy, population health management, and behavioral health. The program description will ensure that all regulatory requirements and National Committee for Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business and aligned with health network and strategic organizational changes.

The revisions are summarized as follows:

- Quality program initiatives;
- Health Network Forum;
- Membership by gender, age, demographics, ethnicity, and spoke language;
- Inclusion of workgroups, UM Workgroup, Brain/Spine, Transplant, UM Authorization Strategy, Bed Day Reduction, and Gender Affirming Care;
- Hierarchy of clinical criteria;
- Long Term Services and Supports;
- Complex CM services;
- Transitional Care Services;
- Palliative Care Services
- UM Committee membership updates;
- Benefit Management Subcommittee membership updates;

The purpose of the 2024 Integrated UM and CM Program Description is to define the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic approach. All health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an effective, and timely manner by delegated and non-delegated providers.

The changes to CalOptima Health's Integrated UM and CM Program Description reflect current clinical operations and are necessary to meet the requirements specified by the Centers of Medicare and Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

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Fiscal Impact

The recommended action to approve the2023 UM Program Evaluation and 2024 CalOptima Health Integrated UM and CM Program Description does not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2023-24 Operating Budget and separate Board actions. Staff will include updated expenditures for the period of July 1, 2024, through December 31, 2024, in the FY 2024-25 Operating Budget.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2023 UM Program Evaluation
2. 2024 UM/CM Integrated Program Description (Redline version)
3. 2024 UM/CM Integrated Program Description (Clean version)
4. Annual Review: 2023 UM Program Evaluation and 2024 UM/CM Integrated Program Description (PowerPoint)

/s/ Michael Hunn *03/08/2024*
Authorized Signature **Date**

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20233 CalOptima Health Utilization Management Program Evaluation

Executive Summary

The 20233 Utilization Management (UM) Program description defines and outlines CalOptima Health's clinical activities to provide optimal utilization and quality health care services that are delivered compassionately at the right time and in the appropriate setting.

CalOptima Health evaluates the UM program structure, scope, processes, and information sources used to determine utilization trends, medical necessity, and benefit coverage determinations. This evaluation of UM activity is reviewed and approved annually by the UM Committee (UMC), the Quality Improvement Health Equity Committee (QIHEC) and the Quality Assurance Committee (QAC). The look back period for the 20223 UM program evaluation is Q4'20212 through the end of Q3'20223.

Program Structure and Process

The UM program was enhanced throughout 20223 to ensure member needs were addressed, while maintaining compliance with regulatory and accreditation standards. Although the staffing model for the UM nursing and non-clinical Teamsdepartment working prior authorization requests and conducting inpatient reviews did not change during the 20223 reporting period, the Medical Director Team was enhanced with additional physician reviewers and targeted specialties., CalOptima implementedHealth also implemented multiple process improvements throughout the year to address operational and clinical enhancements. These included but not limited to the following:

- Improved workflows and oversight to prioritize aging inventory to exceed regulatory turnaround time compliance.

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- ~~UM clinical team standardized templates for medical director reviews~~
- Continued refinement of ~~i~~inpatient (adult) facility clinical rounds to conduct peer to peer and complex discharge planning and support needs.
- Launch of pediatric inpatient focused on long lengths of stay (NICU and PICU) and coordination of CCS eligibility and needs.
- Improved access to real time reporting and tools to address authorization requests
- Enhanced provider portal automation and capabilities.
- Developed referral business rules for UM clinical staff to apply hierarchical criteria and to only approve where appropriate without Medical Director review.
- ~~Addition of a dedicated clinical trainer~~
- Temporary coverage for all vacant roles to minimize the impact of staffing fluctuations.
- Implemented transitions of care to include a touch to all post discharge members ensuring discharge needs such as, physician follow up care and ancillary services are met.
- Refinement of bed days goals.
- Established a Brain/Spine/Pain Workgroup.
- Enhanced the continuity of care process.
- Enhanced the transplant program to include expansion of COE to UCSD and fully coordinated inpatient rounds, lodging and meal assistance to family members/caretakers of transplant members.
- Design review and configuration of the new medical management platform for implementation in 2024.

Program Structure

During 202~~2~~3, CalOptima Health added ~~three~~ five additional ~~m~~Medical ~~d~~Directors to the UM Program to continue to address clinical complexities and the need for additional specialty programs and interventions.

The following specialties and ~~m~~Medical ~~d~~Directors with robust experience in key areas were added to the full-time ~~m~~Medical ~~d~~Director team within the UM Program:

- Internal ~~and Preventative~~ Medicine with Stars and HEDIS quality measures ~~Case Management and Gender Affirming Care~~ experience and expertise
- ~~Family Practice with extensive experience with Population Health Management experience~~
- ~~Surgery and Transplant with experience in performing complex cancer procedures~~
- Emergency Medicine with trauma experience to oversee the CalOptima Health Street Medicine program
- Child and adolescent psychiatry and pharmacy
- Internal Medicine with utilization and quality management experience
- Family Medicine with addiction and correctional health certification.

~~The Deputy Chief Medical Officer and the PACE Medical Director vacated in 2021 were filled during 2022.~~ ~~A dedicated clinical trainer role was added and a process to secure clinical and~~

~~non clinical temporary staffing coverage for any open positions was established.~~
In addition to the above Medical Directors, CalOptima Health added a Chief Equity Officer to focus on areas to include but not limited to, public and mental health focusing on health equity.

Information sources as well as staff assigned activities used to determine benefit coverage and medical necessity remained current and appropriate, in addition the current UM structure supports CalOptima Health's UM functions. Medical Necessity coverage tools and hierarchical protocols are reviewed and approved annually at the UMC~~.~~

Program Scope Impact

Effective January 1, 2022, DCHS mandated Medi-Cal retail pharmacy and pharmacy grievances be carved out of managed care health plans and on January 1, 2022, Magellan Rx began managing the pharmacy benefit for CalOptima Health. CalOptima Health continues to manage the Medicare ~~primary retail~~outpatient pharmacy benefit and ~~Rx~~ grievances as well as physician-administered drug (PAD) ~~medical pharmacy~~ benefits. ~~assisted in the transition by resolving access issues around outpatient pharmacy and educating the members on the variances with the formulary and access continuity of treatment. In addition,~~ The current UM structure is effective in supporting the required CalOptima Health UM functions based on 2023 data and analysis. Throughout 2023 DHCS continued to focus on population health management initiatives targeting transitional care support and Medi-Cal CalAIM community supports/ECM. CalOptima Health operationalized all 14 community supports and continues to increase network of community-based ECM providers based on members needs and preferences.

PROJECTS, PROGRAMS AND INITIATIVES

A. Utilization Management

Oversight of prior authorization (PA) inventory continued to be part of the overall UM ~~p~~Program ~~—~~to improve average turnaround time to decision aligned with CalOptima Health's strategic vision for same day treatment authorizations. ~~Interventions put into place to address a backlog of cases identified during Q4 2021 continue to ensure regulatory and accreditation requirements remain compliant, and members receive timely decisions on requested services.~~

Initiatives implemented or enhanced to support the UM Program include but is not limited to:

- UM Leadership daily morning touchpoint to review outstanding pending inventory.
- Hospital partner engagement to gain EMR access for CalOptima Health staff to send timely discharge summaries and medication reconciliation to the PCP to incorporate in the member outpatient chart.
- Created a Bed Day Reduction Strategy Sub Workgroup to be led by CalOptima Health Medical Directors with the participation of UM and CM staff. This Workgroup will

analyze bed day data identifying opportunities for improvement and the development of interventions to reduce over utilization of inpatient services thus decreasing admits/1000 and ALOS.

- Created an Inpatient Utilization Strategy Sub Workgroup to identify members at risk for a readmission and the development and implementation for focused and targeted support.
- Enhanced post discharge process to include but not limited to, coach members to convene a telehealth PCP or specialty follow-up within 30 days post discharge and coordinated communication will treating providers.
- Enhanced Transitional Care Services (TCS) to include ~~but not limited to, created~~ a TCS High Risk flag as identified by DHCS, UM and CM staff outreach to all discharged members to ensure receipt of post hospital care needs are met and the member has a scheduled appointment with their PCP, and development of a member resource letter to provide members with a single point of contact for navigation assistance through transitions of care.
- Enhanced the PCP Discharge Notice faxed to the PCP. This notice includes the hospital Discharge Summary and Medication Reconciliation list and reminds providers to file in the members outpatient medical chart.
- Review Admit Discharge and Transfer (ADT) data file transfers and identify a mechanism for real time PCP admit, discharge, and transfer notification.

~~The UM Medical Director(s) remained very engaged in the UM process and provided continuing clinical oversight for the administration of the UM Program. This oversight and support included but is not limited to reviewing outcomes in UMC to ensure compliance with regulatory, contractual and accreditation guidelines and clinical evidence based criteria, and by evaluating the program's effectiveness against established goals.~~

UM Medical Directors

The UM Medical Director(s) remained very engaged in the UM process and provided continuing clinical oversight for the administration of the UM Program. This oversight and support included but is not limited to reviewing outcomes in UMC to ensure compliance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, review of over and underutilization patterns, evaluating the UM Program's effectiveness against established goals, and leading Committee's and Sub Workgroups that report into the UMC.

~~The~~ The UM Medical Directors (including Behavioral Health and Pharmacy) are responsible for overseeing provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). The purpose of the BMSC~~is committee~~ is to evaluate new and modified benefits and determine the need for prior authorization. This ~~c~~Committee is

led by the chair Medical Director and includes input from peer Medical Directors, Deputy Chief Medical Officer, and Clinical Leaders within Utilization ~~m~~Management. The~~is~~ activities~~y~~ of this Committee continues to gain provider and member satisfaction ~~by allowing the provider network to inform decisions on what requires prior authorization~~ and allow for access and automation where appropriate.

The assigned UM Medical Director responsible for facilitating the bi-weekly Utilization Management Work Group (UMWG) ensures collective CalOptima Health Clinical leadership, Medical Director leaders, including behavioral health, pharmacy and Deputy Chief Medical Officer all provide input to the development and processes of the UM Program to ensure that quality care is delivered to CalOptima Health members to meet their physical health, behavioral health and social drivers of health needs. The UMWG activities include but is not limited to, providing input to key UM performance indicators, measures, goals, protocols, provide input to UM Department policies and procedures, and provides updates and input to the quarterly UMC.

The assigned UM Medical Director responsible for facilitating the Bed Day Reduction Strategy Sub Workgroup and the Inpatient Utilization Strategy Sub Workgroup lead the Workgroup Teams to review bed day and ED data to identify under and overutilization to develop and implement opportunities for improvement.

The Medical Director team conducted semi~~semi~~weekly facility internal clinical ~~case~~ rounds with the nursing team to support complex discharge needs. In addition, during these rounds' meetings, hospital discharge staff were educated on ECM, community supports and integrated case management available to members in weekly hospital partner rounding.~~and ad hoc meetings with hospitals and health networks to provide guidance in managing complex cases in post-acute and ambulatory settings as appropriate.~~ The Medical Director team also attended the ~~bi-semi~~weekly Clinical Operations Health Network UM CM forum and provided support to include but not limited to; education of regulatory guidance as outlined by new and/or revised APLs and other regulatory requirements.

Lastly, ~~T~~the Medical Director team also provided to the CalOptima Health clinical team and external provider education and consultation on specific topics including, but not limited to:

- Genetic testing
- Gender Affirming Care and Procedures
- Management of administrative days
- Appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria
- Letter of Agreement (LOA) process
- ~~and~~ Evaluation and Medical Director oversight of the appropriateness of one-day inpatient stays~~.~~
- Management of transplant members
- Management of members requiring neuro or spine surgery

The assigned Behavioral Health Medical Director and the Behavioral Health Integration (BHI)

clinical leadership team provided oversight and input on the UM ~~p~~Program throughout the year to ensure that all BH activities are integrated and aligned with the medical program to ensure compliance with UM regulatory and accreditation requirements and to ensure parity in decision-making. The designated BH Medical Director and BH clinical leadership participated in biweekly UM work groups and quarterly~~,~~ Utilization Management Committee (UMC) meetings, and Benefit Management Subcommittee (BMSC) meetings to ensure adequate representation of critical BH topics such as expansion of the autism benefit and development of strategies to address substance use disorder, eating disorders and coordination with the county to serve our shared members during this period.

~~During Q3 2022, a 90-day Emergency Department (ED) Diversion pilot was implemented to determine if focused clinical support of CalOptima in real time within the ED setting would impact members accessing post ED care. The primary measurements of success established for the pilot were:~~

- ~~Increase CalAIM authorized community support.~~
- ~~Increase PCP follow up visits within 30 days of the ED visit.~~
- ~~Decrease unnecessary ED utilization by redirecting to a more appropriate setting.~~

~~The pilot included a CalOptima embedded LVN within the ED to provide real time prior authorizations post stabilization to appropriate alternate levels of care and/or outpatient services including coordination and scheduling services and referrals to case management.~~

- ~~Early outcomes analysis determined that 72% of the members initially identified as high utilizers of ED services were successfully connected with ambulatory care and CalAIm Enhanced Care Management (ECM) services after pilot interventions.~~
- ~~A total of 190 members were seen as a part of the pilot program for the following successful interventions in real time:~~
- ~~PCP Appointments scheduled 16%~~
- ~~Specialty Appointments scheduled 11%~~
- ~~Other Case Management Referrals 4%~~
- ~~Prior Auth Referrals completed 9%~~
    - ~~Transportation issues resolved 3%~~
    - ~~Medication Issues resolved 8%~~
    - ~~Community Support Referrals 13%~~

~~The pilot ended 12/31/2022~~

~~Next Steps:~~

- ~~Additional pilot analysis including claims review~~
- ~~Consideration of automation for specific and targeted services based on analysis and MD review.~~
- ~~Continue program through real time remote communication (Teams channel, telephonic secure email). The Teams channel has been approved and will be~~

~~implemented by the end of Q4 2023.~~

- ~~Collect data on ED teams usage and outcomes throughout Q1 & Q2 2024 and report trends.~~
- ~~An additional teams channel is being established with UCI ED and will be implemented by the end of Q$ 2023.~~

- ~~Identify future opportunities programmatic and remote support to leverage economies of scale~~

~~Auto-~~Authorization Automation Rule Protocols Pilot ~~Pilot~~

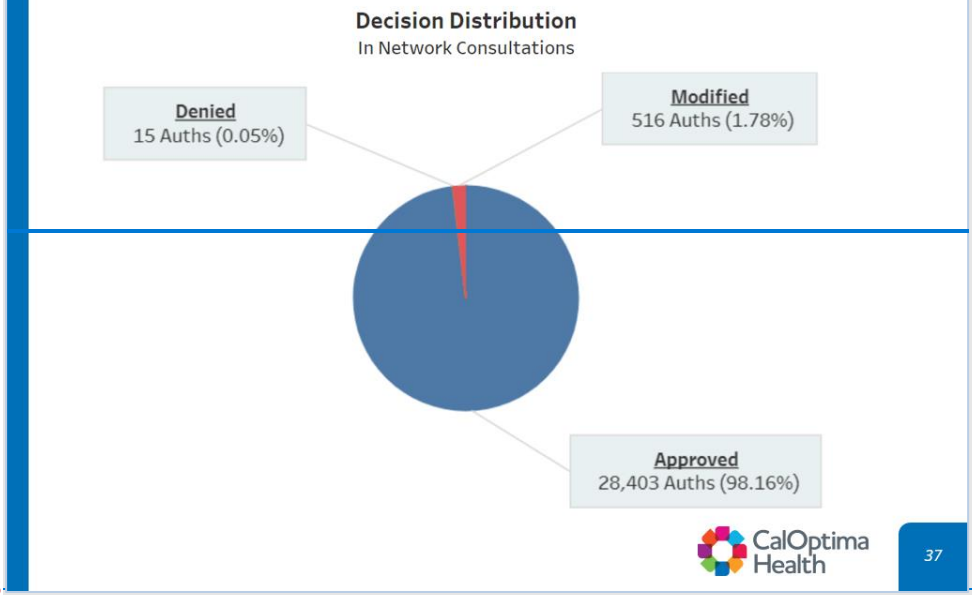
During Q2 2022 an auto-authorization pilot project was implemented for the CCN and COD network to deploy ~~assess~~ automation rules to determine opportunities to auto -authorization or pend for manual review in order to support real time treatment authorization decisions. ~~trends for in network consultations.~~ This pilot and affiliated analysis continued in 2023.~~Each quarter~~ UM leadership and Medical Directors continue to review~~ed~~ utilization patterns. ~~during pilot automation.~~ Below is YTD 2023~~the Q3~~ data ~~for utilization oversight~~ reported to UMC ~~in Q~~20234. The percentage has remained fairly consistent throughout 2023.

	Total Auths	% Approved	% Manual Review
Jan-23	22,382	37.9%	62.1%
Feb-23	20,304	37.8%	62.2%
Mar-23	25,975	37.4%	62.6%
Apr-23	23,655	36.4%	63.6%
~~May-23~~	~~26,090~~	~~36.7%~~	~~63.3%~~
Jun-23	25,972	38.3%	61.7%
Jul-23	23,868	37.2%	62.7%
Aug-23	28,552	35.7%	64.2%
Sep-23	27,013	36.4%	63.5%
Oct-23	25,263	36.2%	63.7%

	Total Auths	% Approved	% Manual Review
Jan-23	22,382	37.9%	62.1%
Feb-23	21,565	38.0%	62.0%
Mar-23	27,108	37.3%	62.7%
Apr-23	24,485	36.4%	63.6%
May-23	26,491	36.6%	63.4%
Jun-23	27,208	38.2%	61.8%
Jul-23	24,730	37.3%	62.7%
Aug-23	28,552	35.8%	64.2%
Sep-23	27,277	35.9%	64.1%

Auto Auth Source: CORE Report AutoAuth_Cercon Referral Count (CC0087_GC) data 1/1/2023-11/30/2023. Data

Q4 Auto Pilot Authorization Overview



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pulled 12/13/2023

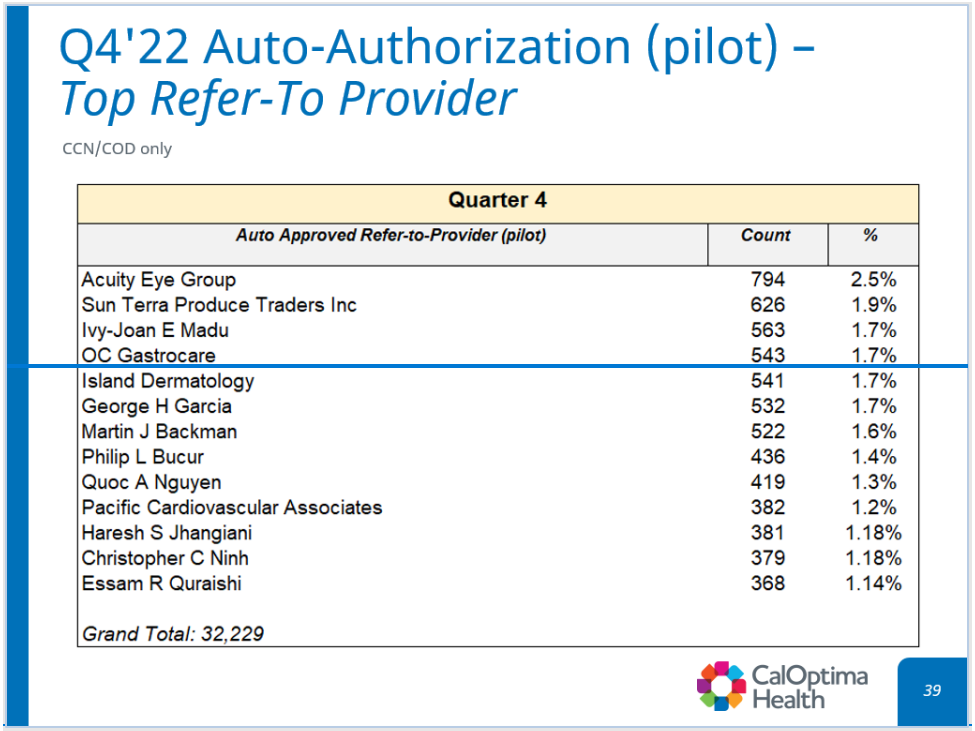
Q4'22 Auto-Authorization (pilot) – *Top Referring Specialty*

CCN/COD only

Quarter 4		
Auto Approved Referring Specality (pilot)	*Count*	*%*
Family Medicine	9873	30.6%
Internal Medicine	3871	12.0%
Nurse Practitioner	3110	9.6%
Clinic (mixed specialty)	1998	6.2%
Physician Assistant	1655	5.1%
Group (mixed specialty)	1084	3.4%
Ophthalmology	1075	3.3%
CalAIM Community Supports	1063	3.3%
General Practice	997	3.1%
Certified Family NP	893	2.8%
Hematology/Oncology	891	2.76%
Orthopaedic Surgery	606	1.88%
Endocrinology/DiabetesMellitus	589	1.83%
Grand Total: 32,229		

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Q4'22 Auto-Authorization (pilot) – *Top Refer-To Provider*

CCN/COD only

Quarter 4		
Auto Approved Refer-to-Provider (pilot)	*Count*	*%*
Acuity Eye Group	794	2.5%
Sun Terra Produce Traders Inc	626	1.9%
Ivy-Joan E Madu	563	1.7%
OC Gastrocare	543	1.7%
Island Dermatology	541	1.7%
George H Garcia	532	1.7%
Martin J Backman	522	1.6%
Philip L Bucur	436	1.4%
Quoc A Nguyen	419	1.3%
Pacific Cardiovascular Associates	382	1.2%
Haresh S Jhangiani	381	1.18%
Christopher C Ninh	379	1.18%
Essam R Quraishi	368	1.14%
Grand Total: 32,229		

B. Behavioral Health Integration

CalOptima Health manages all the administrative functions of Medi-Cal~~,~~ and OneCare (OC) ~~and OneCare Connect (OCC)~~ mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima Health members. The BHI department continues to be directly responsible for BH UM activities including but not limited to prior authorization of routine and urgent outpatient behavioral health services and concurrent review of inpatient psychiatric admission.

C. UM Data Management

~~The~~ UM data reporting design is led by the ~~d~~Director of UM and generated by CalOptima Health's Enterprise Analytics (EA) and Information Technology Services (ITS) ~~d~~Department ~~staff~~. Together with UM ~~d~~Department subject matter experts, EA and ITS maintained a focused effort to improve the visibility and understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima Health and the delegated ~~h~~Health ~~n~~Networks (HNs). ~~Further refinement of d~~Daily inventory reports and denial letter notification report were enhanced ~~continued~~ throughout 202~~2~~3 to ensure continued timely processing of treatment authorization requests and provider and member notifications of denials and modifications. Additional efforts are focused on the development of existing reports from the new medical management system (Jiva) which will be operational in February 2024. ~~being planned to leverage availability of this information to UM, Quality Improvement and Audit and Oversight (A&O) by developing standard queries in the CalOptima Health data mart.~~

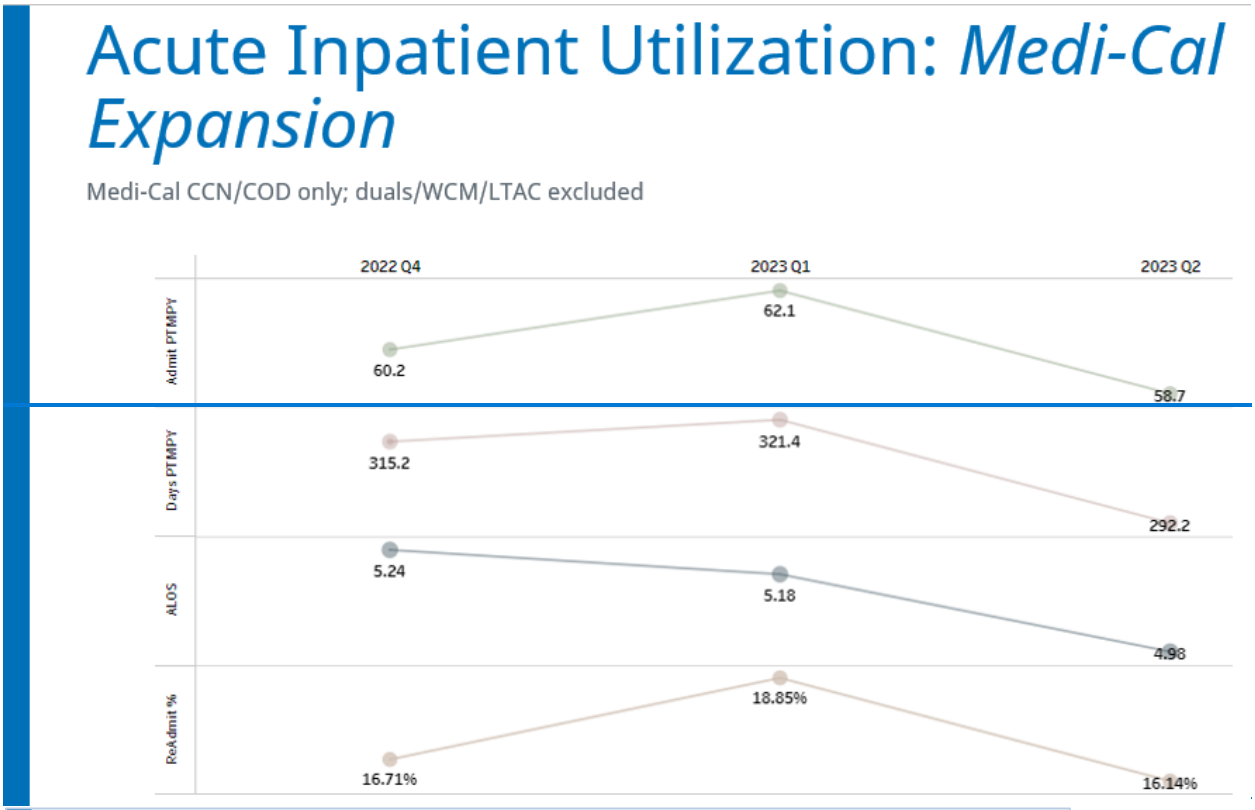
Inpatient Bed day ~~and Emergency Department (ED)~~ Utilization Performance (excludes Health Network data)

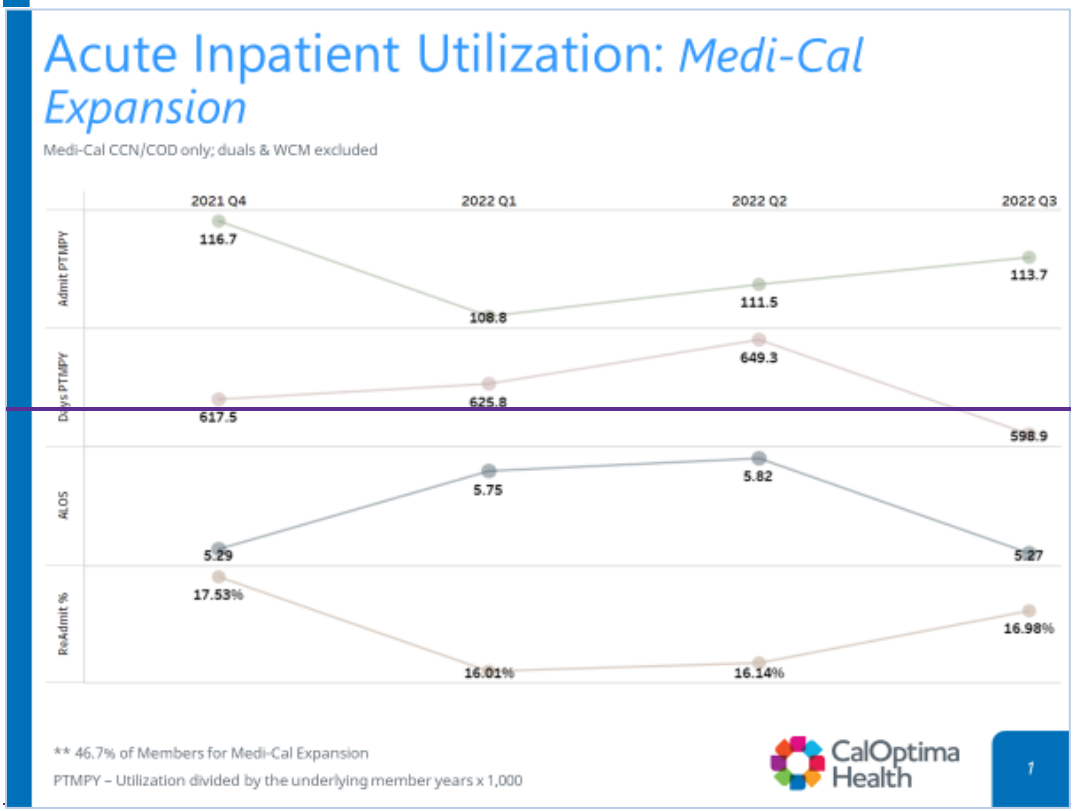
~~**2022 Performance Goals – MCD roll up (excludes WCM and HN data)**~~

~~Metric~~	~~Goal~~	~~2021 Q4~~	~~2022 Q1~~	~~2022 Q2~~	~~2022 Q3~~
~~**ALOS**~~	~~4.3~~	~~5.09~~	~~5.30~~	~~5.31~~	~~4.82~~
~~**Admit PTMPY**~~	~~284~~	~~120.4~~	~~114.2~~	~~116.6~~	~~126.0~~
~~**Days PTMPY**~~	~~358~~	~~613.1~~	~~605.4~~	~~619.5~~	~~607.1~~
~~**Readmit %**~~	~~25%~~	~~16.73%~~	~~15.96%~~	~~15.26%~~	~~16.79%~~

The 2023 goals ~~for 2022~~ were set for a rollup of all Medi-Cal Aid categories. During ~~a~~ 202~~2~~3 the UMC ~~the~~ requested inpatient utilization data to exclude acute rehabilitation and LTAC data. ~~was to split out and report on each MediCal Aid category therefore there is an expediated variance in the goal based on MediCal Aid.~~

~~MediCal Expansion~~





~~Metric~~	~~Goal~~	~~2021 Q4~~	~~2022 Q1~~	~~2022 Q2~~	~~2022 Q3~~

ALOS	4.3	5.29 ↑	5.75 ↑	5.82 ↑	5.27 ↑
Admit PTMPY	284	116.7 ↓	108.8 ↓	111.5 ↓	113.7 ↓
Days PTMPY	358	617.5 ↑	625.8 ↑	649.3 ↑	598.8 ↑
ReAdmit %	25%	17.53% ↓	16.01% ↓	16.14% ↓	16.98% ↓

Medi-Cal Expansion

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	60.2	62.1	105.9	
Days/1000 PTMPY	358	315.2	321.4	553.1	
ALOS	4.3	5.24	5.18	5.22	
Readmit %	25%	17.54%	18.85%	18.27%	

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	60.2	62.1	105.9	103.5
Days/1000 PTMPY	358	315.2	321.4	553.1	518.1
ALOS	4.3	5.24	5.18	5.22	5.01
Readmit %	25.00%	17.54%	18.85%	18.27%	18.65%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.
https://dwtabpr.caloptima.org/#/site/CO/views/MembershipandUtilizationTrends/CoverPage

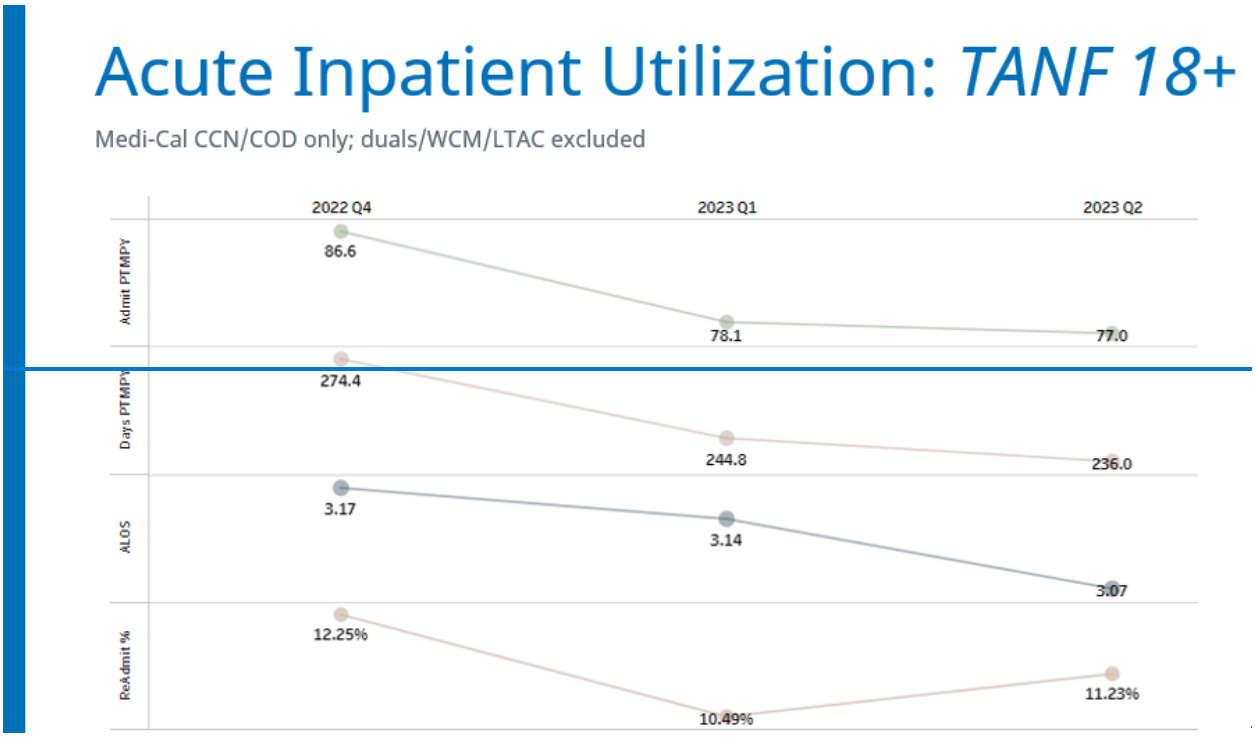
- **Admit/1000 Per Year (PTMPY):** Admits/1000 fell below the goal of 284 in Q4 2022 and 2023 YTD
- **Bed Day/1000 Per Year (PTMPY):** Bed days/100 fell below the goal of 358 in Q4 2022 and 2023 YTD
- **Average Length of Stay (ALOS):** The ALOS for this population remained above the goal of 4.3 in Q4 2022 and 2023 YTDthroughout the 2022 reporting period with an uptick during 2022 Q1 and Q2 and a slight decline during Q3.
- **Readmissions:** Readmits remained below the goal of 25% in Q4 2022 and 2023 YTD

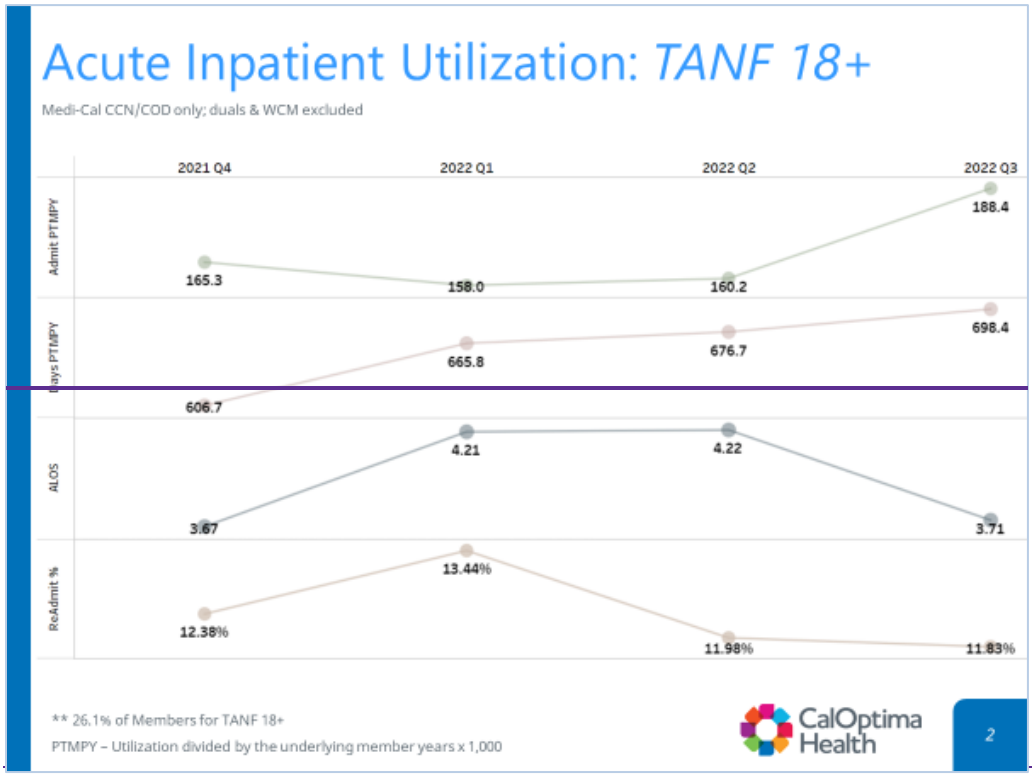
Admits/1000 per Year (PTPMY): Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and an upward trend during Q2 and Q3.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/100 remained above the goal of 358 throughout the 2022 reporting period with an uptick during 2022 Q1 and Q2 and a downward trend during Q3.

- **Readmissions:** Readmits remained below the goal of 25% throughout the 2022 reporting period declining in 2022 Q1 and Q2 with an upward trend in Q3.

~~TANF +18~~





~~Metric~~	~~Goal~~	~~2021 Q4~~	~~2022 Q1~~	~~2022 Q2~~	~~2022 Q3~~
~~ALOS~~	~~4.3~~	~~3.67 ↓~~	~~4.21 ↓~~	~~4.22 ↓~~	~~3.71 ↓~~

~~**Admit PTMPY**~~	~~284~~	~~165.3 ↓~~	~~158.0 ↓~~	~~160.2 ↓~~	~~188.4 ↓~~
~~**Days PTMPY**~~	~~358~~	~~606.7 ↑~~	~~665.8 ↑~~	~~676.7 ↑~~	~~698.4 ↑~~
~~**ReAdmit %**~~	~~25%~~	~~12.38% ↓~~	~~13.44% ↓~~	~~11.98% ↓~~	~~11.83% ↓~~

~~T~~TANF 18+

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	86.6	78.1	141.2	
~~Days/1000 PTMPY~~	~~358~~	~~274.4~~	~~244.8~~	~~428.9~~	
ALOS	4.3	3.17	3.14	3.04	
Readmit %	25%	12.25%	10.49%	12.36%	

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	86.6	78.1	141.2	155.4
Days/1000 PTMPY	358	274.4	244.8	428.9	479.1
ALOS	4.3	3.17	3.14	3.04	3.08
Readmit %	25.00%	12.25%	10.49%	12.36%	13.09%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.
~~https://dwtabpr.caloptima.org/#/site/CO/views/MembershipandUtilizationTrends/CoverPage~~

- **Admits/1000 Per Year (PTMPY):** Admits/1000 fell below the goal of 284 in Q4 2022 and YTD 2023.
- **Bed Days/1000 Per Year (PTMPY):** Bed days fell below the goal of 358 in Q4 2022 and YTD 2023.
- **Average Length of Stay (ALOS):** The ALOS for this population remained below the goal of 4.3 throughout in Q4~~the~~ 2022 and YTD 2023~~reporting period with an uptick during 2022 Q1 and Q2 and a slight decline during Q3.~~
- **Readmissions:** Readmits remained below the goal of 25% in Q4 2022 and YTD 2023

~~**Admits/1000 per Year (PTPMY):** Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and Q2 an upward trend during Q3.~~

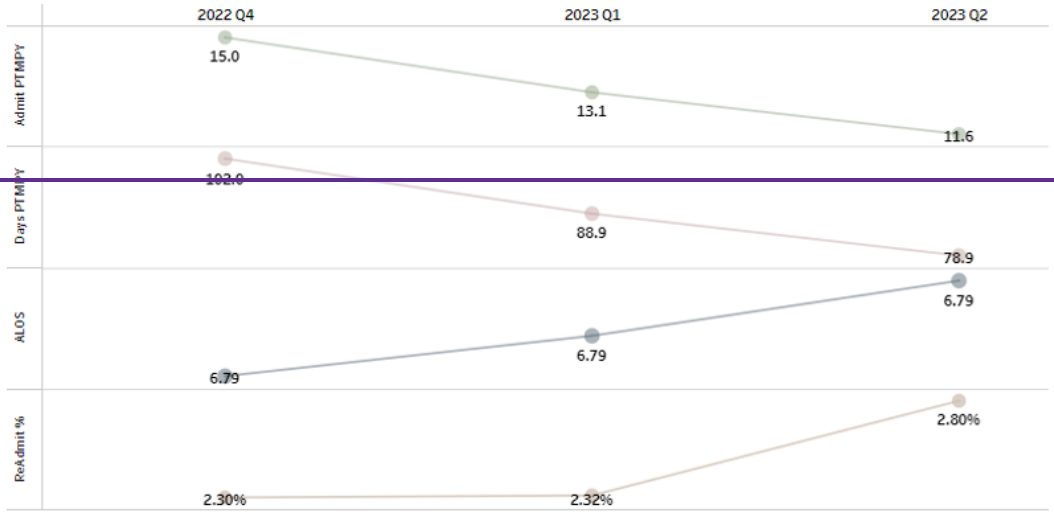
~~**Bed Days/Per Thousand Members Per Year (PTMPY):** Bed Days/100 remained above the goal of 358 throughout the 2022 reporting period with an upward trend throughout 2022 Q1 – Q3.~~

~~**Readmissions:** Readmits remained below the goal of 25% throughout the 2022 reporting period with a slight increase in 2022 Q1 and a downward trend during Q2 and Q3.~~

~~**TANF <18**~~

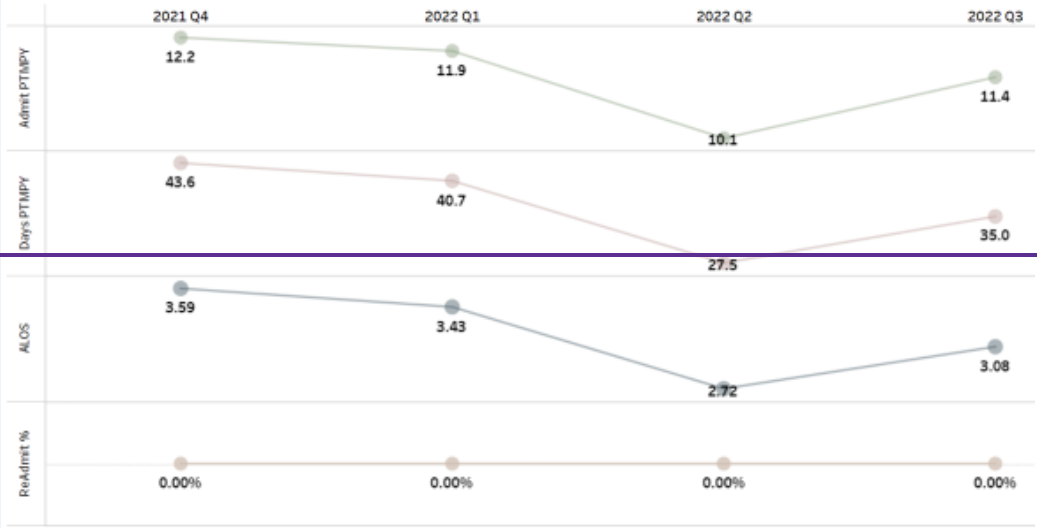
Acute Inpatient Utilization: *TANF under 18*

Medi-Cal CCN/COD only; duals/WCM/LTAC excluded



Acute Inpatient Utilization: *TANF under 18*

Medi-Cal CCN/COD only; duals & WCM excluded



** 19.9% of Members for TANF under 18

PTMPY – Utilization divided by the underlying member years x 1,000

CalOptima Health

3

~~Metric~~	~~Goal~~	~~2021 Q4~~	~~2022 Q1~~	~~2022 Q2~~	~~2022 Q3~~
~~ALOS~~	~~4.3~~	~~3.59 ↓~~	~~3.43 ↓~~	~~2.72 ↓~~	~~3.08 ↓~~
~~Admit PTMPY~~	~~284~~	~~12.2 ↓~~	~~11.9 ↓~~	~~10.1 ↓~~	~~11.4 ↓~~

~~**Days PTMPY**~~	~~358~~	~~43.6 ↓~~	~~40.7 ↓~~	~~27.5 ↓~~	~~35.0 ↓~~
~~**ReAdmit %**~~	~~25%~~	~~0.00%~~	~~0.00%~~	~~0.00%~~	~~0.00%~~

~~Under~~TANF Under ~~<~~18

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	15.0	13.1	27.5	
~~**Days/1000 PTMPY**~~	~~358~~	~~102.0~~	~~88.9~~	~~319.5~~	
ALOS	4.3	6.79	6.79	11.6	
Readmit %	25%	2.30%	2.32%	0.00%	

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	15	13.1	27.5	28
Days/1000 PTMPY	358	102	88.9	319.5	331
ALOS	4.3	6.79	6.79	11.6	11.82
Readmit %	25.00%	2.30%	2.32%	0.00%	0.00%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

- **Admits/1000 Per Year (PTMPY):** Admits/1000 fell below goal of 284 in Q4 2022 and YTD 2023
- **Bed Days/1000 Per Year (PTMPY):** Bed days/1000 fell below goal of 358 in Q4 2022 and YTD 2023
- **Average Length of Stay (ALOS):** The ALOS remained above ~~below the~~ goal of 4.3 in Q4 ~~throughout the~~ 2022 ~~reporting period.~~ and YTD 2023
- **Readmissions**: Readmissions remained below goal of 25% in Q4 2022 and YTD 2023

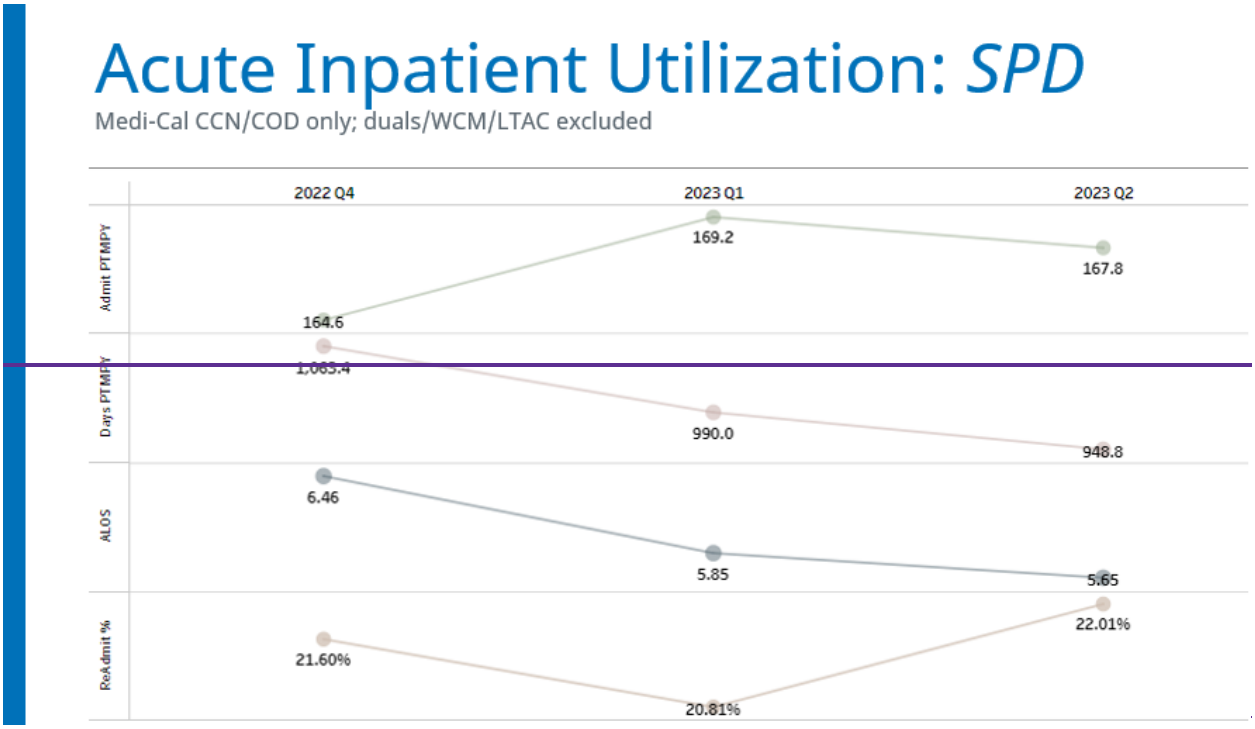
~~**Admits/1000 per Year (PTPMY):** The Admits/1000 remained below the goal throughout the 2022 reporting period.~~

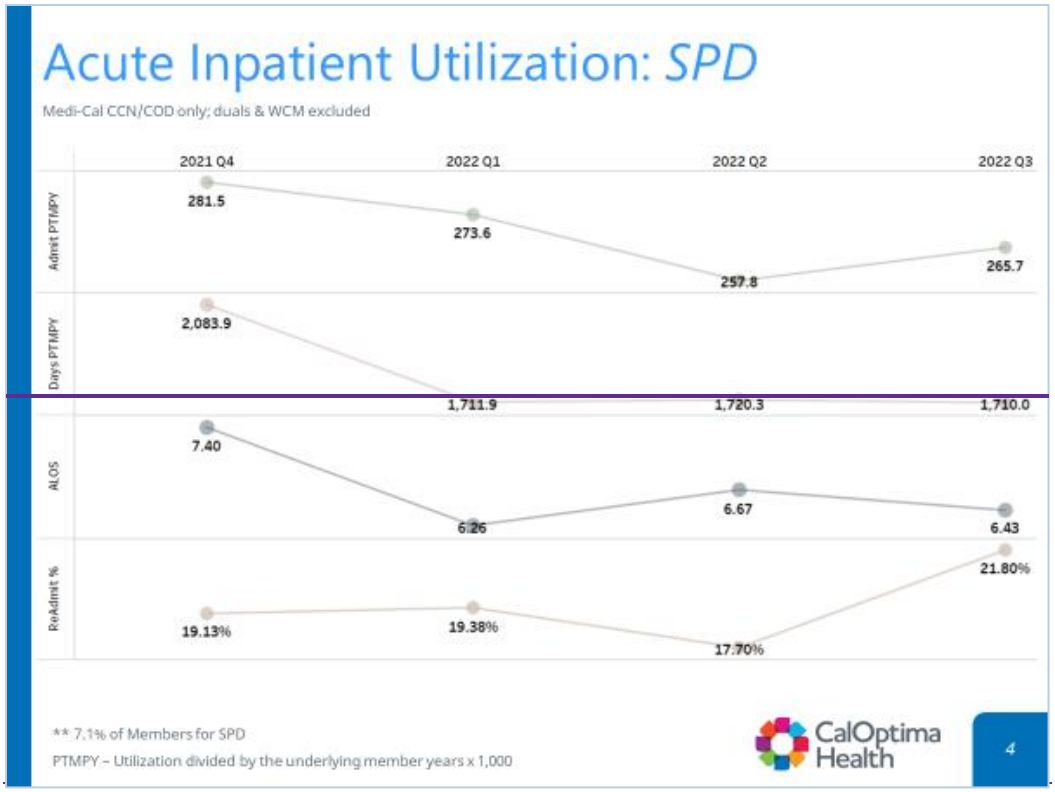
~~**Bed Days/Per Thousand Members Per Year (PTMPY):** Bed Days/1000 remained~~

~~below the goal throughout the reporting period.~~

~~**Readmissions**: Data regarding readmits was unavailable for this population during the 2022 reporting period.~~

~~**SPD**~~





~~Metric~~	~~Goal~~	~~2021 Q4~~	~~2022 Q1~~	~~2022 Q2~~	~~2022 Q3~~
~~ALOS~~	~~4.3~~	~~7.40 ↑~~	~~6.26 ↑~~	~~6.67 ↑~~	~~6.43 ↑~~
~~Admit PTMPY~~	~~284~~	~~281.5 ↓~~	~~273.6 ↓~~	~~257.8 ↓~~	~~265.7 ↓~~
~~Days PTMPY~~	~~358~~	~~2,083.9 ↑~~	~~1,711.9 ↑~~	~~1,720.3 ↑~~	~~1,710.0 ↑~~
~~ReAdmit %~~	~~25%~~	~~19.13% ↓~~	~~19.38% ↓~~	~~17.70% ↓~~	~~21.80% ↓~~

~~SPD~~

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	164.6	169.2	271.3	
~~Days/1000 PTMPY~~	~~358~~	~~1063.4~~	~~990.0~~	~~1577.5~~	
ALOS	4.3	6.46	5.85	5.81	
Readmit %	25%	21.60%	20.81%	24.64%	

SPD

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	164.6	169.2	271.3	268.6
Days/1000 PTMPY	358	1063.4	999	1577.5	1540.2
ALOS	4.3	6.46	5.85	5.81	5.73
Readmit %	25.00%	21.60%	20.81%	24.64%	24.12%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

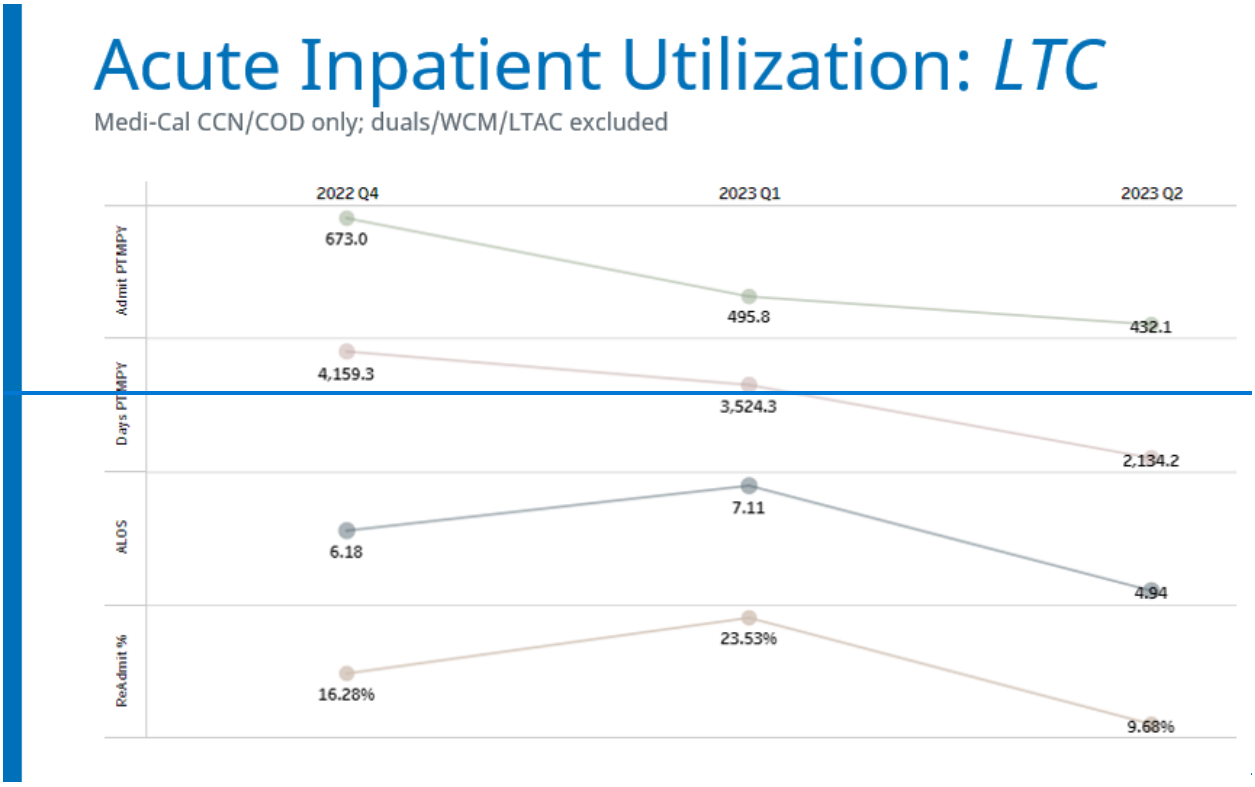
- **Admits/1000 Per Year (PTMPY):** Admits/1000 fell below goal of 284 in Q4 2022 and YTD 2023
- **Bed Days/1000 Per Year (PTMPY):** Bed days were above goal of 258 in Q4 2022 and YTD 2023
- **Average Length of Stay (ALOS):** The ALOS for this population remained above the goal of 4.3 in Q4 ~~throughout the~~ 2022 and YTD 2023~~reporting period with an uptick during 2022 Q2 and a slight decline during Q3.~~
- **Readmissions:** Readmits remained below the goal of 25% in Q4 2022 and YTD 2023 Q3.

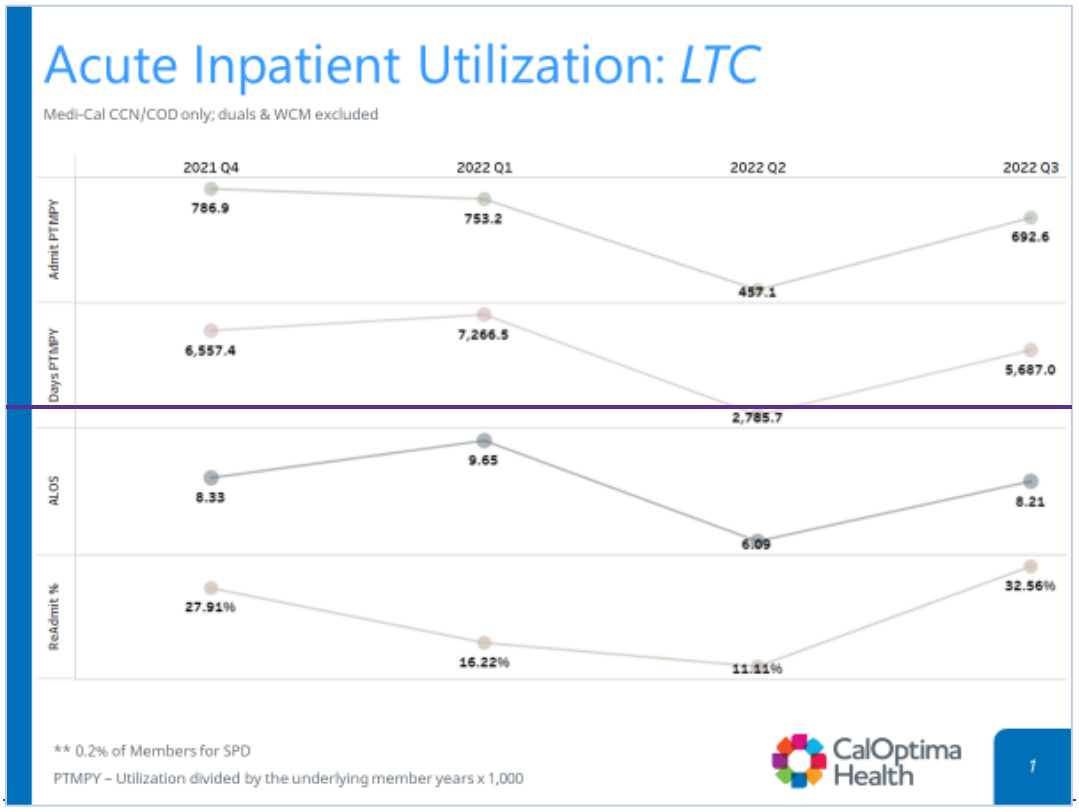
~~**Admits/1000 per Year (PTPMY):** Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and Q2 an upward trend during Q3.~~

~~**Bed Days/Per Thousand Members Per Year (PTMPY):** Bed Days/100 remained significantly above the goal of 358 throughout the 2022 reporting period, however, a downward trend was noted during 2022 Q1 – Q3.~~

~~**Readmissions:** Readmits remained below the goal of 25% throughout the 2022 reporting period with a decrease during 2022 Q2 and an uptick during Q3.~~

~~**Long Term Care (LTC)**~~





~~Metric~~	~~Goal~~	~~2021 Q4~~	~~2022 Q1~~	~~2022 Q2~~	~~2022 Q3~~

Back to Agenda Back to Item

~~**ALOS**~~	~~4.3~~	~~8.33 ↑~~	~~9.65 ↑~~	~~6.09 ↑~~	~~8.21 ↑~~
~~**Admit PTMPY**~~	~~284~~	~~786.9 ↑~~	~~753.2 ↑~~	~~457.1 ↑~~	~~692.6 ↑~~
~~**Days PTMPY**~~	~~358~~	~~6,557.40 ↑~~	~~7,266.50 ↑~~	~~2,785.70 ↑~~	~~5,687.00 ↑~~
~~**ReAdmit %**~~	~~25%~~	~~27.91% ↑~~	~~16.22% ↓~~	~~11.11% ↓~~	~~32.56% ↑~~

~~**LTC**~~

LTC

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	673.0	495.8	435.2	
~~Days/1000 PTMPY~~	~~358~~	~~4159.3~~	~~3524.3~~	~~2159.5~~	
ALOS	4.3	6.18	7.11	4.94	
Readmit %	25%	16.28%	23.53%	9.68%	

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	673	495.8	435.2	446.4
Days/1000 PTMPY	358	4159.3	3524.3	2159.5	2940.9
ALOS	4.3	6.18	7.11	4.94	6.59
Readmit %	25.00%	16.28%	23.53%	9.68%	13.79%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.
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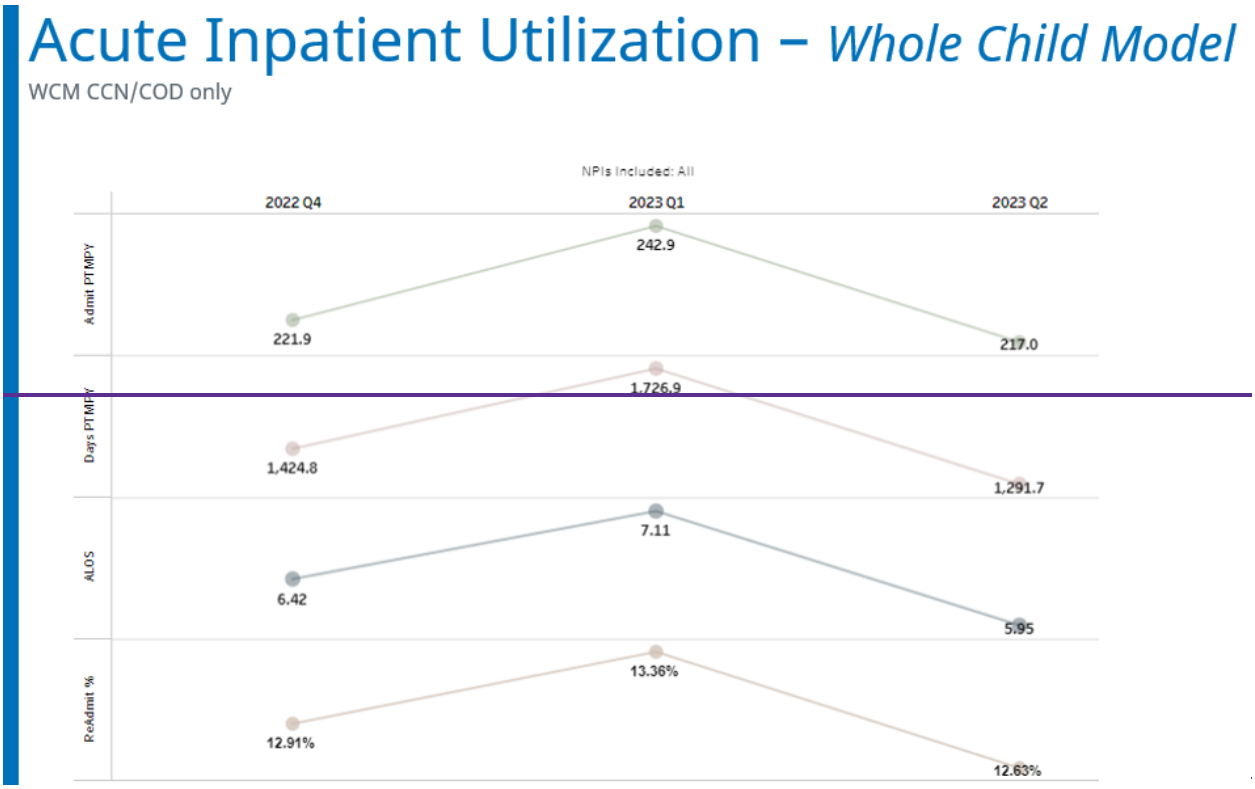
- **Admits/1000 Per Year (PTMPY):** Admits/1000 remained above goal of 284 in Q4 2022 and YTD 2023
- **Bed Days/1000 Per Year (PTMPY):** Bed days/1000 remained above goal of 358 in Q4 2022 and YTD 2023
- **Average Length of Stay (ALOS):** The ALOS remained above the goal in Q4~~throughout the~~ 2022 and YTD 2023~~reporting period.~~
- **Readmissions:** Readmits remained below goal during Q4 2022 and YTD 2023.

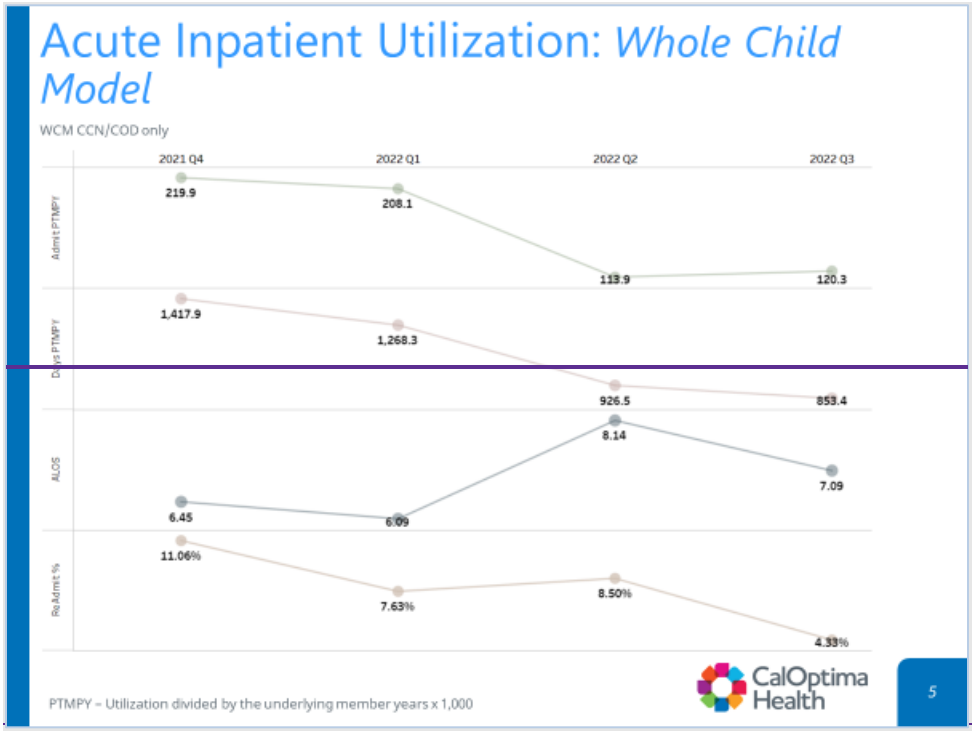
~~**Admits/1000 per Year (PTPMY):** The Admits/1000 remained above the goal throughout the 2022 reporting period with a notable decrease in 2022 Q2.~~

~~**Bed Days/Per Thousand Members Per Year (PTMPY):** Bed Days/1000 remained above the goal throughout the 2022 reporting period with a notable decrease in 2022 Q2.~~

~~**Readmissions:** Readmits remained below goal during 2022 Q1 and Q2.~~

~~**Whole Child Model**~~





~~Metric~~	~~Goal~~	~~2021 Q4~~	~~2022 Q1~~	~~2022 Q2~~	~~2022 Q3~~
~~ALOS~~	~~4.3~~	~~6.45 ↑~~	~~6.09 ↑~~	~~8.14 ↑~~	~~7.09 ↑~~

~~Admit PTMPY~~	~~284~~	~~219.9 ↓~~	~~208.1 ↓~~	~~113.9 ↓~~	~~120.3 ↓~~
~~Days PTMPY~~	~~358~~	~~1,417.9 ↑~~	~~1,268.3 ↑~~	~~926.5 ↑~~	~~853.4 ↑~~
~~ReAdmit%~~	~~25%~~	~~11.06% ↓~~	~~7.63% ↓~~	~~8.50% ↓~~	~~4.33% ↓~~

WCM

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	221.9	242.9	217.0	
~~Days/1000 PTMPY~~	~~358~~	~~1424.8~~	~~1726.9~~	~~1291.7~~	
ALOS	4.3	6.42	7.11	5.95	
Readmit %	25%	12.91%	13.36%	12.63%	

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	221.9	242.9	217	242.8
Days/1000 PTMPY	358	1424.8	1726.9	1291.7	1273
ALOS	4.3	6.42	7.11	5.95	5.24
Readmit %	25.00%	12.91%	13.36%	12.63%	11.99%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.
~~https://dwtabpr.caloptima.org/#/site/CO/views/MembershipandUtilizationTrends/CoverPage~~

- **Admits/1000 Per Year (PTMPY):** Admits/1000 remained below goal of 284 in Q4 2022 and YTD 2023
- **Bed Days/1000 Per Year (PTMPY):** Bed days remained above goal of 358 in Q4 2022 and YTD 2023
- **Average Length of Stay (ALOS):** The ALOS for this population remained above the goal of 4.3 in Q4~~throughout the~~ 2022 ~~r~~and YTD 2023~~eporting period with an uptick during 2022 Q2 and a slight decline during Q3.~~
- **Readmissions:** Readmits remained below the goal of 25% in Q4 2022 and YTD 2023

~~**Admits/1000 per Year (PTPMY):** Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and Q2 an upward trend during Q3.~~

~~**Bed Days/Per Thousand Members Per Year (PTMPY):** Bed Days/100 remained significantly above the goal of 358 throughout the 2022 reporting period, however, a downward trend was noted during 2022 Q2 – Q3.~~

~~**Readmissions:** Readmits remained below the goal of 25% throughout the 2022 reporting period with a decrease during 2022 Q3~~

EMERGENCY DEPARTMENT UTILIZATION PERFORMANCE ~~BY AID CODE LINE OF BUSINESS~~

Medi-Cal Expansion

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	492.4	480.6	497.9	495.0

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits/1000 PTMPY	492.4	480.6	497.9	

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.
~~https://dwtabpr.caloptima.org/#/site/CO/views/MembershipandUtilizationTrends/CoverPage~~

Medi-Cal Expansion ED utilization remained fairly flat since Q4 2022, however there is a slight uptick in Q2 2023.

TANF 18+

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	549.6	533.9	545.4	550.0

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits/1000 PTMPY	549.6	533.9	545.4	

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.
~~https://dwtabpr.caloptima.org/#/site/CO/views/MembershipandUtilizationTrends/CoverPage~~

Medi-Cal TANF 18+ ED utilization remained fairly flat since Q4 2022 with a slight uptick in Q2 2023 from Q1 2023.

TANF Under 18

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits/1000 PTMPY	459.5	398.3	370.2	

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	459.5	398.3	370.2	333.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023. https://dwtabpr.caloptima.org/#/site/CO/views/MembershipandUtilizationTrends/CoverPage

Medi-Cal TANF under 18 ED utilization trended downward from Q4 2022.

SPD

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits/1000 PTMPY	644.8	640.5	706.6	

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	644.8	640.5	706.6	748.6

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023. https://dwtabpr.caloptima.org/#/site/CO/views/MembershipandUtilizationTrends/CoverPage

Medi-Cal SPD ED utilization trended down in Q1 2023 and then had an uptick in Q2 2023.

LTC

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits/1000 PTMPY	259.2	389.5	342.9	

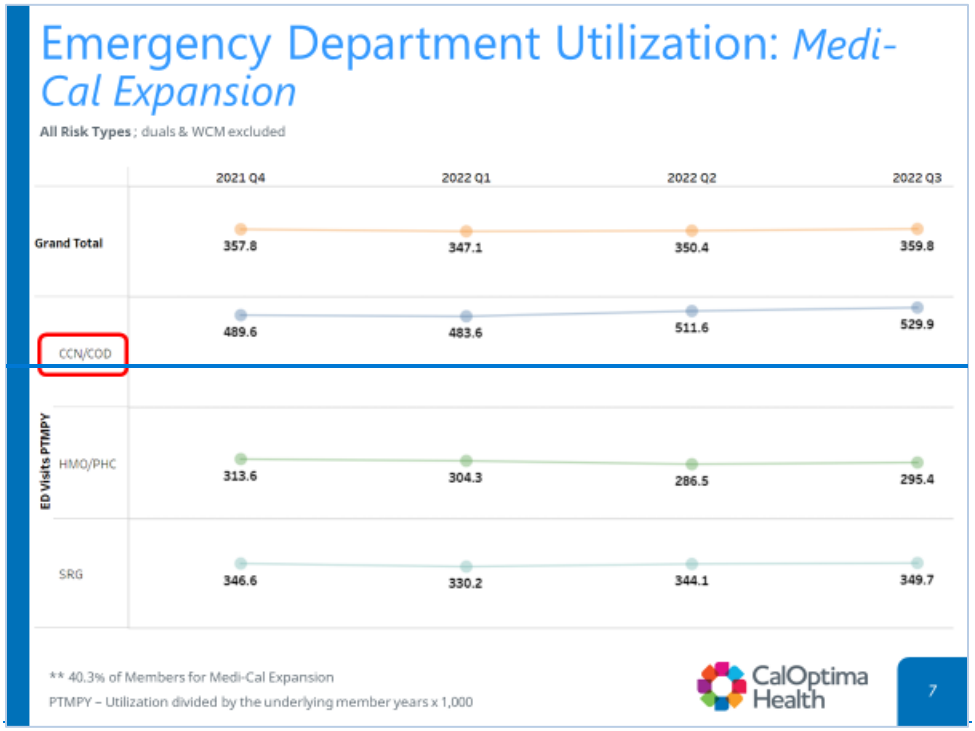
Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	259.2	389.5	342.9	341.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023. https://dwtabpr.caloptima.org/#/site/CO/views/MembershipandUtilizationTrends/CoverPage

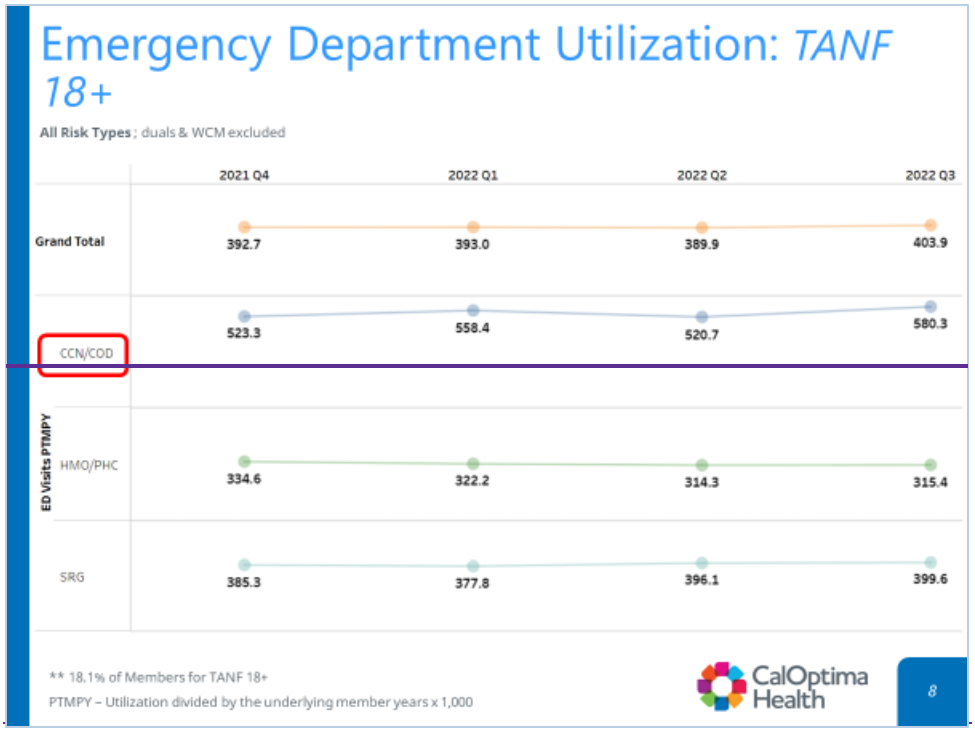
Medi-Cal LTC ED utilization had an uptick in Q1 2023 and then trended down in Q2 2023.

~~Line of Business~~	~~2021 Q4~~	~~2022 Q1~~	~~2022 Q2~~	~~2022 Q3~~
~~MediCal Expansion~~	~~489.6~~	~~483.6~~	~~511.6~~	~~529.9~~
~~TANF 18+~~	~~523.3~~	~~558.4~~	~~520.7~~	~~580.3~~

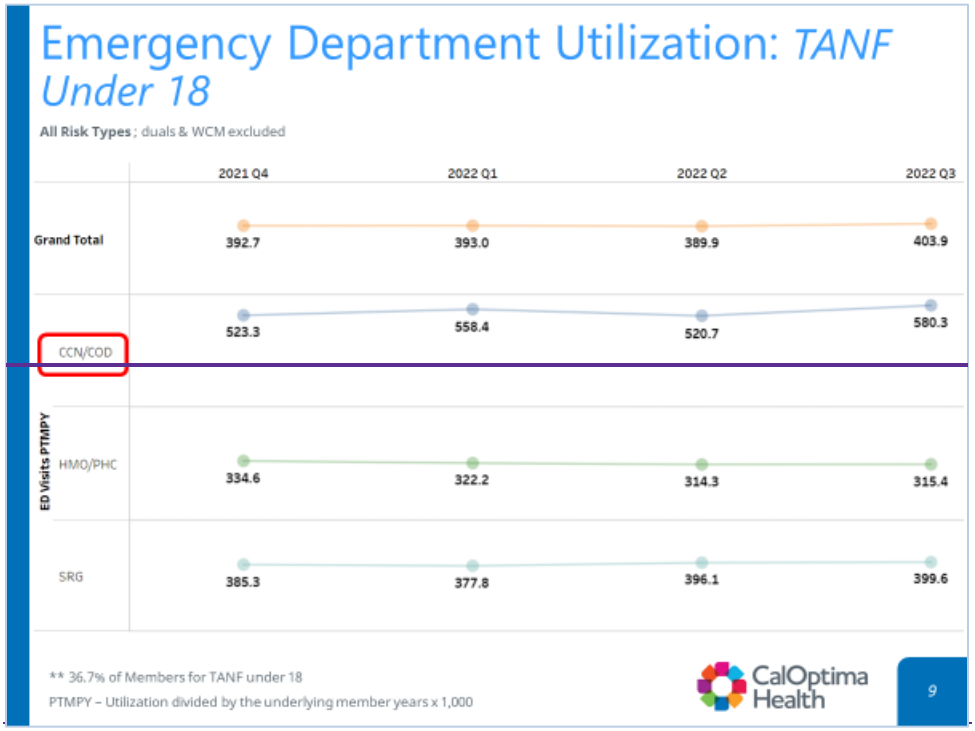
~~**TANF <18**~~	~~355.7~~	~~342.9~~	~~368.8~~	~~375.1.~~
~~**SPD**~~	~~772.6~~	~~700.1~~	~~688.0~~	~~748.3~~
~~**LTC**~~	~~480.9~~	~~487.4~~	~~385.7~~	~~386.2~~
~~**WCM**~~	~~519.7~~	~~491.2~~	~~278.1~~	~~293.2~~



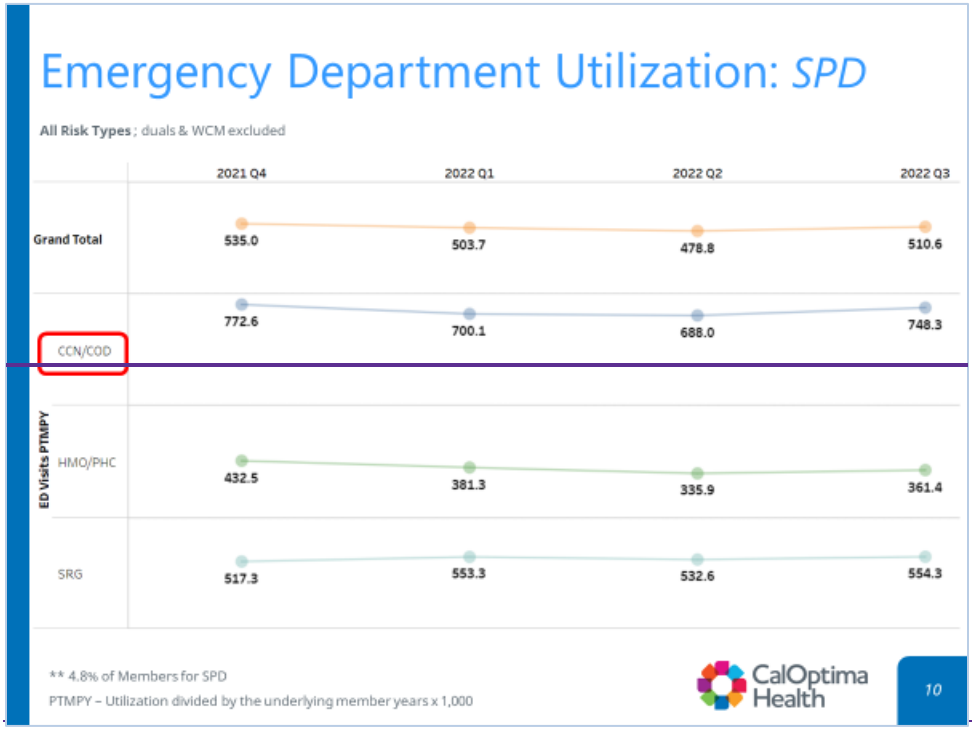
~~MediCal Expansion: **ED utilization declined in 2022 Q1 from 2021 Q4 and then trended upward 2022 Q2 and Q3.**~~



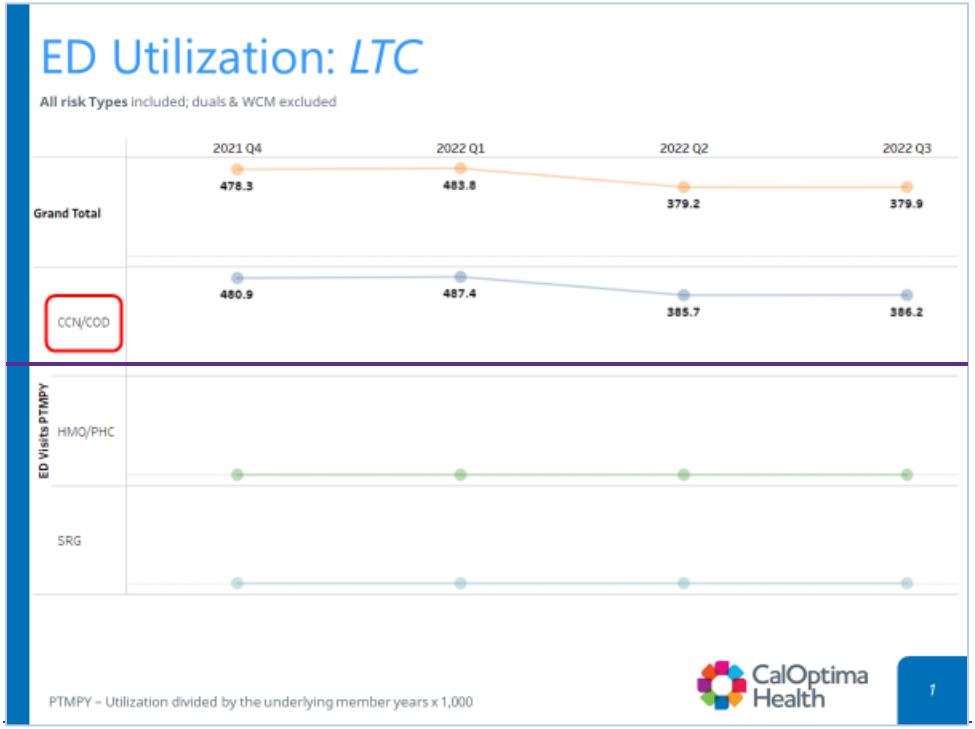
~~TANF 18+~~**~~: ED utilization increased during 2022 Q1 from 2021 Q4, trended down in Q2 and back up again in Q3.~~**



~~TANF <18: **ED utilization decreased during 2022 Q1 from 2021 Q4 then trended up during Q2 and Q3.**~~



~~SPD: **ED utilization decreased during 2022 Q1 from 2021 Q4 and continued the downward trend through Q2 with an increase in Q3.**~~



~~LTC: ED utilization increased slightly during 2022 Q1 from 2021 Q4 then trended downward during Q2 and Q3.~~

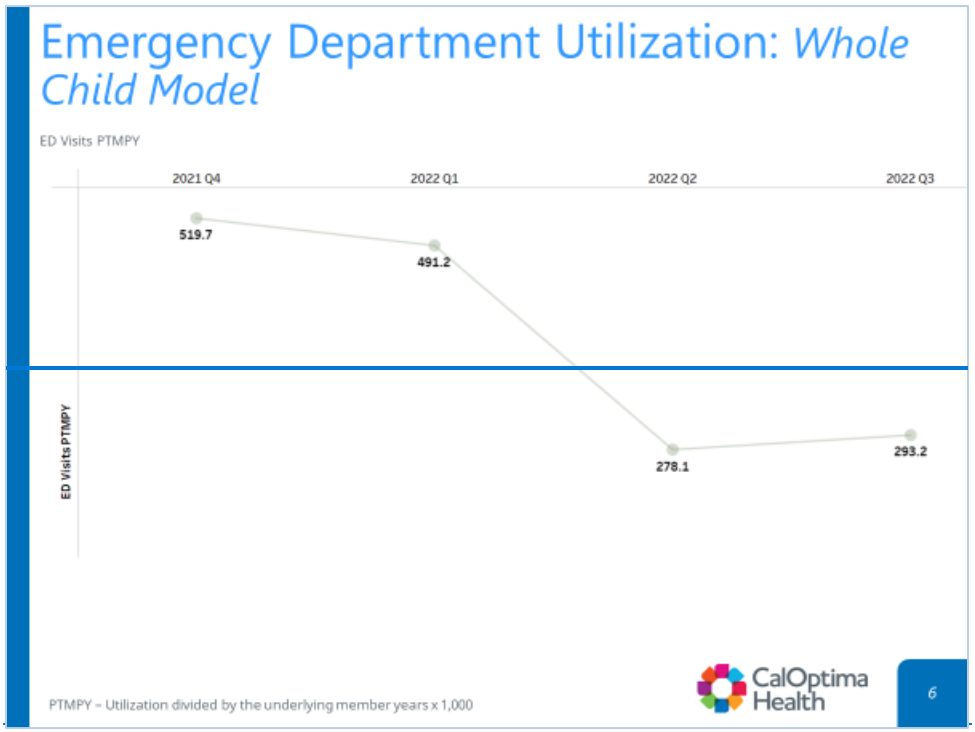
Whole Child Model (WCM)

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits/1000 PTMPY	656.43	630.72	568.57	

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	656.7	630.05	568.57	576.7

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.
~~https://dwtabpr.caloptima.org/#/site/CO/views/MembershipandUtilizationTrends/CoverPage~~

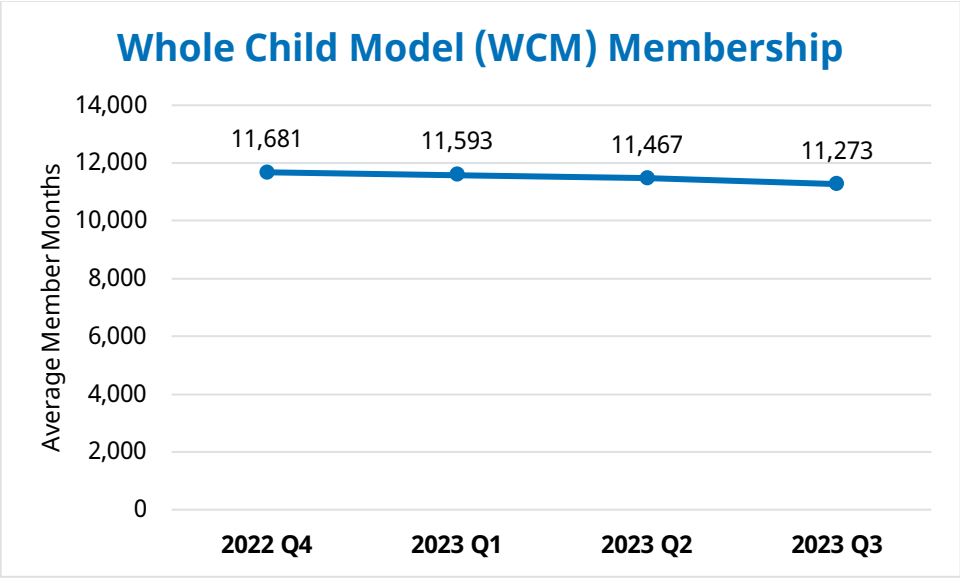
ED utilization has declined since Q4 2022



~~WCM: ED utilization decreased during 2022 Q1 from 2021 Q4 and continued with a significant downward trend during Q2 and Q3.~~

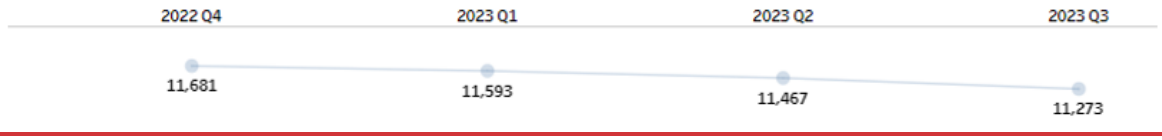
~~Whole – Child Model (WCM)~~

Whole Child Model (WCM)



Source: Membership and Utilization Trends Tableau report, WCM Membership reflecting Q4 2022 – Q3 2023. Data pulled 12/13/2023

Whole-Child Model (WCM) Membership



Average Member Months

Whole-Child Model (WCM) Membership



CalOptima Health

19

WCM Member Counts

Reporting Period: September 2023

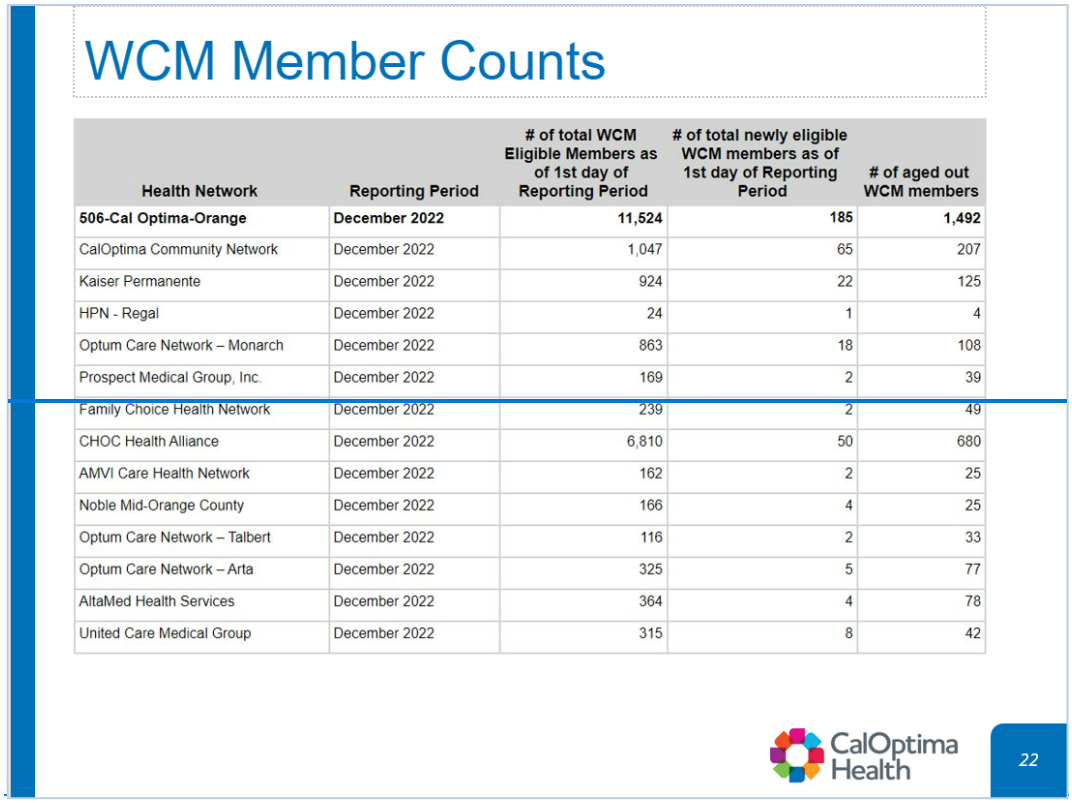
Health Network	# of total WCM Eligible Members as of 1st day of Reporting Period	# of total newly eligible WCM members as of 1st day of Reporting Period	# of aged out WCM members
506-Cal Optima-Orange	**11,141**	**182**	**1,473**
CalOptima Community Network	1,171	71	218
Kaiser Permanente	918	16	129
HPN - Regal	19	1	6
Optum Care Network – Monarch	727	8	104
Prospect Medical Group, Inc.	163	1	41
Family Choice Health Network	204	4	47
CHOC Health Alliance	6,594	68	671
AMVI Care Health Network	161	0	30
Noble Mid-Orange County	150	0	17
Optum Care Network – Talbert	98	1	23
Optum Care Network – Arta	296	5	70
AltaMed Health Services	341	6	79
United Care Medical Group	299	1	38

WCM Counts

Reporting Period: November 2023			
Health Network	**# of Total WCM Eligible Members as of 1st Day of Reporting Period**	**# of Total Newly Eligible WCM Members as of 1st Day of Reporting Period**	**# of Aged Out WCM Members**
506 -CalOptima Health	**11,008**	**123**	**1,490**
CalOptima Health Community Network	1,092	30	219
Kaiser Permanente	905	12	141
HPN - Regal	16	1	4
Optum Care Network - Monarch	719	13	99
Prospect Medical Group	158	2	39
Family Choice Health Network	197	4	43
CHOC Health Alliance	6,583	48	693
AMVI Care Health Network	155	0	27
Noble Mid - Orange County	151	1	16
Optum Care Network - Talbert	92	0	23
Optum Care Network - Arta	295	4	66
AltaMed Health Services	350	8	78
United Care Medical Group	292	0	42

WCM counts source: Core Report WCM Member Counts (CC0218). Reporting Period November 2023. Data pulled 12/13/2023

CalOptima Health's CCN network continues to have the majority of the WCM followed by CHOC Health Alliance.



WCM Member Counts

Health Network	Reporting Period	# of total WCM Eligible Members as of 1st day of Reporting Period	# of total newly eligible WCM members as of 1st day of Reporting Period	# of aged out WCM members
506-Cal Optima-Orange	**December 2022**	**11,524**	**185**	**1,492**
CalOptima Community Network	December 2022	1,047	65	207
Kaiser Permanente	December 2022	924	22	125
HPN - Regal	December 2022	24	1	4
Optum Care Network – Monarch	December 2022	863	18	108
Prospect Medical Group, Inc.	December 2022	169	2	39
Family Choice Health Network	December 2022	239	2	49
CHOC Health Alliance	December 2022	6,810	50	680
AMVI Care Health Network	December 2022	162	2	25
Noble Mid-Orange County	December 2022	166	4	25
Optum Care Network – Talbert	December 2022	116	2	33
Optum Care Network – Arta	December 2022	325	5	77
AltaMed Health Services	December 2022	364	4	78
United Care Medical Group	December 2022	315	8	42

UTILIZATION STATISTICS

Referrals Processed Q4 2022 - Q3 2023 (CCN/COD)

Year	Quarter	LOB	Prospectve Routine	Prospective Urgent	Retro/ Post Service
2022	**Qtr 4**	Medi-Cal	25,073	6,576	1,780
		One Care	N/A	N/A	N/A
2023	**Qtr 1**	Medi-Cal	28,022	6,935	3,075
		One Care	1,927	368	78
	Qtr 2	Medi-Cal	31,422	8,138	2,760
		One Care	2,972	443	120
	Qtr 3	Medi-Cal	32,427	7,756	3,707
		One Care	3,141	476	146
Grand Total			124,984	30,692	11,666

Referrals Processed Source: CORE report Authorization Turn Around Summary CC0003A GC. Data Q42022-Q32023. Data pulled 11/3/2023

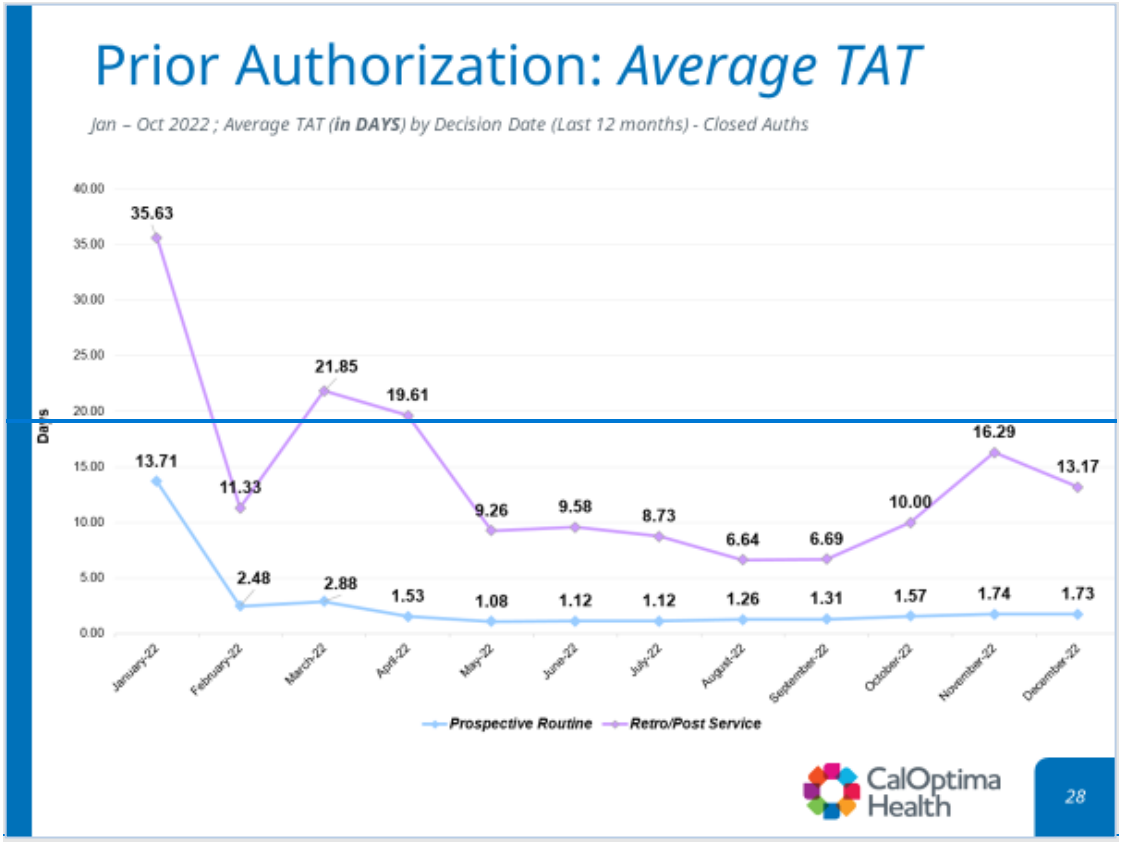
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		One Care	N/A	N/A	N/A
2023	Qtr 1	Medi-Cal	28,022	6,935	3,075
		One Care	1,927	368	78
	Qtr 2	Medi-Cal	31,422	8,138	2,760
		One Care	2,972	443	120
	Qtr 3	Medi-Cal	32,427	7,756	3,707
		One Care	3,141	476	146
Grand Total			124,984	30,692	11,666

Medi-Cal referrals continued to increase across all quarters from Q4 2022 – Q3 2023, with the exception retrospective referrals in Q2 2022.

OneCare was effective January 1, 2023, there was an increase quarter over quarter in 2023

Prior Authorization Turn Around Time



Prior Authorization Turnaround Time Compliance (TAT) Q4 2021 - Q3 2022						
	Year	Quarter	LOB	Prospective Rou	Prospective Urg	Retro / P Servic
2021		Qtr4	Medi-Ca	65.18%	87.31%	70.55%
			OneCar	60.00%	50.00%	100.00
			OneCar Connec	94.41%	90.32%	86.36%
2022		Qtr1	Medi-Ca	90.15%	99.10%	63.60%
			OneCar	87.50%	100.00%	-
			OneCar Connec	99.43%	98.44%	90.65%
		Qtr2	Medi-Ca	99.96%	99.74%	100.00
			OneCar	100.00%	100.00%	-
			OneCar Connec	99.94%	100.00%	99.24%
		Qtr3	Medi-Ca	99.99%	99.95%	100.00
			OneCar	100.00%	100.00%	100.00
			OneCar Connec	100.00%	100.00%	100.00

Prior Authorization Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023						
Year	Goal	Quarter	LOB	Prospectve Routine	Prospective Urgent	Retro/ Post Service
2022	95%	Qtr 4	Medi-Cal	99.62%	99.71%	100.00%
			One Care	N/A	N/A	N/A
2023	95%	Qtr 1	Medi-Cal	99.67%	99.67%	98.86%
			One Care	99.43%	100.00%	100.00%
		Qtr 2	Medi-Cal	99.92%	99.90%	99.64%
			One Care	99.83%	98.65%	100.00%
		Qtr 3	Medi-Cal	99.94%	99.86%	100.00%
			One Care	99.97%	100.00%	98.63%

Source: CORE report Authorization Turn Around Summary (CC0003A_GC). Data Q4 2022-Q3 2023. Data pulled 11/3/2023

Prior Authorization Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023

Year	Goal	Quarter	LOB	Prospectve Routine	Prospective Urgent	Retro/ Post Service
2022	95%	Qtr 4	Medi-Cal	99.62%	99.71%	100.00%
			One Care	N/A	N/A	N/A
2023	95%	Qtr 1	Medi-Cal	99.67%	99.67%	98.86%
			One Care	99.43%	100.00%	100.00%
		Qtr 2	Medi-Cal	99.92%	99.90%	99.64%
			One Care	99.83%	98.65%	100.00%
		Qtr 3	Medi-Cal	99.94%	99.86%	100.00%
			One Care	99.97%	100.00%	98.63%

~~Q4 2021 TAT compliance reflects the ongoing resolution of the backlog that was identified in Q3 2021.The backlog was resolved 01/27/2022. The results of these efforts are evident with compliance in all areas at the beginning of 2022 Q2.~~

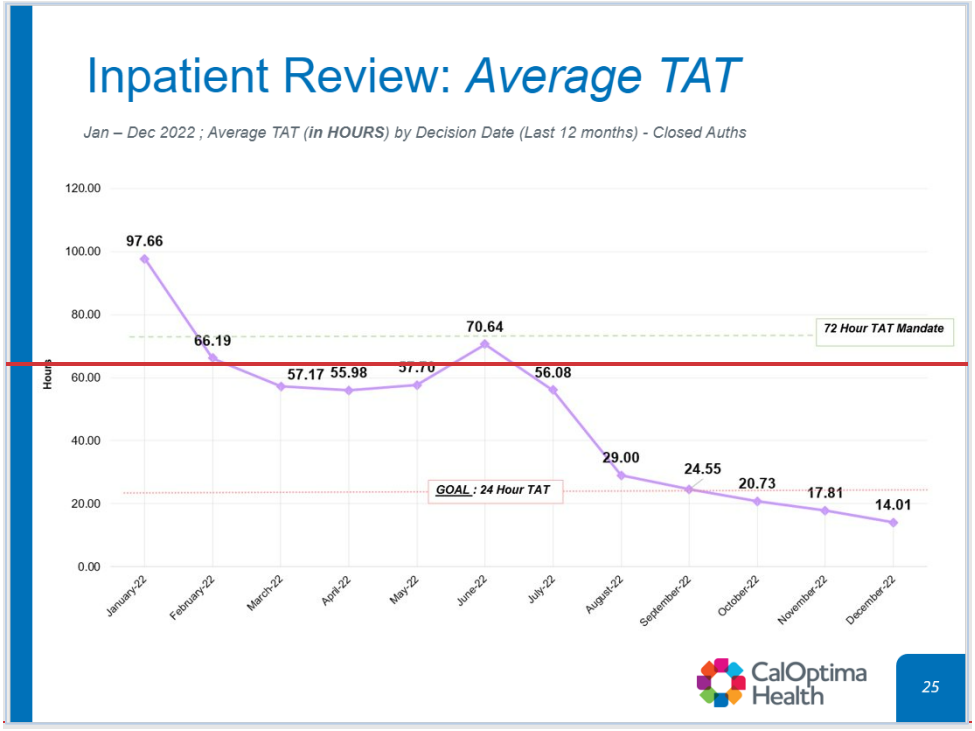
Prior authorization turnaround time compliance remained compliant since Q4 2022, trending in the 98th percentile and above and has continued to meet quarter over quarter goal of 95%.

Utilization Statistics - Inpatient Review Turn Around Time ~~Authorization Average time to decision - January 2022 thru December 2022~~

Inpatient Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023 (CCN/COD)

Year	Goal	Quarter	LOB	Urgent	Retro/ Post Service
2022	95%	Qtr 4	Medi-Cal	96.47%	84.54%
			One Care	N/A	N/A
2023	95%	Qtr 1	Medi-Cal	98.22%	84.47%
			One Care	99.13%	100.00%
		Qtr 2	Medi-Cal	99.41%	88.62%
			One Care	99.14%	100.00%
		Qtr 3	Medi-Cal	98.68%	85.28%
			One Care	98.55%	90.91%

Source: Authorization Turn Around Summary (CC0003I GC). Data Q4 2022 – Q3 2023. Data pulled 11/3/2023



Inpatient Turn Around Compliance

Inpatient Turn Around Compliance (TAT) Q4 2021 - Q3 2022				
Year	Quarter	LOB	Urgent Inpatient	Retrospective Inpatient
2021	Qtr4	Medi-Cal	62.35%	69.10%
2022	Qtr1	Medi-Cal	68.34%	77.38%
		OneCare	0.00%	100.00%
		OneCare Connect	66.47%	76.92%
	Qtr2	Medi-Cal	71.79%	73.49%
		OneCare	100.00%	100.00%
		OneCare Connect	78.42%	83.33%
	Qtr3	Medi-Cal	89.79%	78.07%
		OneCare	50.00%	-
		OneCare Connect	93.72%	80.00%

Inpatient Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023

Year	Goal	Quarter	LOB	Urgent	Retro/ Post Service
2022	95%	Qtr 4	Medi-Cal	96.47%	84.54%
			One Care	N/A	N/A
2023	95%	Qtr 1	Medi-Cal	98.22%	84.47%
			One Care	99.13%	100.00%
		Qtr 2	Medi-Cal	99.41%	88.62%
			One Care	99.14%	100.00%
		Qtr 3	Medi-Cal	98.68%	85.28%
			One Care	98.55%	90.91%

Medi-Cal and OneCare inpatient urgent turnaround time compliance remained stable since Q4 2022. An identified delay in UM assignment for retro post services cases surfaced due to pended claims and/or provider dispute resolutions (PDR). UM continues to ensure expedited review and continued process improvements to communicate retro case assignments in real time.

Referrals Processed Q4 2021 – Q3 2022

Year	Quarter	LOB	Prospective Routine	Prospectivi Urgent	Retro / Post Service
2021	Qtr4	Medi-Cal	37,414	6,256	421
		OneCare	5	2	2
		OneCare Connect	1,878	341	154
2022	Qtr1	Medi-Cal	44,678	5,857	684
		OneCare	8	4	-
		OneCare Connect	1,936	320	107
	Qtr2	Medi-Cal	47,626	7,682	1,180
		OneCare	9	2	-
		OneCare Connect	1,543	304	131
	Qtr3	Medi-Cal	42,298	8,359	611
		OneCare	11	2	2
		OneCare Connect	2,146	346	121

~~Grand Total~~	~~179,552~~	~~29,475~~	~~3,413~~

~~Referrals Received Q4 2021 – Q3 2022~~	
~~Faxes~~	~~251,346~~
~~COLAS~~	~~198,728~~
~~• COLAS Auto Approved~~	~~75,136~~
~~Total~~	~~450,074~~

OVER AND UNDERUTILIZATION

In 2023 CalOptima Health ~~During 2022 we~~ continued to enhance over and underutilization identification and monitoring. ~~the identification and process for monitoring over and underutilization as organization wide initiative to ensure appropriate monitoring of activities with CalOptima related to over and underutilization.~~ A dedicated Medical Director is assigned to monitor CalOptima Health utilization patterns including outlier trends compared between Health Networks including the CalOptima Health Community Network (CCN) and CalOptima Health Direct (COD) network. Quarterly Health Network clinical discussions were launched with delegated Health Networks and CalOptima Health staff to include but not limited to, Chief Medical Officer, Deputy Chief Medical Officer and Clinical Operations Executive Leadership. Discussions were related to utilization trends against KPIs and Health Network Workplans.

Metric~~s~~ benchmarks have been identified as indicators for over and underutilization, ~~are identified throughout the organization as good indicators of over and underutilization, as well as drilling down into the metrics to ensure proper identification of over and underutilization.~~
Metrics from the following area are included and are~~will be reviewed~~ analyzed on an annual basis to ensure they are indicative of over and underutilization monitoring.

- ~~The integrated utilization metrics include (p~~Physical, ~~/~~behavioral health (BH) and pharmacy prior authorization ~~Rx) inpatient and prior authorization UM measure,~~
- Physical and BH inpatient
- ~~a~~Appeal volumes to include ~~and~~ overturn rate~~s~~
- ~~, m~~Member grievances~~,~~
- Potential quality issues (PQI)
- ~~a~~Adult and children's access to PCP services~~, measures indicative of~~
- ~~a~~Appropriate utilization for pharmaceuticals~~,~~
- ~~o~~Outlier reporting from the Compliance Department regarding fraud, waste and abuse ~~department within CalOptima, referral pattern analyses, member utilization, UM related member complaints, potential quality issues (PQI) monitoring, and measures related to behavioral health care.~~

Over and underutilization ~~was~~ data analysis was ~~monitored, tracked, managed, and~~ reported by UM leadership during 202~~2~~3 and reported to UMC, QI~~H~~EC and the Quality Assurance Committee (QAC).

OPERATIONAL PERFORMANCE

Authorization Utilization for Expedited ~~/~~ Urgent, Standard ~~/~~ Routine, and Retrospective Requests — Medical

Summary of Medi-Cal referral volume (Q4 202~~1~~2 to Q3 202~~2~~3)

~~Referrals Processed~~		~~Referrals Received~~		~~Turnaround Time Compliance (TAT)~~	
~~Routine~~	~~177,262~~	~~Faxed~~	~~251,346~~	~~Routine TAT~~	~~90.87%~~
~~+ Urgent~~	~~27,931~~	~~COLAS~~	~~198,728~~	~~Urgent TAT~~	~~96.95%~~
~~Retro~~	~~2,734~~	~~Auto Auth~~	~~93,341~~	~~Retro TAT~~	~~89.94%~~
~~Total~~	~~207,927 *~~	~~Total~~	~~543,415~~		

Referrals Processed		Referrals Processed		Turnaround Time Compliance (TAT)	
Routine	132,456	Faxed	253,775	Routine	99.80%
Urgent	33,768	COLAs	316,094	Urgent	99.77%
Retro	12.843	Auto Auth	129,739	Retro	99.62%
Total	166,237	Total	699,608		

Referrals Processed		Referrals Processed		Turnaround Time Compliance (TAT)	
Routine	132,456	Faxed	253,775	Routine	99.80%
Urgent	33,768	COLAs	316,094	Urgent	99.77%
Retro	12.843	Auto Auth	129,739	Retro	99.62%
Total	166,237	Total	699,608		

Sources: Authorization Turn Around Summary (CC0003A_GC), UM Incoming Fax Report (CC0195), Cercon Referral Count (CC0087), and Auto Authorization Trend Report

Q4 2022 – Q3 2023 turnaround met goal of >95%.

~~VI.~~ Authorization Utilization for Expedited ~~/~~ Urgent, ~~/~~ Routine ~~/~~, and Retro Requests – Pharmacy

	Turnaround Time Compliance (TAT)
Routine	100%
Urgent	100%
Retro	100%

Pharmacy Turnaround Time Source: CORE report Authorization Turn Around Summary (CC0003A_GC) YTD 2023 (Jan 2023 – October 2023)

~~Annual summary of turnaround time compliance for~~

CY 2023~~22:~~ pharmacy prior authorization turnaround time processing is above goal of 98%. -

~~LOB~~	~~TAT Compliance~~
~~OC~~	~~99.89%~~
~~OCC~~	~~99.92%~~

	TAT Compliance
Routine	100%
Urgent	100%
Retro	100%

~~Pharmacy Prior Authorization TAT processing time are above the goal of 98% for all plans. Pharmacy metric targets were achieved for 2022.~~

~~VII.~~ Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)

~~2,6062,8774,3704,595~~

LTC Referrals Processed Q4 2022 - Q3 2023

Year	Quarter	Routine	Urgent
2022	Qtr 4	2,606	None to Report
2023	Qtr 1	2,877	None to Report
	Qtr 2	4,370	None to Report
	Qtr 3	4,595	None to Report

LTC Referrals Processed Source: LTSS Authorization Turnaround Detail (LT0027C-GC)

- ~~LTSS consistently met required turnaround times throughout the year in 2022.~~

LTC Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023

Year	Goal	Quarter	Routine	Urgent
2022	95%	Qtr 4	96.76%	None to Report
2023	95%	Qtr 1	94.10%	None to Report
		Qtr 2	93.25%	None to Report
		Qtr 3	96.90%	None to Report

LTC Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023				
Year	**Goal**	**Quarter**	**Routine**	**Urgent**
2022	**95%**	**Qtr 4**	96.76%	None to Report
2023	**95%**	**Qtr 1**	94.10%	None to Report
		Qtr 2	93.25%	None to Report
		Qtr 3	96.90%	None to Report

LTC Turnaround Time Compliance Source: S Authorization Turnaround Detail (LT0027C-GC)

LTSS met required turnaround times (TAT) in Q4 2022.

TAT fell below the 95% threshold in Q1 2023 and Q2 2023. Based on a root cause analysis, ~~A process improvement plan was implemented resulting in 96.90% TAT in Q3 2023. The TAT didn't impact member care.~~ errors were discovered in the Turnaround time report on October 23, 2023. The errors resulted in the mis categorization of pended authorizations as noncompliant. In October of 2023 the 23 authorizations reported as non-compliant were reversed to be compliant. The report was adjusted to correct this issue. Ongoing efforts are taking place to continuously review the non-compliant cases and determine additional root causes. No root causes have been found to impact member care.

- ~~LTSS metric targets decreased in Q1 & Q@ 2023 and improved to goal in Q3 2023 due to a process improvement plan. Member care was not impacted:~~
- ~~CBAS TAT~~
  - ~~CBAS CEDT: 99.90%~~
  - ~~CBAS Routine: 99.80%~~
  - ~~CBAS Expedited: None received~~
    - ~~Members participating in CBAS Q4 2020 & Q1 Q3 2021: Potentially program eligible members.~~

~~Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)~~					
~~Year~~	~~Quarter~~	~~LOB~~	~~Members Participating in CBAS Q4 2019-Q3 2021 / Potentially Program-Eligible Members~~	~~% Participating~~	~~Change from Previous Qtr.~~
~~2021~~	~~Q4~~	~~Medi-Cal~~	~~2,657/99,910~~	~~2.65~~	~~↑~~
		~~OCC~~	~~151/19,965~~	~~1.01~~	~~↓~~
~~2022~~	~~Q1~~	~~Medi-Cal~~	~~2,738/120,535~~	~~2.27%~~	~~↑~~
		~~OCC~~	~~151/14,591~~	~~1.03%~~	~~↑~~
	~~Q2~~	~~Medi-Cal~~	~~2780/122,953~~	~~2.26%~~	~~↓~~
		~~OCC~~	~~167/14,288~~	~~1.17%~~	~~↑~~

	~~Q3~~	~~Medi-Cal~~	~~2,871/126,808~~	~~2.26%~~	~~NC~~
		~~OCC~~	~~173/14,667~~	~~1.18%~~	~~↑~~

- ~~80% of authorized CBAS participation days will be utilized/delivered Q4 2021~~

~~CBAS Participation Days Used / Days Authorized~~				
~~Year~~	~~Qtr.~~	~~CBAS Participation Days Used / Days Authorized~~	~~% Used~~	~~Change from Previous Qtr.~~
~~2021~~	~~Q4~~	~~117,601/104,003~~	~~88.43%~~	~~↑~~
~~2022~~	~~Q1~~	~~171,621/131,161~~	~~76.42%~~	~~↓~~
	~~Q2~~	~~166,668/154,217~~	~~92.5%~~	~~↑~~
	~~Q3~~	~~182,267/140,056~~	~~76.84%~~	~~↓~~

~~* Change in tableau reporting will true-up in future data~~

CBAS TAT Compliance: LTSS Authorization Turnaround Detail (LT0027C_GC)

CBAS Turnaround Time Compliance (TAT) Q1 2023 - Q3 2023				
Year	Goal	Quarter	TAT Compliance	Volume
2023	95%	Qtr 1	51.06%	1,731
		Qtr 2	34.08%	1,815
		Qtr 3	79.72%	2,141

CBAS Turnaround Time Compliance Source: Authorization Inventory (Tableau)

CBAS Turnaround Time Compliance (TAT) Q1 2023 - Q3 2023

Year	Goal		
2023	95%	~~Qtr 1~~	~~51.06%~~
		Qtr 2	34.08%
		Qtr 3	79.72%

Beginning in Q1 2023 C~~AB~~BAS TAT compliance dropped. During Q1 and Q2 2023 there was not a clear mechanism to report the CBAS TAT. In addition, additional centers were opening resulting in an increase in volume and an impact in Turnaround time. In August 2023 an incident of TAT was reported to CalOptima Health leading to a SWAT analysis of the process and inventory. Approximately 335 aged inventory requests were identified and resolved within 2 days of identification. Processes were developed to support improved efficiency for staff, and additional support was implemented to monitor and control the Turnaround time for CBAS authorizations. The current TAT is 2.42 days with a 99.8% compliance rate.

~~Summary of issues include:~~

- ~~On 8/15/23 a contracted CBAS Center expressed concerns about the length of time it was taking to receive authorization for CBAS services~~
- ~~A "SWAT Team" of approximately 14 LTSS and UM staff members were trained to assist with the 335 aged inventory authorization requests. This "SWAT Team" resolved the inventory on 8/19/23 and 8/20/23~~
- ~~All CBAS authorizations have been completed within TAT requirements since the resolution.~~
- ~~TAT for 2023 was recalculated to review year-to-date corrected submission and reported to the Compliance Department.~~

~~CBAS process improvements to address TAT issues:~~

- ~~CBAS Team required to process all faxes daily~~
- ~~CBAS Supervisor monitors the routine fax in box daily and requests help from LTSS staff and/or UM when needed~~
- ~~Implemented a Daily Stand Up to discuss compliance and a strategy to ensure TAT is met daily.~~
- ~~CBAS will implement 12-month reauthorizations (currently and 6-months).~~
- ~~ITS E-Ticket submitted to allow CBAS providers to submit requests via the Provider Portal, this should be effective in Q2 2024.~~
- ~~Developed a CBAS Tip Sheet to reduce the number of corrections needed with authorization requests.~~
- ~~The CBAS Supervisor is meeting with new centers to provide training and there are joint meetings with the CalOptima Health QI Nurse Specialist when possible.~~

CBAS Days Used Q4 2022 - Q3 2023				
Year	Quarter	Days Used / Days Authorized	% Used	Change From Previous Qtr.
2022	Qtr 4	81,150 /165,447	49.05%	-27.79%
2023	Qtr 1	90,699 / 158,990	57.04%	7.99%
	Qtr 2	103,577 / 159,725	64.84%	7.80%
	Qtr 3	N/A	N/A	N/A

**Discontinued reporting this metric.*

CBAS Days Used Source: CBAS Auth vs Claims X Ctr X month (Tableau)

- ~~LTC routine turnaround time goal is >95%. Goal met.~~
  - ~~Q4 2022: 96.76%~~
  - ~~Q1 2023: 94.10%~~
  - ~~Q2 2023: 93.25%~~
  - ~~Q3: 2023: 96.90%~~
- ~~LTC Urgent: None received.~~
- ~~The TAT fell below the 95% threshold in Q1 & Q2, and a process improvement plan was implemented resulting in 96.90% TAT in Q3. The TAT did not impact member care.~~

MSSP ~~Ddischarges will not exceed Nnew A~~admissions goal will exceed discharges by 5 per quarter.~~by more than 2 members during the quarter.~~

~~MSSP Admissions / Discharges~~			
~~Year~~	~~Qtr.~~	~~Admissions / Discharges~~	~~Change from Previous Qtr.~~
~~2021~~	~~Q4~~	~~18/21~~	~~Admissions ↓~~
~~2022~~	~~Q1~~	~~29/21~~	~~Admissions ↑~~
	~~Q2~~	~~32/25~~	~~Admissions ↑~~
	~~Q3~~	~~41/39~~	~~Admissions NC~~

~~MSSP G~~goal ~~not met in Q4 2022 due to the PHE.~~ The goal was not met due to staffing constraints. Continue with this goal.
~~Goal improvement in 2024~~3.~~

MSSP Admissions & Discharges					
Year	Quarter	Admissions	Change From Previous Qtr.	Discharges	Change From Previous Qtr.
2022	Qtr 4	33	-8	33	-6
2023	Qtr 1	31	-2	32	-1
	Qtr 2	50	19	19	-13
	Qtr 3	N/A	N/A	N/A	N/A

**Discontinued reporting this metric.*

MSSP Admissions & Discharges Source: MSSP Departmental Spreadsheet

UTILIZATION PERFORMANCE / OUTCOMES

LTC and CBAS Transition

~~Analysis of inpatient and ED data in 2021 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than anticipated.~~

~~Review of 2021 ED Data will be conducted, and additional interventions may be applied as needed.~~
~~LTC Nursing facility members transitioned to the Community:~~

~~LTC Nursing Facility Members Transition to the Community~~					
~~Year~~	~~Qtr.~~	~~LOB~~	~~LTC Nursing Facility Members Transition to the Community~~	~~% Transitioned~~	~~Change from Previous Qtr.~~
~~2021~~	~~Q4~~	~~Medi-Cal~~	~~126 /4,751~~	~~2.65%~~	~~↓~~
		~~OCC~~	~~7/175~~	~~2.65%~~	~~↓~~
~~2022~~	~~Q1~~	~~Medi-Cal~~	~~141/4,628~~	~~3.05%~~	~~↑~~
		~~OCC~~	~~5/165~~	~~3.03%~~	~~↑~~
	~~Q2~~	~~Medi-Cal~~	~~194/4,869~~	~~3.98%~~	~~↑~~

		~~OCC~~	~~7/164~~	~~3.98%~~	†
	~~Q3~~	~~Medi-Cal~~	~~200/4,868~~	~~4.11%~~	†
		~~OCC~~	~~4 / 161~~	~~7.14%~~	†

LTC Nursing Facility Members Transition to the Community

LTC Nursing Facility Members Transition to the Community					
Year	Quarter	LOB	LTC Nursing Facility Members / Transition to Community	% Transitioned	Change From Previous Qtr.
2022	Qtr 4	Medi-Cal	220 / 4,918	4.47%	.36%
		One Care	9 / 173	5.20%	-1.94%
2023	Qtr 1	Medi-Cal	177 / 5,433	3.26%	-1.21%
		One Care	7 / 157	4.46%	-0.74%
	Qtr 2	Medi-Cal	231 / 5,525	4.18%	0.92%
		One Care	4 / 193	2.07%	-1.19%
	Qtr 3	Medi-Cal	224 / 5,602	3.99%	0.19%

LTC Nursing Facility Members Transition to the Community Source: LTC ~~Dischagrge~~Discharge Tracking (LT0040)

~~LTC Nursing Facility Members Transition to the Community~~					
~~Year~~	~~Quarter~~	~~LOB~~	~~LTC Nursing Facility Members / Transition to Community~~	~~% Transitioned~~	~~Change From Previous Qtr.~~
~~2022~~	~~Qtr 4~~	~~Medi-Cal~~	~~220/4,918~~	~~4.47%~~	~~.36%~~
		~~One Care~~	~~9/173~~	~~5.20%~~	~~-1.94%~~
~~2023~~	~~Qtr 1~~	~~Medi-Cal~~	~~177/5,433~~	~~3.26%~~	~~-1.21%~~
		~~One Care~~	~~7/157~~	~~4.46%~~	~~-.74%~~
	~~Qtr 2~~	~~Medi-Cal~~	~~231/5,525~~	~~4.18%~~	~~.92%~~
		~~One Care~~	~~4/193~~	~~2.07%~~	~~-1.19%~~
	~~Qtr 3 *~~	~~Medi-Cal~~	~~224/5,602~~	~~3.99%~~	~~.19%~~
		~~One Care~~	~~6/207~~	~~2.90%~~	~~.83%~~

~~CBAS participants who transition to LTC~~					
~~Year~~	~~Qtr.~~	~~LOB~~	~~CBAS participants who transition to LTC~~	~~% Transitioned~~	~~Change from Previous Qtr.~~

~~2021~~	~~Q4~~	~~Medi-Cal~~	~~4/2,657~~	~~0.15%~~	~~↓~~
		~~OCC~~	~~0/1~~	~~0.00%~~	~~↓~~
~~2022~~	~~Q1~~	~~Medi-Cal~~	~~8/2,738~~	~~0.29%~~	~~↓~~
		~~OCC~~	~~1/151~~	~~0.66%~~	~~↑~~
	~~Q2~~	~~Medi-Cal~~	~~8/2,780~~	~~0.29%~~	~~↑~~
		~~OCC~~	~~0/167~~	~~0.00%~~	~~←~~
	~~Q3~~	~~Medi-Cal~~	~~9/2,780~~	~~0.31%~~	~~↑~~
		~~OCC~~	~~1/173~~	~~0.58%~~	~~←~~

CBAS: Track CBAS participants who transition to LTC~~.~~ CBAS Members Discharged to LTC (LT0047)

CBAS Participants who Transitioned to LTC					
Year	**Quarter**	**LOB**	**Participants who Transitioned**	**% Transitioned**	**Change From Previous Qtr.**
2022	**Qtr 4**	Medi-Cal	12 / 2,711	.44%	.13%
		One Care	0	0.00%	0.00%
2023	**Qtr 1**	Medi-Cal	5 / 2,638	.19%	.58%
		One Care	0	0.00%	0.00%
	Qtr 2	Medi-Cal	6 / 2,565	.23%	.04%
		One Care	0	0.00%	0.00%
	Qtr 3	Medi-Cal	N/A	N/A	N/A
		One Care	N/A	N/A	N/A

CBAS Participants who transition to LTC Source: CBAS Members Discharged to LTC (LT0047)

~~CBAS Participants who Transitioned to LTC~~					
~~Year~~	~~Quarter~~	~~LOB~~	~~Participants who Transitioned~~	~~% Transitioned~~	~~Change From Previous Qtr.~~
~~2022~~	~~Qtr 4~~	~~Medi-Cal~~	~~12/2,711~~	~~.44%~~	~~.13%~~
		~~One Care~~	~~0~~	~~0~~	~~0~~
~~2023~~	~~Qtr 1~~	~~Medi-Cal~~	~~5/2,638~~	~~.19%~~	~~.58%~~
		~~One Care~~	~~0~~	~~0~~	~~0~~
	~~Qtr 2~~	~~Medi-Cal~~	~~6/2565~~	~~.23%~~	~~.04%~~

		~~One Care~~	~~0~~	~~0~~	~~0~~
	~~Qtr 3 *~~	~~Medi-Cal~~	~~N/A~~	~~N/A~~	~~N/A~~
		~~One Care~~	~~N/A~~	~~N/A~~	~~N/A~~

*~~Discontinued reporting this metric~~

Members Residing in LTC / Potential Nursing Home Eligible

Year	Quarter	LOB	Residing in LTC / Potentially Nuring Home Eligible	% Residing in ltC	Change From Previous Qtr.
2022	Qtr 4	Medi-Cal	4,918 / 128,249	3.83%	-0.01%
		One Care	173 / 16,622	1.18%	-0.06%
2023	Qtr 1	Medi-Cal	5,433 / 140,951	3.85%	0.02%
		One Care	157 / 17,332	0.91%	-0.27%
	Qtr 2	Medi-Cal	5,525 / 144,632	3.82%	-0.03%
		One Care	193 / 18,075	1.07%	0.16%
	Qtr 3	Medi-Cal	5,602 / 129.956	4.31%	0.49%
		One Care	207 / 14,089	1.47%	0.40%

Members Residing in LTC Source: LTC Active Census (LT0012 GC) and Tableau Membership Detail

~~**Members Residing in LTC / Potential Nursing Home Eligible**~~

~~Year~~	~~Quarter~~	~~LOB~~	~~Residing in LTC / Potentially Nuring Home Eligible~~ and Tableaua Membership Detail	~~% Residing in ltC~~	~~Change From Previous Qtr.~~
~~2022~~	~~Qtr 4~~	~~Medi-Cal~~	~~4,918/128,249~~	~~3.83%~~	~~-.01%~~
		~~One Care~~	~~173/14,622~~	~~1.18%~~	~~-.06%~~
	~~Qtr 1~~	~~Medi-Cal~~	~~5,433/140,951~~	~~3.85%~~	~~.02%~~
		~~One Care~~	~~157/17,332~~	~~.91%~~	~~-.27%~~
~~2023~~	~~Qtr 2~~	~~Medi-Cal~~	~~5,525/144,632~~	~~3.82%~~	~~-.03%~~
		~~One Care~~	~~193/18,075~~	~~1.07%~~	~~.16%~~
	~~Qtr 3~~	~~Medi-Cal~~	~~5,602/129,956~~	~~4.31%~~	~~.49%~~
		~~One Care~~	~~207/14,089~~	~~1.47%~~	~~.40%~~

Members Residing in LTC/ Potentially Nursing Home Eligible Members					
Year	Qtr	LOB	Members Residing in L Potentially Nursing Hom Eligible Mem	% Residing in LT	Change from Previous Qtr.
2021	Q4	Medi-	4,751/99,910	4.76%	↑
		OCC	175/14,965	1.17%	↓
2022	Q1	Medi-	4,628/120,535	3.84%	↓
		OCC	165/14,591	1.13%	↓
	Q2	Medi-	4,869/122,593	3.96%	↓
		OCC	164/14,288	1.15%	↑
	Q3	Medi-	4,468/126,808	3.84%	↓
		OCC	182/14,667	1.24%	↑

PHARMACY UTILIZATION

- ~~Retail Pharmacy: $PMPM costs for CY22 are below expected spend for OneCare and above expected spend for OneCare Connect. OneCare Connect drug cost increases are primarily driven by increased utilization of brand diabetes and chemotherapy medications.~~

Goals were met for two of the three adherence measures for~~ird~~rd year to date through the third quarter. Interventions include provider faxes, member educational materials, medication therapy management-eligible member education, and individual member refill reminders phone calls.

Pharmacy Utilization			
	Medication Adherence for Diabetes Medications	Medication Adherence for Hypertension (RAS antagonists	Medication Adherence Cholesterol (Statins)
Rate	91%	91%	88%
Goal	90%	91%	91%

Source: Authorization Turn Around Summary (CC0003A_GC). YTD 2023 (Jan'23-Oct'23)

Pharmacy Utilization			
	Medication Adherence for Diabetes Medications	Medication Adherence for Hypertension (RAS antagonists	Medication Adherence Cholesterol (Statins)
Rate	91%	91%	88%
Goal	90%	91%	91%

~~Pharmacy Utilization~~			
~~Measure~~	~~Medication Adherence for Diabetes Medications~~	~~Medication Adherence for Hypertension (RAS antagonists)~~	~~Medication Adherence for Cholesterol (Statins)~~
~~Rate~~	~~9189%~~	~~88%~~	
~~Goal~~	~~9088%~~	~~9189%~~	~~9188%~~

~~INTER-RATER RELIABILITY (IRR) (PHYSICIANS, NURSES, PHARMACY) PERTAINS TO AGENCY QUALITY REVIEW OF UM, CBAS, MSSP, LTC BY ANNUAL ASSESSMENT OF APPROPRIATE GUIDELINE APPLICATION.~~

INTER-RATER RELIABILITY (IRR)

~~The~~ IRR is~~was~~ administered annually to evaluate the consistency with which Medical Directors and clinical staff apply UM criteria decision making in compliance with the UM Program. IRR metric targets were achieved for 202~~2~~3. ~~All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.~~

All of the clinical reviewers within the ~~m~~Medical ~~m~~Management Department ~~UM Prior Authorization as a whole~~ passed IRR testing~~, there was 1 staff member that didn't pass~~ with a score of 90% or greater except one nurse in the ~~p~~Prior ~~a~~Authorization Department. The Staff that didn't pass ~~will undergo~~underwent robust ~~additional~~ MCG re-~~-~~training, cases were overseen through spot audits during re-training and was assigned additional cases that passed on second attempt above 90%. ~~may be assigned additional cases for review.~~

Department	IRR Score
UM Clinical Staff: Prior Authorization	99.3%
UM Clinical Staff: Concurrent Review	99.5%
Utilization Management	99.7%
Medical Directors	99.5%
Pharmacy: RPh	98.6%
LTSS: LTC	97.5%
LTSS: CBAS	97.0%
LTSS: MSSP	99.0%
CalAIM	100.0%
Behavioral Health	97.0%

Source: https://learn.mcg.com/local/mcg_reports/index.php?c=report&a=completion

Department	IRR Score
UM Clinical Staff: Prior Authorization	
UM Clinical Staff: Concurrent Review	99.5%
Utilization Management	99.7%
Medical Directors	
Pharmacy: RPh	98.6%
LTSS: LTC	
LTSS: CBAS	
LTSS: MSSP	
Behavioral Health	

~~Department~~	~~IRR Score~~
~~UM Clinical Staff: Prior Authorization~~	~~96%~~
~~UM Clinical Staff: Concurrent Review~~	~~96%~~
~~Physicians~~	~~99%~~
~~Pharmacy~~	~~94%~~
~~LTSS: LTC~~	~~97%~~
~~LTSS: CBAS~~	~~97%~~
~~LTSS: MSSP~~	~~97%~~
~~Behavioral Health~~	~~98%~~

~~Member and Provider Satisfaction~~

Member Satisfaction

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals, Member and Provider Experience Surveys, including the CAHPS survey, related to the UM Program. Complaints about the UM Program demonstrated some trends in the following categories:

- Member feedback obtained through Grievances and Appeals:
  - ~~o~~ Approved referrals/authorizations to providers who are no longer contracted with CalOptima Health. ~~Access to providers, specifically providers no longer contracted with CalOptima health.~~
  - Approved referrals/authorizations to ~~P~~providers who are not seeing new patients.
  - Approved referrals/authorizations ~~for~~to ~~P~~providers ~~was~~ unable to ~~see~~treat the member due to the type of care the member required or the members age was not in the scope

of their specialty practice.

- Approved referrals/authorizations to providers with limited panels,~~Limitation of members ability to see certain providers,~~ as there are some providers who only see members already affiliated with their organization.

- Member Feedback from the 202~~2~~3 CAHPS ~~s~~Survey reporting measurement year 2022 data:
  - ~~Only 71.3% of adult members and 73.0% of child members usually or always got an appointment with a specialist as soon as needed, with a decrease from 81.4% from the previous survey for adult members.~~
  - ~~78.1% of adult members reported through survey questions~~ 78.1% of adult members reported through survey questions as usually or always got an appointment with a specialist as soon as needed, this is an increase from 71.3% from the previous survey for adult members.
  - 81.3% of adult members reported through survey questions that they felt it was usually or always easy to get the care, tests, or treatment needed, with a decrease from 90.5% from the previous survey.
  - ~~Only 80.8~~ 84.77% of child members reported through survey questions that they felt it was usually or always easy to get the care, tests, or treatment a child needed, with an increase ~~decrease~~ from 80.8% ~~85.6%~~ from the previous survey.

PROVIDER EXPERIENCE

To evaluate provider experience, CalOptima Health analyzed provider grievances, provider UM appeals, and provider claims disputes. The top reason for provider grievances are claims disputes. The top reasons for provider UM appeals were denial for no medical necessity, no prior authorization obtained prior to services, and retroactive authorization denied for non-timely submission. The majority of provider UM appeals were upheld at 96% upheld. The top reasons for provider claims disputes were for level of payment including underpaid claims, contract rates, fee schedule, bundling, down coding, and DRG payments. Based on provider experience data, CalOptima Health continues to educate providers on prior authorization requirements and claims payment policies.

~~o~~

~~• Provider feedback from CalOptima Provider Satisfaction survey 2022:~~
  ~~o 55% of providers reported being satisfied or very satisfied with the UM Program experience, with further examples citing~~
    ~~▪ Rapid response to questions~~
    ~~▪ Access to direct referrals~~
    ~~▪ Timely processing of treatment requests~~
  ~~o 10% of providers reported being somewhat dissatisfied or very dissatisfied with the UM Program Experience, with examples citing.~~

- ~~Challenges with the Authorization Dept processing retro authorization requests for Private Duty Nursing~~
- ~~Denial policy is not in guide with standards of care~~

Potential Quality Issues (PQIs) are reviewed by ~~the~~ CalOptima Health Medical Directors. PQIs that are leveled as quality of care are presented individually to the Credential and Peer Review Committee. ~~and t~~Trend data related to authorization issues is reported quarterly at the Utilization Management Committee. In 202~~2~~3, there were a total of ~~27~~85 PQIs related to related to treatment authorizations, of which 31 (37%) were related to authorizations denied or delayed.~~the UM Program:~~

Potential Quality Issues (PQIs)				
	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Authorization Denied or Delayed	12	13	6	5

Potential Quality Issues Source: CORE report Quality of Care Issues Against Providers (QI0089)~~)~~

Potential Quality Issues (PQIs)				
	~~Q1 2023~~	~~Q2 2023~~	~~Q3 2023~~	~~Q4 2023~~
Authorization Denied or Delayed	12	13	6	

~~Potential Quality Issues (PQIs)~~					
	~~Q1~~	~~Q2~~	~~Q3~~	~~Q4~~	~~TOTAL~~
~~Authorization Denied or Delayed~~	~~0~~	~~5~~	~~9~~	~~13~~	~~27~~

CalOptima is continually looking at improving response times to treatment authorizations including proactive peer to peer consultations and communication to expediate health plans decisions.

SUMMARY

Process improvements developed and implemented in 2022 as a result of the UM backlog continued in 2023, efforts are reflected in the UM referral statistics outlines above. Medi-Cal

and OC prior authorization turnaround time compliance remained above goal of 95% from Q4 2022 – Q3 2023. Pharmacy turnaround time compliance was 100% in 2023.

While TANF 18+ remained under the inpatient bed day goals, the other aid code categories were above goal in ALOS, Medi-Cal inpatient turnaround time goals were met in Q4 2022-Q3 2023, however retrospective goals were not met in all quarters.

~~In January 2022, UM resolved the backlog of UM of treatment authorization requests that were identified in Q4 2021. The resolution was reflected in the Q2 2022 turnaround time data. The CalOptima UM leadership team worked with the analytics team to develop real time reporting capabilities and implemented internal structural changes to improve the timeliness and operational effectiveness of the UM program.~~

Additional improvements included the addition of four (4) ~~m~~Medical ~~d~~Director for newly developed positions to support Medical Management Departments. ~~leaders, dedicated clinical trainer, and filling several key roles that were vacant in 2021.~~ Process improvements contributing to the 2023 UM Program include but is not limited to, ~~such as~~ improved workflows, standardized documentation templates, enhanced LOA process, enhanced continuity of care process, and implementation of a TCS program. ~~and improved real time reporting all contributed to UM Program enhancements during 2022.~~ In addition, the following workgroups were developed to concentrate on specific areas within Medical Management, Neuro/Spine Workgroup, Transplant Workgroup, ~~Bed day~~Bed Day Reduction Workgroup, and the UM Auth Strategy Workgroup.

Staffing metrics and productivity standards were developed to ensure staff are working to their full capability and to address staffing needs. ~~CalOptima enhanced monitoring protocols internally to align and oversee direct network and delegated Health Networks. Major initiatives included improvements to CalOptima's operational process and improvements to leadership oversight to address treatment authorizations fluctuating inventory and staffing needs. Continuous improvement took place during 2022 based on monitoring, auditing and outcomes.~~

The UMC, ~~and the~~ UM Medical Directors and Behavioral Health Medical Director continue to guide and support the CalOptima Health integrated UM/CM ~~p~~Programs, ~~both~~ (medical, ~~and~~ behavioral and pharmacy). The UMC, QIHEC and Medical Director's ~~team including behavioral health leadership~~ continued to guide and support process improvement, review and address over and under ~~utilization trends~~ utilization trends and continues to enhance the CalOptima Health ~~p~~Program through ~~c~~Committee and ~~w~~Workgroup efforts.

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2023 CalOptima Health Utilization Management Program Evaluation

Executive Summary

The 2023Utilization Management (UM) Program description defines and outlines CalOptima Health's clinical activities to provide optimal utilization and quality health care services that are delivered compassionately at the right time and in the appropriate setting.

CalOptima Health evaluates the UM program structure, scope, processes, and information sources used to determine utilization trends, medical necessity, and benefit coverage determinations. This evaluation of UM activity is reviewed and approved annually by the UM Committee (UMC), the Quality Improvement Health Equity Committee (QIHEC) and the Quality Assurance Committee (QAC). The look back period for the 2023 UM program evaluation is Q4'2022 through the end of Q3'2023.

Program Structure and Process

The UM program was enhanced throughout 2023 to ensure member needs were addressed, while maintaining compliance with regulatory and accreditation standards. Although the staffing model for the UM nursing and non-clinical Teams did not change during the 2023 reporting period, the Medical Director Team was enhanced with additional physician reviewers and targeted specialties. CalOptima Health also implemented multiple process improvements throughout the year to address operational and clinical enhancements. These included but not limited to the following:

- Improved workflows and oversight to prioritize aging inventory to exceed regulatory turnaround time compliance.
- Continued refinement of inpatient (adult) facility clinical rounds to conduct peer to peer and complex discharge planning and support needs.
- Launch of pediatric inpatient focused on long lengths of stay (NICU and PICU) and

coordination of CCS eligibility and needs.
- Improved access to real time reporting and tools to address authorization requests
- Enhanced provider portal automation and capabilities.
- Developed referral business rules for UM clinical staff to apply hierarchical criteria and to only approve where appropriate without Medical Director review.
- Temporary coverage for all vacant roles to minimize the impact of staffing fluctuations.
- Implemented transitions of care to include a touch to all post discharge members ensuring discharge needs such as, physician follow up care and ancillary services are met.
- Refinement of bed days goals.
- Established a Brain/Spine/Pain Workgroup.
- Enhanced the continuity of care process.
- Enhanced the transplant program to include expansion of COE to UCSD and fully coordinated inpatient rounds, lodging and meal assistance to family members/caretakers of transplant members.
- Design review and configuration of the new medical management platform for implementation in 2024.

Program Structure

During 2023, CalOptima Health added five additional Medical Directors to the UM Program to continue to address clinical complexities and the need for additional specialty programs and interventions.

The following specialties and Medical Directors with robust experience in key areas were added to the full-time Medical Director team within the UM Program:
- Internal Medicine with Stars and HEDIS quality measures experience and expertise
- Emergency Medicine with trauma experience to oversee the CalOptima Health Street Medicine program
- Child and adolescent psychiatry and pharmacy
- Internal Medicine with utilization and quality management experience
- Family Medicine with addiction and correctional health certification.

In addition to the above Medical Directors, CalOptima Health added a Chief Equity Officer to focus on areas to include but not limited to, public and mental health focusing on health equity.

Information sources as well as staff assigned activities used to determine benefit coverage and medical necessity remained current and appropriate, in addition the current UM structure supports CalOptima Health's UM functions. Medical Necessity coverage tools and hierarchical protocols are reviewed and approved annually at the UMC

Program Scope Impact

Effective January 1, 2022, DCHS mandated Medi-Cal retail pharmacy and pharmacy grievances be carved out of managed care health plans and on January 1, 2022, Magellan Rx began managing the pharmacy benefit for CalOptima Health. CalOptima Health continues to manage the Medicare outpatient pharmacy benefit and

grievances as well as physician-administered drug (PAD) benefits. The current UM structure is effective in supporting the required CalOptima Health UM functions based on 2023 data and analysis. Throughout 2023 DHCS continued to focus on population health management initiatives targeting transitional care support and Medi-Cal CalAIM community supports/ECM. CalOptima Health operationalized all 14 community supports and continues to increase network of community-based ECM providers based on members needs and preferences.

PROJECTS, PROGRAMS AND INITIATIVES

A. Utilization Management

Oversight of prior authorization (PA) inventory continued to be part of the overall UM Program to improve average turnaround time to decision aligned with CalOptima Health's strategic vision for same day treatment authorizations.

Initiatives implemented or enhanced to support the UM Program include but is not limited to:

- UM Leadership daily morning touchpoint to review outstanding pending inventory.
- Hospital partner engagement to gain EMR access for CalOptima Health staff to send timely discharge summaries and medication reconciliation to the PCP to incorporate in the member outpatient chart.
- Created a Bed Day Reduction Strategy Sub Workgroup to be led by CalOptima Health Medical Directors with the participation of UM and CM staff. This Workgroup will analyze bed day data identifying opportunities for improvement and the development of interventions to reduce over utilization of inpatient services thus decreasing admits/1000 and ALOS.
- Created an Inpatient Utilization Strategy Sub Workgroup to identify members at risk for a readmission and the development and implementation for focused and targeted support.
- Enhanced post discharge process to include but not limited to, coach members to convene a telehealth PCP or specialty follow-up within 30 days post discharge and coordinated communication will treating providers.
- Enhanced Transitional Care Services (TCS) to include a TCS High Risk flag as identified by DHCS, UM and CM staff outreach to all discharged members to ensure receipt of post hospital care needs are met and the member has a scheduled appointment with their PCP, and development of a member resource letter to provide members with a single point of contact for navigation assistance through transitions of care.
- Enhanced the PCP Discharge Notice faxed to the PCP. This notice includes the hospital Discharge Summary and Medication Reconciliation list and reminds providers to file in the members outpatient medical chart.
- Review Admit Discharge and Transfer (ADT) data file transfers and identify a mechanism for real time PCP admit, discharge, and transfer notification.

UM Medical Directors

The UM Medical Director(s) remained very engaged in the UM process and provided continuing clinical oversight for the administration of the UM Program. This oversight and support included but is not limited to reviewing outcomes in UMC to ensure compliance with regulatory, contractual and

accreditation guidelines and clinical evidence-based criteria, review of over and underutilization patterns, evaluating the UM Program's effectiveness against established goals, and leading Committee's and Sub Workgroups that report into the UMC.

The UM Medical Directors (including Behavioral Health and Pharmacy) are responsible for overseeing provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). The purpose of the BMSC is to evaluate new and modified benefits and determine the need for prior authorization. This Committee is led by the chair Medical Director and includes input from peer Medical Directors, Deputy Chief Medical Officer, and Clinical Leaders within Utilization Management. The activities of this Committee continues to gain provider and member satisfaction and allow for access and automation where appropriate.

The assigned UM Medical Director responsible for facilitating the bi-weekly Utilization Management Work Group (UMWG) ensures collective CalOptima Health Clinical leadership, Medical Director leaders, including behavioral health, pharmacy and Deputy Chief Medical Officer all provide input to the development and processes of the UM Program to ensure that quality care is delivered to CalOptima Health members to meet their physical health, behavioral health and social drivers of health needs. The UMWG activities include but is not limited to, providing input to key UM performance indicators, measures, goals, protocols, provide input to UM Department policies and procedures, and provides updates and input to the quarterly UMC.

The assigned UM Medical Director responsible for facilitating the Bed Day Reduction Strategy Sub Workgroup and the Inpatient Utilization Strategy Sub Workgroup lead the Workgroup Teams to review bed day and ED data to identify under and overutilization to develop and implement opportunities for improvement.

The Medical Director team conducted semiweekly facility internal clinical rounds with the nursing team to support complex discharge needs. In addition, during these rounds' meetings, hospital discharge staff were educated on ECM, community supports and integrated case management available to members in weekly hospital partner rounding. The Medical Director team also attended the bi-weekly Clinical Operations Health Network UM CM forum and provided support to include but not limited to; education of regulatory guidance as outlined by new and/or revised APLs and other regulatory requirements.

Lastly, the Medical Director team also provided to the CalOptima Health clinical team and external provider education and consultation on specific topics including, but not limited to:

- Genetic testing
- Gender Affirming Care and Procedures
- Management of administrative days
- Appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria
- Letter of Agreement (LOA) process
- Evaluation and Medical Director oversight of the appropriateness of one-day inpatient stays
- Management of transplant members
- Management of members requiring neuro or spine surgery

The assigned Behavioral Health Medical Director and the Behavioral Health Integration (BHI) clinical leadership team provided oversight and input on the UM Program throughout the year to ensure that

all BH activities are integrated and aligned with the medical program to ensure compliance with UM regulatory and accreditation requirements and to ensure parity in decision-making. The designated BH Medical Director and BH clinical leadership participated in biweekly UM work groups and quarterly Utilization Management Committee (UMC) meetings, and Benefit Management Subcommittee (BMSC) meetings to ensure adequate representation of critical BH topics such as expansion of the autism benefit and development of strategies to address substance use disorder, eating disorders and coordination with the county to serve our shared members during this period.

Authorization Automation Rule Protocols Pilot

During Q2 2022 an auto-authorization pilot project was implemented for the CCN and COD network to deploy automation rules to determine opportunities to auto authorization or pend for manual review in order to support real time treatment authorization decisions. This pilot and affiliated analysis continued in 2023.UM leadership and Medical Directors continue to review utilization patterns. Below is YTD 2023 data reported to UMC 2023. The percentage has remained fairly consistent throughout 2023.

	Total Auths	% Approved	% Manual Review
Jan-23	22,382	37.9%	62.1%
Feb-23	21,565	38.0%	62.0%
Mar-23	27,108	37.3%	62.7%
Apr-23	24,485	36.4%	63.6%
May-23	26,491	36.6%	63.4%
Jun-23	27,208	38.2%	61.8%
Jul-23	24,730	37.3%	62.7%
Aug-23	28,552	35.8%	64.2%
Sep-23	27,277	35.9%	64.1%

Auto Auth Source: CORE Report AutoAuth_Cercon Referral Count (CC0087_GC) data 1/1/2023-11/30/2023. Data pulled 12/13/2023

B. Behavioral Health Integration

CalOptima Health manages all the administrative functions of Medi-Cal and OneCare (OC) mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima Health members. The BHI department continues to be directly responsible for BH UM activities including but not limited to prior authorization of routine and urgent outpatient behavioral health services and concurrent review of inpatient psychiatric admission.

C. UM Data Management

UM data reporting design is led by the Director of UM and generated by CalOptima Health's Enterprise Analytics (EA) and Information Technology Services (ITS) Department. Together with UM Department subject matter experts, EA and ITS maintained a focused effort to improve the visibility

and understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima Health and the delegated Health Networks (HNs). Daily inventory reports and denial letter notification report were enhanced throughout 2023 to ensure continued timely processing of treatment authorization requests and provider and member notifications of denials and modifications. Additional efforts are focused on the development of existing reports from the new medical management system (Jiva) which will be operational in February 2024.

Inpatient Bed day Utilization Performance (excludes Health Network data)

The 2023 goals were set for a rollup of all Medi-Cal Aid categories. During 2023 the UMC requested inpatient utilization data to exclude acute rehabilitation and LTAC data.

Medi-Cal Expansion

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	60.2	62.1	105.9	103.5
Days/1000 PTMPY	358	315.2	321.4	553.1	518.1
ALOS	4.3	5.24	5.18	5.22	5.01
Readmit %	25.00%	17.54%	18.85%	18.27%	18.65%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

- **Admit/1000 Per Year (PTMPY):** Admits/1000 fell below the goal of 284 in Q4 2022 and 2023 YTD
- **Bed Day/1000 Per Year (PTMPY):** Bed days/100 fell below the goal of 358 in Q4 2022 and 2023 YTD
- **Average Length of Stay (ALOS):** The ALOS for this population remained above the goal of 4.3 in Q4 2022 and 2023 YTD
- **Readmissions:** Readmits remained below the goal of 25% in Q4 2022 and 2023 YTD

TANF 18+

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	86.6	78.1	141.2	155.4
Days/1000 PTMPY	358	274.4	244.8	428.9	479.1
ALOS	4.3	3.17	3.14	3.04	3.08
Readmit %	25.00%	12.25%	10.49%	12.36%	13.09%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

- **Admits/1000 Per Year (PTMPY):** Admits/1000 fell below the goal of 284 in Q4 2022 and YTD 2023.
- **Bed Days/1000 Per Year (PTMPY):** Bed days fell below the goal of 358 in Q4 2022 and YTD 2023.
- **Average Length of Stay (ALOS):** The ALOS for this population remained below the goal of 4.3 throughout in Q4 2022 and YTD 2023
- **Readmissions:** Readmits remained below the goal of 25% in Q4 2022 and YTD 2023

TANF Under 18

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	15	13.1	27.5	28
Days/1000 PTMPY	358	102	88.9	319.5	331
ALOS	4.3	6.79	6.79	11.6	11.82
Readmit %	25.00%	2.30%	2.32%	0.00%	0.00%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

- **Admits/1000 Per Year (PTMPY):** Admits/1000 fell below goal of 284 in Q4 2022 and YTD 2023
- **Bed Days/1000 Per Year (PTMPY):** Bed days/1000 fell below goal of 358 in Q4 2022 and YTD 2023
- **Average Length of Stay (ALOS):** The ALOS remained above goal of 4.3 in Q4 2022 and YTD 2023
- **Readmissions**: Readmissions remained below goal of 25% in Q4 2022 and YTD 2023

SPD

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	164.6	169.2	271.3	268.6
Days/1000 PTMPY	358	1063.4	999	1577.5	1540.2
ALOS	4.3	6.46	5.85	5.81	5.73
Readmit %	25.00%	21.60%	20.81%	24.64%	24.12%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

- **Admits/1000 Per Year (PTMPY):** Admits/1000 fell below goal of 284 in Q4 2022 and YTD 2023
- **Bed Days/1000 Per Year (PTMPY):** Bed days were above goal of 258 in Q4 2022 and YTD 2023
- **Average Length of Stay (ALOS):** The ALOS for this population remained above the goal of 4.3 in Q4 2022 and YTD 2023
- **Readmissions:** Readmits remained below the goal of 25% in Q4 2022 and YTD 2023 Q3.

LTC

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	673	495.8	435.2	446.4
Days/1000 PTMPY	358	4159.3	3524.3	2159.5	2940.9
ALOS	4.3	6.18	7.11	4.94	6.59
Readmit %	25.00%	16.28%	23.53%	9.68%	13.79%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

- **Admits/1000 Per Year (PTMPY):** Admits/1000 remained above goal of 284 in Q4 2022 and YTD 2023
- **Bed Days/1000 Per Year (PTMPY):** Bed days/1000 remained above goal of 358 in Q4 2022 and YTD 2023
- **Average Length of Stay (ALOS):** The ALOS remained above the goal in Q4 2022 and YTD 2023
- **Readmissions:** Readmits remained below goal during Q4 2022 and YTD 2023.

WCM

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	221.9	242.9	217	242.8
Days/1000 PTMPY	358	1424.8	1726.9	1291.7	1273
ALOS	4.3	6.42	7.11	5.95	5.24
Readmit %	25.00%	12.91%	13.36%	12.63%	11.99%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

- **Admits/1000 Per Year (PTMPY):** Admits/1000 remained below goal of 284 in Q4 2022 and YTD 2023
- **Bed Days/1000 Per Year (PTMPY):** Bed days remained above goal of 358 in Q4 2022 and YTD 2023
- **Average Length of Stay (ALOS):** The ALOS for this population remained above the goal of 4.3 in Q4 2022 and YTD 2023
- **Readmissions:** Readmits remained below the goal of 25% in Q4 2022 and YTD 2023

EMERGENCY DEPARTMENT UTILIZATION PERFORMANCE

Medi-Cal Expansion

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	492.4	480.6	497.9	495.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

Medi-Cal Expansion ED utilization remained fairly flat since Q4 2022, however there is a slight uptick in Q2 2023.

TANF 18+

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	549.6	533.9	545.4	550.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

Medi-Cal TANF 18+ ED utilization remained fairly flat since Q4 2022 with a slight uptick in Q2 2023 from Q1 2023.

TANF Under 18

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	459.5	398.3	370.2	333.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

Medi-Cal TANF under 18 ED utilization trended downward from Q4 2022.

SPD

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	644.8	640.5	706.6	748.6

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

Medi-Cal SPD ED utilization trended down in Q1 2023 and then had an uptick in Q2 2023.

LTC

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	259.2	389.5	342.9	341.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

Medi-Cal LTC ED utilization had an uptick in Q1 2023 and then trended down in Q2 2023.

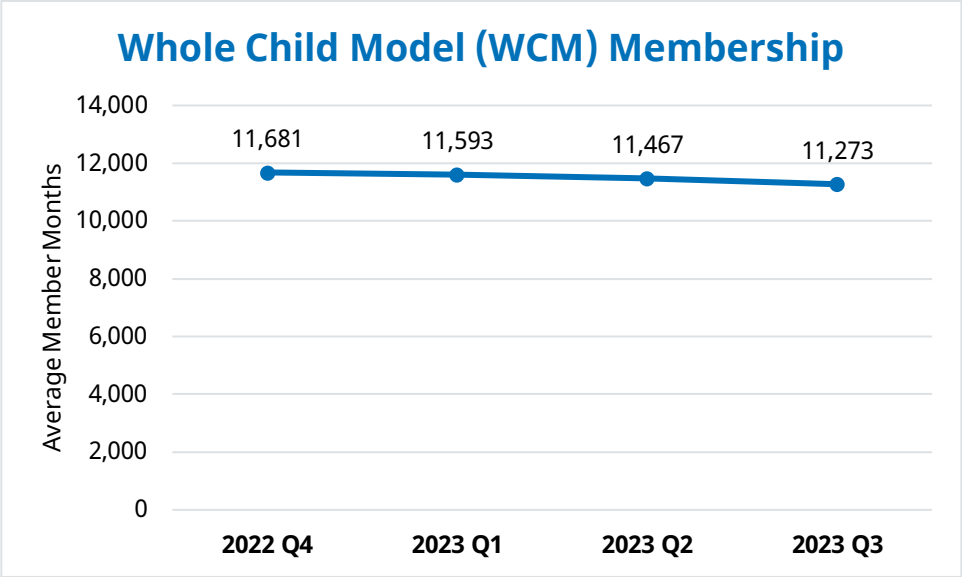
Whole Child Model (WCM)

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	656.7	630.05	568.57	576.7

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

ED utilization has declined since Q4 2022

Whole Child Model (WCM)



Source: Membership and Utilization Trends Tableau report, WCM Membership reflecting Q4 2022 – Q3 2023. Data pulled 12/13/2023

WCM Counts

Reporting Period: November 2023			
Health Network	**# of Total WCM Eligible Members as of 1st Day of Reporting Period**	**# of Total Newly Eligible WCM Members as of 1st Day of Reporting Period**	**# of Aged Out WCM Members**
506 -CalOptima Health	**11,008**	**123**	**1,490**
CalOptima Health Community Network	1,092	30	219
Kaiser Permanente	905	12	141
HPN - Regal	16	1	4
Optum Care Network - Monarch	719	13	99
Prospect Medical Group	158	2	39
Family Choice Health Network	197	4	43
CHOC Health Alliance	6,583	48	693
AMVI Care Health Network	155	0	27
Noble Mid - Orange County	151	1	16
Optum Care Network - Talbert	92	0	23
Optum Care Network - Arta	295	4	66
AltaMed Health Services	350	8	78
United Care Medical Group	292	0	42

WCM counts source: Core Report WCM Member Counts (CC0218). Reporting Period November 2023. Data pulled 12/13/2023

CalOptima Health's CCN network continues to have the majority of the WCM followed by CHOC Health Alliance.

UTILIZATION STATISTICS

Referrals Processed Q4 2022 - Q3 2023 (CCN/COD)					
Year	**Quarter**	**LOB**	**Prospectve Routine**	**Prospective Urgent**	**Retro/ Post Service**
2022	**Qtr 4**	Medi-Cal	25,073	6,576	1,780
		One Care	N/A	N/A	N/A
2023	**Qtr 1**	Medi-Cal	28,022	6,935	3,075
		One Care	1,927	368	78
	Qtr 2	Medi-Cal	31,422	8,138	2,760
		One Care	2,972	443	120
	Qtr 3	Medi-Cal	32,427	7,756	3,707
		One Care	3,141	476	146
Grand Total			124,984	30,692	11,666

Referrals Processed Source: CORE report Authorization Turn Around Summary CC0003A_GC. Data Q42022-Q32023. Data pulled 11/3/2023

Medi-Cal referrals continued to increase across all quarters from Q4 2022 – Q3 2023, with the exception retrospective referrals in Q2 2022.

OneCare was effective January 1, 2023, there was an increase quarter over quarter in 2023

Prior Authorization Turn Around Time

Prior Authorization Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023						
Year	Goal	Quarter	LOB	Prospectve Routine	Prospective Urgent	Retro/ Post Service
2022	95%	Qtr 4	Medi-Cal	99.62%	99.71%	100.00%
			One Care	N/A	N/A	N/A
2023	95%	Qtr 1	Medi-Cal	99.67%	99.67%	98.86%
			One Care	99.43%	100.00%	100.00%
		Qtr 2	Medi-Cal	99.92%	99.90%	99.64%
			One Care	99.83%	98.65%	100.00%
		Qtr 3	Medi-Cal	99.94%	99.86%	100.00%
			One Care	99.97%	100.00%	98.63%

Source: CORE report Authorization Turn Around Summary (CC0003A_GC). Data Q4 2022-Q3 2023. Data pulled 11/3/2023

Prior authorization turnaround time compliance remained compliant since Q4 2022, trending in the 98th percentile and above and has continued to meet quarter over quarter goal of 95%.

Utilization Statistics - Inpatient Review Turn Around Time

Inpatient Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023 (CCN/COD)					
Year	Goal	Quarter	LOB	Urgent	Retro/ Post Service
2022	95%	Qtr 4	Medi-Cal	96.47%	84.54%
			One Care	N/A	N/A
2023	95%	Qtr 1	Medi-Cal	98.22%	84.47%
			One Care	99.13%	100.00%
		Qtr 2	Medi-Cal	99.41%	88.62%
			One Care	99.14%	100.00%
		Qtr 3	Medi-Cal	98.68%	85.28%
			One Care	98.55%	90.91%

Source: Authorization Turn Around Summary (CC0003I_GC). Data Q4 2022 – Q3 2023. Data pulled 11/3/2023

Medi-Cal and OneCare inpatient urgent turnaround time compliance remained stable since Q4 2022. An identified delay in UM assignment for retro post services cases surfaced due to pended claims and/or provider dispute resolutions (PDR). UM continues to ensure expedited review and continued process improvements to communicate retro case assignments in real time.

Over and Underutilization

In 2023 CalOptima Health continued to enhance over and underutilization identification and monitoring. A dedicated Medical Director is assigned to monitor CalOptima Health utilization patterns including outlier trends compared between Health Networks including the CalOptima Health Community Network (CCN) and CalOptima Health Direct (COD) network. Quarterly Health Network clinical discussions were launched with delegated Health Networks and CalOptima Health staff to include but not limited to, Chief Medical Officer, Deputy Chief Medical Officer and Clinical Operations Executive Leadership. Discussions were related to utilization trends against KPIs and Health Network Workplans.

Metric benchmarks have been identified as indicators for over and underutilization, Metrics from the following area are included and are analyzed on an annual basis to ensure they are indicative of over and underutilization monitoring.

- Physical, behavioral health (BH) and pharmacy prior authorization
- Physical and BH inpatient
- Appeal volumes to include overturn rates
- Member grievances
- Potential quality issues (PQI)
- Adult and children's access to PCP services
- Appropriate utilization for pharmaceuticals
- Outlier reporting from the Compliance Department regarding fraud, waste and abuse

Over and underutilization data analysis was reported by UM leadership during 2023 and reported to UMC, QIHEC and the Quality Assurance Committee (QAC).

OPERATIONAL PERFORMANCE

Authorization Utilization for Expedited/Urgent, Standard/Routine, and Retrospective Requests — Medical

Summary of Medi-Cal referral volume (Q4 2022 to Q3 2023)

Referrals Processed	
Routine	132,456
Urgent	33,768
Retro	12.843
Total	166,237

Referrals Processed	
Faxed	253,775
COLAs	316,094
Auto Auth	129,739
Total	699,608

Turnaround Time Compliance (TAT)	
Routine	99.80%
Urgent	99.77%
Retro	99.62%

Sources: Authorization Turn Around Summary (CC0003A_GC), UM Incoming Fax Report (CC0195), Cercon Referral Count (CC0087), and Auto Authorization Trend Report

Q4 2022 – Q3 2023 turnaround met goal of >95%.

Authorization Utilization for Expedited/Urgent, Routine, and Retro Requests – Pharmacy

	Turnaround Time Compliance (TAT)
Routine	100%
Urgent	100%
Retro	100%

Pharmacy Turnaround Time Source: CORE report Authorization Turn Around Summary (CC0003A_GC) YTD 2023 (Jan 2023 – October 2023)

CY 2023 pharmacy prior authorization turnaround time processing is above goal of 98%.

Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)

LTC Referrals Processed Q4 2022 - Q3 2023

Year	Quarter	Routine	Urgent
2022	**Qtr 4**	2,606	None to Report
2023	**Qtr 1**	2,877	None to Report
	Qtr 2	4,370	None to Report
	Qtr 3	4,595	None to Report

LTC Referrals Processed Source: LTSS Authorization Turnaround Detail (LT0027C-GC)

LTC Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023

Year	Goal	Quarter	Routine	Urgent
2022	**95%**	**Qtr 4**	96.76%	None to Report
2023	**95%**	**Qtr 1**	94.10%	None to Report
		Qtr 2	93.25%	None to Report
		Qtr 3	96.90%	None to Report

LTC Turnaround Time Compliance Source: S Authorization Turnaround Detail (LT0027C-GC)

LTSS met required turnaround times (TAT) in Q4 2022.

TAT fell below the 95% threshold in Q1 2023 and Q2 2023. Based on a root cause analysis, errors were discovered in the Turnaround time report on October 23, 2023. The errors resulted in the mis categorization of pended authorizations as noncompliant. In October of 2023 the 23 authorizations reported as non-compliant were reversed to be compliant. The report was adjusted to correct this issue. Ongoing efforts are taking place to continuously review the non-compliant cases and determine additional root causes. No root causes have been found to impact member care.

CBAS TAT Compliance: LTSS Authorization Turnaround Detail (LT0027C_GC)

CBAS Turnaround Time Compliance (TAT) Q1 2023 - Q3 2023

Year	Goal	Quarter	TAT Compliance	Volume
2023	95%	Qtr 1	51.06%	1,731
		Qtr 2	34.08%	1,815
		Qtr 3	79.72%	2,141

CBAS Turnaround Time Compliance Source: Authorization Inventory (Tableau)

Beginning in Q1 2023 CBAS TAT compliance dropped. During Q1 and Q2 2023 there was not a clear mechanism to report the CBAS TAT. In addition, additional centers were opening resulting in an increase in volume and an impact in Turnaround time. In August 2023 an incident of TAT was reported to CalOptima Health leading to a SWAT analysis of the process and inventory. Approximately 335 aged inventory requests were identified and resolved within 2 days of identification. Processes were developed to support improved efficiency for staff, and additional support was implemented to monitor and control the Turnaround time for CBAS authorizations. The current TAT is 2.42 days with a 99.8% compliance rate.

CBAS Days Used Q4 2022 - Q3 2023

Year	Quarter	Days Used / Days Authorized	% Used	Change From Previous Qtr.
2022	Qtr 4	81,150 /165,447	49.05%	-27.79%
2023	Qtr 1	90,699 / 158,990	57.04%	7.99%
	Qtr 2	103,577 / 159,725	64.84%	7.80%
	Qtr 3	N/A	N/A	N/A

**Discontinued reporting this metric.*

CBAS Days Used Source: CBAS Auth vs Claims X Ctr X month (Tableau)

MSSP admissions goal will exceed discharges by 5 per quarter.

The goal was not met due to staffing constraints. Continue with this goal.

MSSP Admissions & Discharges

Year	Quarter	Admissions	Change From Previous Qtr.	Discharges	Change From Previous Qtr.
2022	Qtr 4	33	-8	33	-6
2023	Qtr 1	31	-2	32	-1
	Qtr 2	50	19	19	-13
	Qtr 3	N/A	N/A	N/A	N/A

**Discontinued reporting this metric.*

MSSP Admissions & Discharges Source: MSSP Departmental Spreadsheet

UTILIZATION PERFORMANCE / OUTCOMES

LTC and CBAS Transition

LTC Nursing Facility Members Transition to the Community

LTC Nursing Facility Members Transition to the Community					
Year	Quarter	LOB	LTC Nursing Facility Members / Transition to Community	% Transitioned	Change From Previous Qtr.
2022	Qtr 4	Medi-Cal	220 / 4,918	4.47%	.36%
		One Care	9 / 173	5.20%	-1.94%
2023	Qtr 1	Medi-Cal	177 / 5,433	3.26%	-1.21%
		One Care	7 / 157	4.46%	-0.74%
	Qtr 2	Medi-Cal	231 / 5,525	4.18%	0.92%
		One Care	4 / 193	2.07%	-1.19%
	Qtr 3	Medi-Cal	224 / 5,602	3.99%	0.19%

LTC Nursing Facility Members Transition to the Community Source: LTC Discharge Tracking (LT0040)

CBAS: Track CBAS participants who transition to LTC CBAS Members Discharged to LTC (LT0047)

CBAS Participants who Transitioned to LTC					
Year	Quarter	LOB	Participants who Transitioned	% Transitioned	Change From Previous Qtr.
2022	Qtr 4	Medi-Cal	12 / 2,711	.44%	.13%
		One Care	0	0.00%	0.00%
2023	Qtr 1	Medi-Cal	5 / 2,638	.19%	.58%
		One Care	0	0.00%	0.00%
	Qtr 2	Medi-Cal	6 / 2,565	.23%	.04%
		One Care	0	0.00%	0.00%
	Qtr 3	Medi-Cal	N/A	N/A	N/A
		One Care	N/A	N/A	N/A

CBAS Participants who transition to LTC Source: CBAS Members Discharged to LTC (LT0047)

**Discontinued reporting this metric*

Members Residing in LTC / Potential Nursing Home Eligible					
Year	Quarter	LOB	Residing in LTC / Potentially Nuring Home Eligible	% Residing in ltC	Change From Previous Qtr.
2022	Qtr 4	Medi-Cal	4,918 / 128,249	3.83%	-0.01%
		One Care	173 / 16,622	1.18%	-0.06%
2023	Qtr 1	Medi-Cal	5,433 / 140,951	3.85%	0.02%
		One Care	157 / 17,332	0.91%	-0.27%
	Qtr 2	Medi-Cal	5,525 / 144,632	3.82%	-0.03%
		One Care	193 / 18,075	1.07%	0.16%
	Qtr 3	Medi-Cal	5,602 / 129.956	4.31%	0.49%
		One Care	207 / 14,089	1.47%	0.40%

Members Residing in LTC Source: LTC Active Census (LT0012_GC) and Tableau Membership Detail

PHARMACY UTILIZATION

Goals were met for two of the three adherence measures for year to date through the third quarter. Interventions include provider faxes, member educational materials, medication therapy management-eligible member education, and individual member refill reminders phone calls.

Pharmacy Utilization			
	Medication Adherence for Diabetes Medications	Medication Adherence for Hypertension (RAS antagonists	Medication Adherence Cholesterol (Statins)
Rate	91%	91%	88%
Goal	90%	91%	91%

Source: Authorization Turn Around Summary (CC0003A_GC). YTD 2023 (Jan'23-Oct'23)

INTER-RATER RELIABILITY (IRR)

IRR is administered annually to evaluate the consistency with which Medical Directors and clinical staff apply UM criteria decision making in compliance with the UM Program. IRR metric targets were achieved for 2023.

All of the clinical reviewers within the Medical Management Department passed IRR testing with a score of 90% or greater except one nurse in the Prior Authorization Department. The Staff that didn't pass underwent robust MCG re-training, cases were overseen through spot audits during re-training and was assigned additional cases that passed on second attempt above 90%.

Department	IRR Score
UM Clinical Staff: Prior Authorization	99.3%
UM Clinical Staff: Concurrent Review	99.5%
Utilization Management	99.7%
Medical Directors	99.5%
Pharmacy: RPh	98.6%
LTSS: LTC	97.5%
LTSS: CBAS	97.0%
LTSS: MSSP	99.0%
CalAIM	100.0%
Behavioral Health	97.0%

Source: https://learn.mcg.com/local/mcg_reports/index.php?c=report&a=completion

MEMBER SATISFACTION

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals, Member and Provider Experience Surveys, including the CAHPS survey, related to the UM Program. Complaints about the UM Program demonstrated some trends in the following categories:

- Member feedback obtained through Grievances and Appeals:
  - Approved referrals/authorizations to providers who are no longer contracted with CalOptima Health. Approved referrals/authorizations to providers who are not seeing new patients.
  - Approved referrals/authorizations to providers unable to treat the member due to the type of care the member required or the members age was not in the scope of their specialty practice.
  - Approved referrals/authorizations to providers with limited panels, as there are some providers who only see members already affiliated with their organization.

- Member Feedback from the 2023 CAHPS Survey reporting measurement year 2022 data:
  - 78.1% of adult members reported through survey questions as usually or always got an appointment with a specialist as soon as needed, this is an increase from 71.3% from the previous survey for adult members.
  - 81.3% of adult members reported through survey questions that they felt it was usually or always easy to get the care, tests, or treatment needed, with a decrease from 90.5% from the previous survey.
  - 84.77% of child members reported through survey questions that they felt it was usually or always easy to get the care, tests, or treatment a child needed, with an increase from 80.8% from the previous survey.

PROVIDER EXPERIENCE

To evaluate provider experience, CalOptima Health analyzed provider grievances, provider UM appeals, and provider claims disputes. The top reason for provider grievances are claims disputes. The top reasons for provider UM appeals were denial for no medical necessity, no prior authorization obtained prior to services, and retroactive authorization denied for non-timely submission. The majority of provider UM appeals were upheld at 96% upheld. The top reasons for provider claims disputes were for level of payment including underpaid claims, contract rates, fee schedule, bundling, down coding, and DRG payments. Based on provider experience data, CalOptima Health continues to educate providers on prior authorization requirements and claims payment policies.

Potential Quality Issues (PQIs) are reviewed by CalOptima Health Medical Directors. PQIs that are leveled as quality of care are presented individually to the Credential and Peer Review Committee. Trend data related to authorization issues is reported quarterly at the Utilization Management Committee. In 2023, there were a total of 85 PQIs related to related to treatment authorizations, of which 31 (37%) were related to authorizations denied or delayed.

Potential Quality Issues (PQIs)				
	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Authorization Denied or Delayed	12	13	6	5

Potential Quality Issues Source: CORE report Quality of Care Issues Against Providers (QI0089)

CalOptima is continually looking at improving response times to treatment authorizations including proactive peer to peer consultations and communication to expediate health plans decisions.

SUMMARY

Process improvements developed and implemented in 2022 as a result of the UM backlog continued in 2023, efforts are reflected in the UM referral statistics outlines above. Medi-Cal and OC prior authorization turnaround time compliance remained above goal of 95% from Q4 2022 – Q3 2023. Pharmacy turnaround time compliance was 100% in 2023.

While TANF 18+ remained under the inpatient bed day goals, the other aid code categories were above goal in ALOS, Medi-Cal inpatient turnaround time goals were met in Q4 2022-Q3 2023, however retrospective goals were not met in all quarters.

Additional improvements included the addition of four (4) Medical Director for newly developed positions to support Medical Management Departments. Process improvements contributing to the 2023 UM Program include but is not limited to, improved workflows,

standardized documentation templates, enhanced LOA process, enhanced continuity of care process, and implementation of a TCS program. In addition, the following workgroups were developed to concentrate on specific areas within Medical Management, Neuro/Spine Workgroup, Transplant Workgroup, Bed Day Reduction Workgroup, and the UM Auth Strategy Workgroup.

Staffing metrics and productivity standards were developed to ensure staff are working to their full capability and to address staffing needs.

The UMC, UM Medical Directors and Behavioral Health Medical Director continue to guide and support the CalOptima Health integrated UM/CM Program (medical, behavioral and pharmacy). The UMC, QIHEC and Medical Director's continued to guide and support process improvement, review and address over and under-utilization trends and continues to enhance the CalOptima Health Program through Committee and Workgroup efforts.

20243

INTEGRATED UTILIZATION MANAGEMENT AND CASE MANAGEMENT PROGRAM DESCRIPTION

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20234 UTILIZATON MANAGEMENT - PROGRAM

SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Dabbah, Zeinab, M.D. ***Date***
Deputy Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. ***Date***

Board of Directors Chair:

Clayton M. Corwin **Date:**

_____ _____

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WeE AreRE CalOptimaALOPTIMA HealthEALTH

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that oOur Medicaid (Medi-Cal) and Medicare members deserve the highest quality of care and service across the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision. while upholding our values.

Our Mission

To serve membermembers' 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 same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In 2022, CalOptima Health's Board of Directors and eExecutive tTeam worked together to develop the 2023 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved by the CalOptima Health Board of Directors in June 2022 and will continue to be reviewed and updated, at a minimum of annually, based on CalOptima Health Board of Directors and Executive Team input. The core strategy of the Strategic Plan is an inter-agency co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision. and oOur Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima Health.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation

- Accountabilities and Results Tracking
- Future Growth -

What HAT ISIsS CalOptima ALOPTIMA HealthEALTH?

Our Unique Dual Role

CalOptima Health operates as both a public agency and a community health plan.

In this dual role, CalOptima Health must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

What hat We Offer

Medi-Cal

In California, Medicaid is known as Medi-Cal. Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, Affordable Care Act (ACA) expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Health Medi-Cal. On January 1, 2024, a new law in California now allows adults ages 26 through 49 to qualify for full Medi-Cal regardless of immigration status. Other Medi-Cal eligibility rules, including income limits, still apply. This latest expansion of Medi-Cal means that all Californians now have access to coverage; prior expansions extended coverage to undocumented children, young adults and people over 50.

Scope of Services

CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019.

Certain services are not covered by CalOptima Health but may be provided by a different agency, but coordinated by CalOptima Health are including those indicated below:

- Specialty mental health and substance use disorder services are administered by the Orange County Health Care Agency (HCA).
- Dental services are provided through the Medi-Cal Dental Program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima Health has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are

described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through a specific Memoranda of Understanding (MOU) with certain community agencies, including the HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long- -Term Services and Supports

Since July 1, 2015, the Department of Health Care Services (DHCS) ~~HAS~~ has integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members into the scope of benefits provided by CalOptima Health. CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO D-SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima Health has been offering OC to low- income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled and dual eligible members in Orange County.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B and reside in Orange County. Enrollment in OC is by member choice and voluntary. OC has an innovative Model of Care, which is the structure for supporting consistent provision of quality of care. Each member has a Case Management single point of contact, a ~~c~~Case ~~m~~Manager or a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the ~~c~~Case ~~m~~Management team works with our members and their doctors (PCP. specialists, behavioral health provider) to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

~~OneCare Connect~~

~~The OneCare Connect (OCC)) Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. The OneCare Connect (OCC)~~

~~program, as part of Cal MediConnect, a demonstration program operating in seven counties throughout California, was discontinued 12/31/2022 and all members were bridged into OneCare ensuring continuity of care for their existing services.~~

~~Program of All Inclusive Care for the Elderly (PACE)~~

~~In 2013, CalOptima Health launched the PACE program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.~~
~~To be a CalOptima Health PACE participant, members must be at least 55 years old, live in Orange County and be determined to be:~~

- ~~Eligible for nursing facility services by the State of California.~~
- ~~Able to live safely at home or in a community setting with proper support.~~
- ~~Able to receive all non-emergent services within the CalOptima Health network.~~

~~Scope of Services~~

~~PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home care staff, activity staff and transportation staff who are committed to planning, coordinating, and delivering the most fitting and personalized health care to our participants.~~
~~PACE participants must receive all needed services — other than emergency care — from CalOptima Health PACE providers and are personally responsible for any unauthorized or out of network services.~~
~~CalOptima Health's Utilization Management team is the designated lead for administrative and nursing clinical review functions for PACE program inpatient admissions and works directly with the IDT for clinical determinations and transition coordination.~~

Quality P[rogram ~~ROGRAM~~ I]nitiatives ~~NITIATIVES~~

CalOptima Health's QI[HE ~~Work Plan~~ Priority Areas and] Goals ~~and Objectives are aligned~~[align] with CalOptima Health's 2022–25 Strategic Goals[and DHCS Bold Goals~~.~~]

1) Maternal Health
    - Close racial/ethnic disparities in well-child visits and immunizations by 50%
    - Close maternity care disparity for Black and Native American persons by 50%
2) Children's Preventive Care
    - Exceed the 50th percentile for all children's preventive care measures
3) Behavioral Health Care
    - Improve maternal and adolescent depression screening by 50%
    - Improve follow-up for mental health substance disorder by 50%
4) Program Goals

- Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set MCAS)
- OneCare: Attain a Four-Star Rating for Medicare

1) ~~Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational and community levels.strategies to reduce health disparities and increase utilization of preventive health care.~~
2) ~~Improve quality of care and member experience by attaining an National Committee for Quality Assurance (NCQA) Health Plan Rating of 5.0, and at least a Four Star Rating for Medicare.~~
3) ~~Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare and Hospital Quality.~~

~~These top three priority goals were chosen to be aligned~~ align ~~with CalOptima Health's strategic objectives as well as continued goals related to access to care and NCQA accreditation. The 2023 QI Work Plan details the strategies for childhood~~ immunizations including~~, COVID-19 and other immunizations. The Work Plan includes~~ , including targeted communication and member incentives. ~~The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be~~are measured and monitored in the QI Work Plan, ~~reported to QIC quarterly and evaluated annually.~~

Comprehensive Community Cancer Screening and Support Program

The Comprehensive Community Cancer Screening and Support Program was approved by the CalOptima Health Board of Directors in December 2022. The program aims to create a health ethos with respect to breast cancer, cervical cancer, colorectal cancer and lung cancer. CalOptima Health strives to be the health care exemplar for all Orange County residents.

The goal of the program is to create a culture of cancer prevention, early detection and collaboration with partners such as physicians, Cancer Centers and the community to work towards dramatically decreasing late-stage cancer incidence and ensuring CalOptima Health Medi-Cal members have equitable access to high quality care. Increasing cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs.
~~is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon and lung cancer in certain smokers.~~
~~CalOptima Health seeks to create a new Orange County health ethos with respect to cancer care by earlier a laser onlaser detection and diagnosis of these four specific cancers. \~~

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

~~It will create a culture of cancer prevention, early detection and collaboration with partners toward a~~

~~shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high-quality care.~~ The program will use a phased-in approach to invest over the next five years in the following three pillars:

~~1)~~1. Community and member awareness and engagement

~~2)~~2. Access to cancer screening

~~3)~~3. Improved member experience throughout cancer treatment

The measurement of this program will evaluate the comparison of newly diagnosed cancer rates to baseline rates. As of October 2, 2023, 3,718 CalOptima Health members were newly diagnosed with cancer this year.~~As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer.~~ ~~Increasing cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs.~~

Five-Year Hospital Quality Program

Five-Year Hospital Quality Program 2023-2027. ~~-~~CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience, and patient safety. Hospitals may earn annual incentives based on achievement of benchmarks.

~~CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play a critical role in the delivery of care to members. For many years, CalOptima Health has been providing quality driven incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. Beginning January 1, 2023, CalOptima Health has established a Hospital Quality Program for its contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures serve to:~~

- ~~Support hospital quality standards for Orange County in support of CalOptima Health's mission~~
- ~~Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts~~
- ~~Recognize hospitals demonstrating quality performance~~
- ~~Provide comparative information on CalOptima Health hospital performance~~
- ~~Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members~~

~~The program launchesd January 1, 2023, and extends through December 31, 2027. It includes two initiatives: Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.~~

~~This initiative will include the following principles:~~

~~1. Leverage publicly available, industry-standard measures from the Centers for Medicare &~~

Medicaid Services (CMS) and the Leapfrog Group including:

- CMS Quality
- CMS Patient Experience
- Leapfrog Hospital and Surgery Center Rating
- Leapfrog Hospital Safety Grade

2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
   - Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare
   - Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating
   - Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital
   - Surgery Center Rating will not qualify for incentive payments
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of a budget for a five year period from 2023–2027 to fund the hospital incentive pool. The amount that each hospital may earn will be based on their proportion of services provided to CalOptima Health members, i.e., proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Incentive awards will be based on performance compared with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments to eligible hospitals.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational ~~therapy~~therapy, and financial assistance. As of July 1, 2019, through SB 586, the state integrated CCS services into CalOptima Health's Medi-Cal managed care plan benefit, now called Whole Child Model (WCM). The goal of this transition and integration was to improve health care coordination by providing all needed care (CCS and non-CCS services including utilization management, transportation, care coordination, case management and complex case management) into a managed care plan (MCP), rather than providing CCS services separately. The WCM services successfully transitioned to CalOptima Health in 2019 as the 5th MCP awarded this pilot program. The HCA in Orange County continues to have the CCS program operate the medical eligibility determination processes, the Medical Therapy Unit and

Program and CCS service authorizations for non- CalOptima Health enrollees. CalOptima Health works closely with the county CCS office to align protocols and ensure continuity of care for CCS-eligible members.

California Advancing and Innovating Medi-Cal (CalAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, ~~program~~program, and payment reforms across Medi-Cal.

CalOptima ~~h~~Health implemented CalAIM~~im~~ on 1/1/2022 and continues to work on expanding member access to services and supports. CalOptima Health's CalAIM program was established based upon three primary goals:

1. Identification and management of member risk and need through whole person care approaches and addressing social determinants of health.
2. Development of a consistent and seamless delivery of care and services through reduction of complexity and increase ~~in~~flexibility.
3. Improved member outcomes, reduction of health disparities, improved health equity and ~~transformation and~~ innovation through value-based initiatives, modernization of ~~systems and~~ payment reform.

Enhanced Care Management and Community Supports

In a phased approach since January 2022, CalOptima Health has launched Enhanced Care Management (ECM) as well as all 14 Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Members are identified to participate in ECM services through either a risk stratification approach that proactively identifies members as falling into one of the 10 DHCS identified Populations of Focus (POF) or members who meet the DHCS eligibility criteria can be referred in so that they can receive the services.

ECM providers are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and Engagement
2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

CalOptima Health has partnered with several local Community Based Organizations to provide the 14 Community Supports to our members in a medically appropriate, community-

rooted, cost-effective manner. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits, and discharge delays.

The 14 Community Supports are:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications) includes Personal Emergency Response Systems (PERS)
12. Medically Tailored Meals/Medically Supportive Foods
13. Sobering Centers
14. Asthma Remediation

~~All a~~Authorizations for ECM and Community Supports can be~~are~~ requested through the CalOptima Health Connect Portal and are managed by CalOptima Health's LTSS CalAIM team to determine eligibility.

~~OneCare Connect~~

~~The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. The OneCare Connect (OCC) program, as part of Cal MediConnect, a demonstration program operating in seven counties throughout California was discontinued 12/31/2022 and all members were bridged into OneCare ensuring continuity of care for their existing services~~

~~Program of All-Inclusive Care for the Elderly (PACE)~~

~~In 2013, CalOptima Health launched the PACE program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.~~

~~To be a CalOptima Health PACE participant, members must be at least 55 years old, live in Orange County and be determined to be:~~

- ~~Eligible for nursing facility services by the State of California.~~
- ~~Able to live safely at home or in a community setting with proper support.~~

- Able to receive all non-emergent services within the CalOptima Health network.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants.
PACE participants must receive all needed services — other than emergency care — from CalOptima Health PACE providers and are personally responsible for any unauthorized or out-of-network services.

CalOptima Health's Utilization Management team is the designated lead for administrative and nursing clinical review functions for PACE program inpatient admissions and works directly with the IDT for clinical determinations and transition coordination.

Pharmacy Administration Changes

Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances are the responsibility of Medi-Cal Rx.

CalOptima Health Pharmacy Management staff continue to assist members with medication-related access issues. CalOptima Health-retained responsibilities to include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect OneCare or PACE.

Population Health Management (PHM) Program

CalOptima Health's PHM Program aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Program integrates physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. The PHM services includes basic population health management, care management, complex care management, ECM, and transitional care services.

CalOptima Health's PHM Program address the following four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Considering patient safety or outcomes across settings

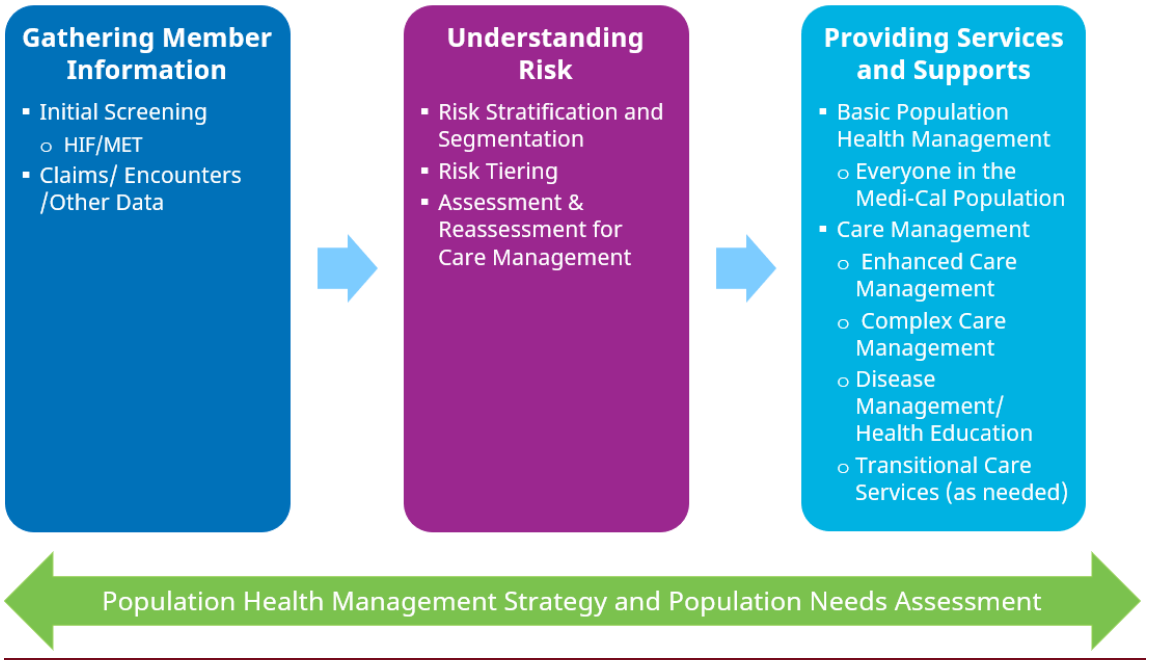
4. Managing multiple chronic conditions

The PHM Framework outlines ~~three~~ four key components for operationalizing the program:

1. Population Health Management Strategy and Population Needs Assessment;
2. G~~g~~athering member information;
3. U~~, u~~nderstanding risk~~,~~; and
4. P~~p~~roviding services.

PHM Framework





The goals of the PHM program are to establish:

- Trust and meaningful engagement with members
- Data-driven risk stratification and predictive analytics to address gaps in care
- Revisions to standardize assessment processes
- Care management services for all high-risk members
- Robust transitional care services (TCS)
- Effective strategies to address health disparities, Social Determinants of Health (SDOH) and upstream drivers of health
- Interventions to support health and wellness for all members

CalOptima Health analyzes the PHM Program annually and uses key performance indicators~~,~~ such as Primary Care, ambulatory care, ED visit and inpatient utilization and quality measures, such as HEDIS, to measure the effectiveness of the PHM Program.

CalOptima Health Direct Network and Health Network Entities

Direct Network and Contracted Health Networks Entities

Providers have several options for participating in CalOptima Health's programs providing health care to CalOptima Health members. Providers can participate through the CalOptima Health Direct (COD) network, CalOptima Health Community Network (CCN), or through a Health Network (HN) affiliation.

CalOptima Health members can choose a Primary Care Provider (PCP) in CalOptima's Community Network (CCN) or one of ~~12~~ 10 HNs, representing more than 10,000 practitioners. CalOptima Health members that do not choose a PCP are provisionally assigned to CalOptima Health's Direct Administrative network for forty-five (45) days until they choose a HN and PCP.

CalOptima Health Direct (COD)

CalOptima Health Direct (COD) network is composed of two elements: CalOptima Health Direct- Administrative (COD-A) and the CalOptima Health Community Network (CCN).

- CalOptima Health Direct-Administrative (COD-A) is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima Health's OneCare program~~s~~), share of cost members, newly eligible members transitioning to a HN from CCN, and members residing outside of Orange County.
- CalOptima Health Community Network (CCN) - provides doctors with an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and ~~available~~is available for HN eligible members, supplementing the existing HN delivery model and creating additional capacity for access for certain covered services that are not the financial risk of the HN.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with HNs that are delegated to perform certain clinical and administrative functions on behalf of CalOptima Health through a variety of risk models to provide care to members. The following contract risk models are currently in place with HNs:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to ~~1,293~~1,260 primary care ~~providers (~~providers (PCPs), ~~8,160~~9,053 specialists, ~~45~~ 44 hospitals, ~~34~~ 52 Community Health Centers clinics and ~~98~~ 107 long-term care~~-~~ facilities.

Provider Network Data (as of January 31, 2023)

	Number of Providers
Primary Care Providers	1,293
Specialists	8,160
Pharmacies	565
Acute and Rehab Hospitals	45
Community Health Centers	34
Long-Term Care Facilities	98

Provider Network Data (as of October 31, 2023)

	Number of Providers
Primary Care Providers	**1,260**
Specialists	**9,053**
Pharmacies	**553**
Acute and Rehab Hospitals	**44**
Community Health Centers	**52**
Long-Term Care Facilities	**107**

CalOptima Health contracts with the following Health Network~~N~~s as Shared Risk Group (SRG), Physician-Hospital Consortia (PHC), or Health Maintenance Organization (HMO) ~~benefit programs~~:

Health Network/Delegate	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
~~AMVI/Prospect Medical Group~~		~~SRG~~
AMVI Care Medical Group	PHC	PHC
~~Arta – Optum Care Network~~	~~SRG~~	~~SRG~~
CHOC Health Alliance	PHC	
Family Choice Medical Group		SRG
Family Choice Health Services	HMO	
HPN – Regal Medical Group	HMO	HMO
~~Kaiser Permanente~~	~~HMO~~	
~~Monarch –~~ Optum Care Network ~~– Monarch~~	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Prospect Medical Group	HMO	HMO
~~Talbert – Optum Care Network~~	~~SRG~~	~~SRG~~
United Care Medical Group	SRG	SRG

~~Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:~~

CalOptima Health delegates UM activities for a portion of the CalOptima Health membership to HNs that demonstrate the ability to meet CalOptima Health's standards, as outlined in the UM Program Description and CalOptima Health policies and procedures. Delegated clinical functions may include but are not limited to Utilization Management, Basic and Complex Case Management and navigation and referrals to CalAIM community supports, ECM, and community organizations.

- ~~Utilization management~~
- ~~Basic and complex case management~~
- ~~Claims~~
- ~~Contracting and Provider Network development~~
- ~~Provider Relations~~
- ~~Credentialing of practitioners~~

- ~~Customer services membership Demographics~~

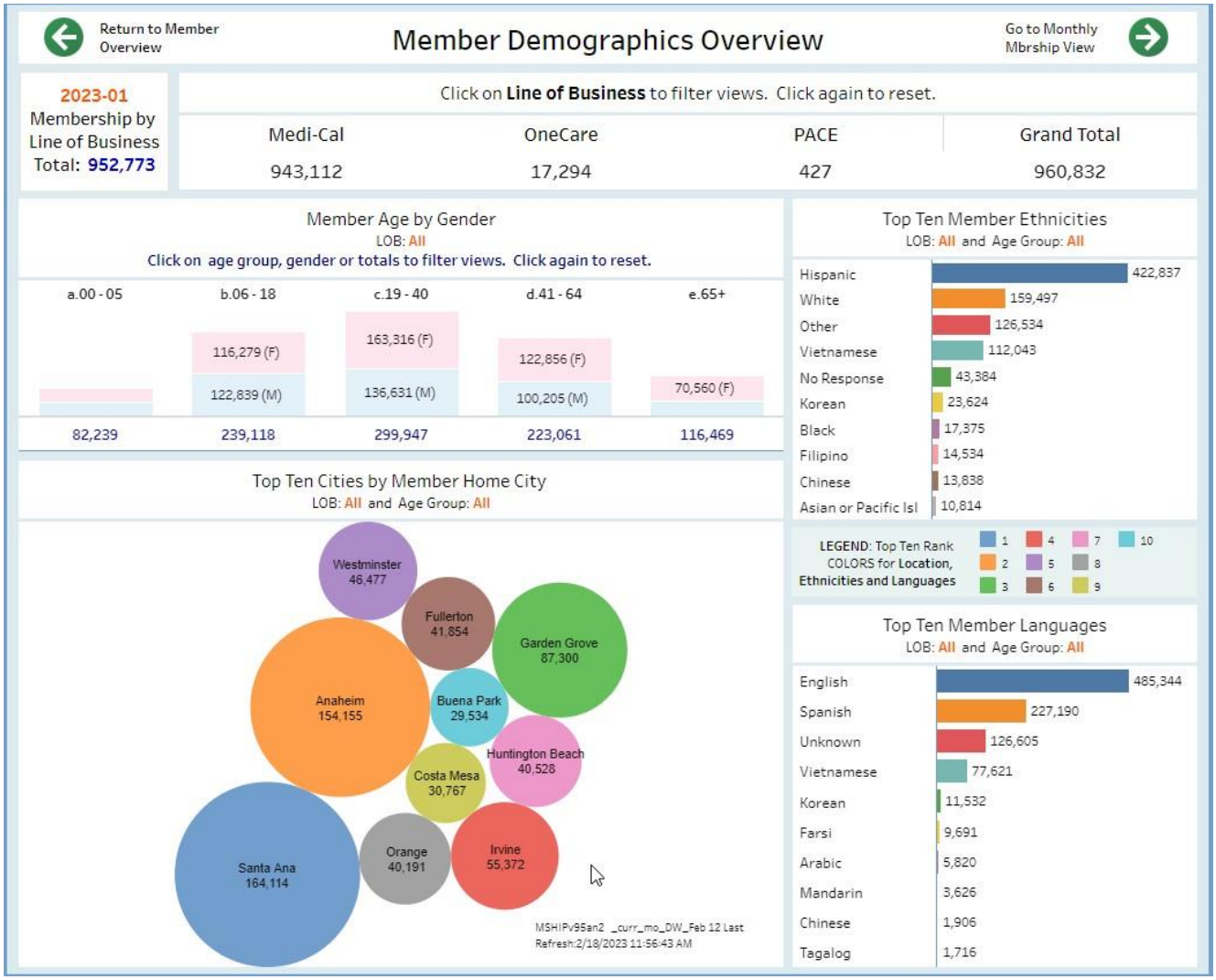
CalOptima Health retains accountabilities for all delegated functions and services, and monitors the performance of the delegated HN through the following processes:

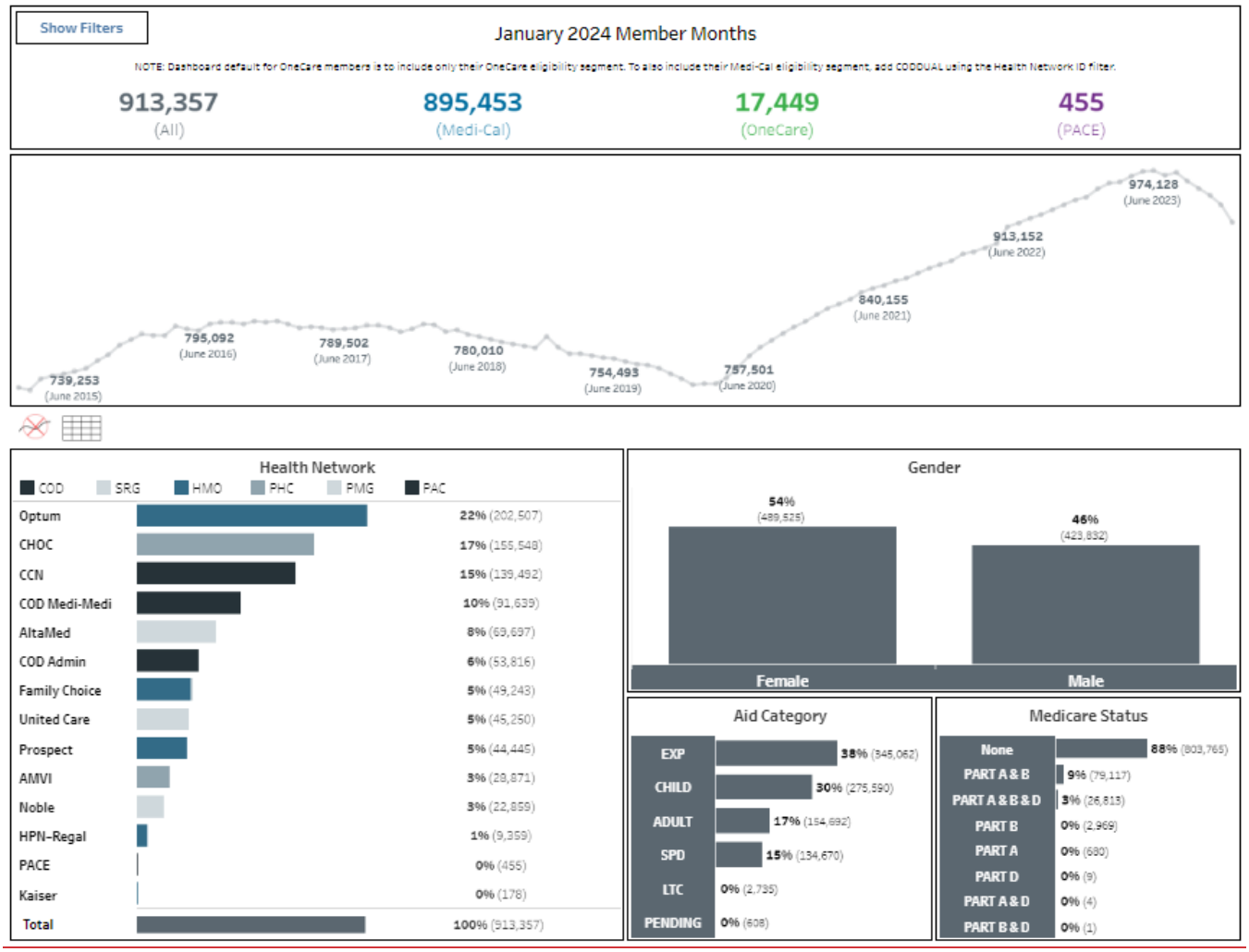
- Frequent reporting of key performance metrics that are required and/or developed by CalOptima Health's Internal Audit Department and reported to the Delegation Oversight Committee (DOC) and/or Quality Improvement Health Equity Committee (QIHEC).
- Annual and ad hoc audits of UM activities by CalOptima Health's Internal Audit Department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Center for Medicare & Medicaid Services (CMS), NCQA, and CalOptima Health standards and program requirements.
- Annual approval of the HNs UM Program (or portions of the program that are delegated), as well as any significant changes that occur during the contract year.

In the event the HN does not adequately perform contractually specified delegated duties, CalOptima Health takes further action, including increasing the frequency or number of focused audits, requiring the HN to implement corrective actions, imposing sanctions, capitation review, or de-delegation.

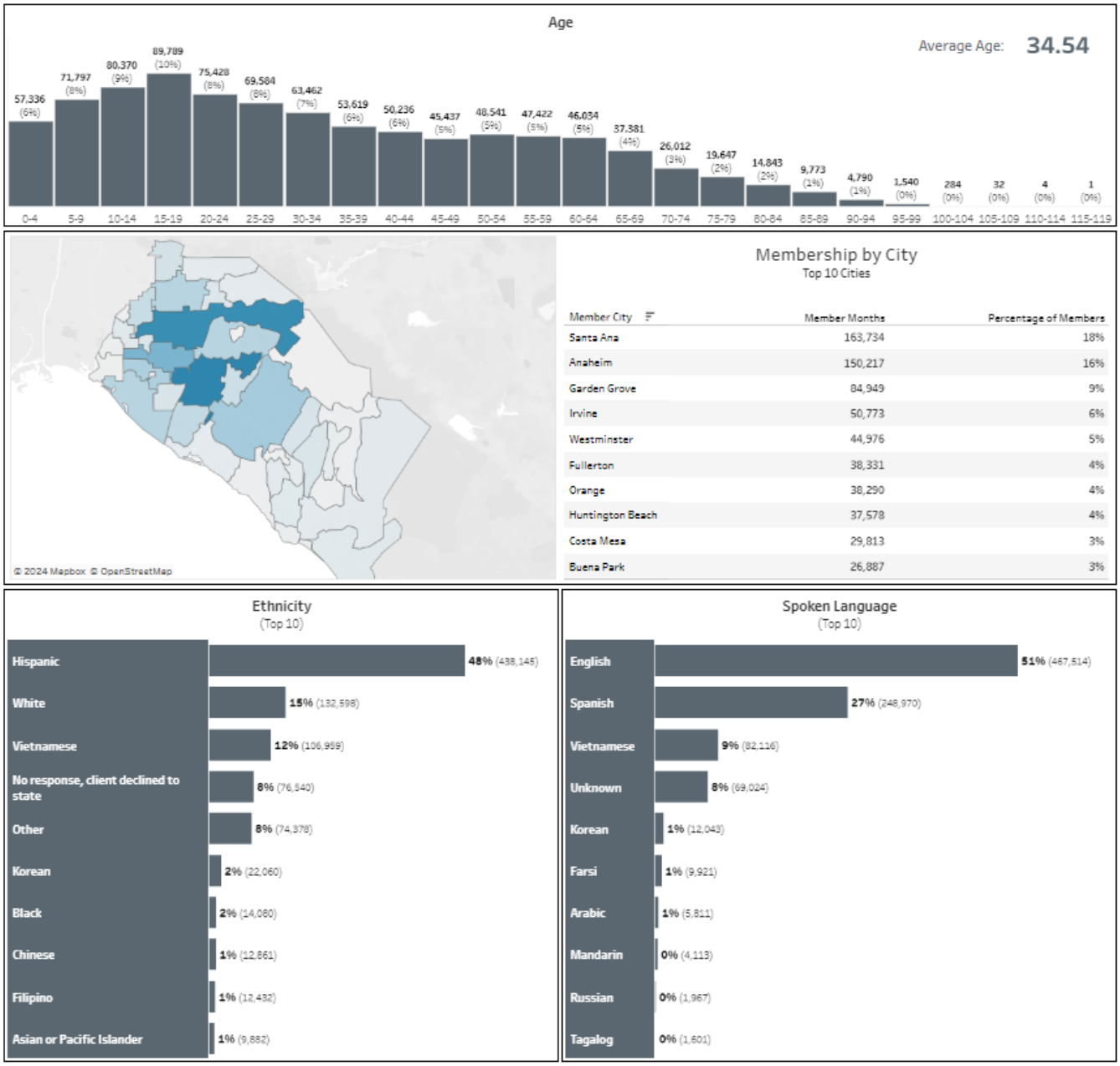
Health Network Forum

Lead by Executive Director of Clinical Operations and Medical Director Liaison, the forum includes representation from Health Networks and CalOptima Health who come together to discuss programmatic enhancements and changes to the implementation and operation of medical management programs. This forum allows all Health Networks the opportunity to provide feedback and discuss how to improve operations establishing a cohesive and unified approach to managing CalOptima Health members, regardless of who is managing the care of the member.


Return to Member Overview
Member Demographics Overview
Go to Monthly Mbrship View
2023-01
Membership by Line of Business
Total: 952,773
Click on Line of Business to filter views. Click again to reset.
Medi-Cal
OneCare
PACE
Grand Total
943,112
17,294
427
960,832
Member Age by Gender
LOB: All
Click on age group, gender or totals to filter views. Click again to reset.
a.00 - 05
b.06 - 18
c.19 - 40
d.41 - 64
e.65+
116,279 (F)
122,839 (M)
163,316 (F)
136,631 (M)
122,856 (F)
100,205 (M)
70,560 (F)
82,239
239,118
299,947
223,061
116,469
Top Ten Member Ethnicities
LOB: All and Age Group: All
Hispanic 422,837
White 159,497
Other 126,534
Vietnamese 112,043
No Response 43,384
Korean 23,624
Black 17,375
Filipino 14,534
Chinese 13,838
Asian or Pacific Isl 10,814
LEGEND: Top Ten Rank COLORS for Location, Ethnicities and Languages
1 2 3 4 5 6 7 8 9 10
Top Ten Cities by Member Home City
LOB: All and Age Group: All
Westminster 46,477
Fullerton 41,854
Garden Grove 87,300
Anaheim 154,155
Buena Park 29,534
Huntington Beach 40,528
Costa Mesa 30,767
Santa Ana 164,114
Orange 40,191
Irvine 55,372
MSHIPv95an2 _curr_mo_DW_Feb 12 Last Refresh:2/18/2023 11:56:43 AM
Top Ten Member Languages
LOB: All and Age Group: All
English 485,344
Spanish 227,190
Unknown 126,605
Vietnamese 77,621
Korean 11,532
Farsi 9,691
Arabic 5,820
Mandarin 3,626
Chinese 1,906
Tagalog 1,716



Source: Membership Dashboard tableau, *data pulled 1/5/2024*



Source: Membership Dashboard tableau, *data pulled 1/5/2024*

UTILIZATION~~TILIZATION~~ MANAGEMENT~~ANAGEMENT~~ PROGRAM~~ROGRAM~~

Utilization Management Purpose

The purpose of the Utilization Management (UM) Program is to define the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic approach to review health care services, treatment, and supplies, and provide quality, coordinated health care services to CalOptima Health members. The ~~Utilization Management~~ UM Program includes review and analysis of utilization trends including identification of under and over-utilization to determine members are receiving appropriate services. All health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an effective, and timely manner by delegated and non-delegated providers.

UM Scope

The ~~scope of the~~ UM Program is comprehensive ~~and applies to~~with a scope that encompasses all eligible members across all product types, age categories and range of diagnoses within CalOptima Health's membership. ~~Additionally, the scope of the~~In addition, the UM program ~~is to oversee~~scope includes oversight of continuity of care and assurances for access to appropriate services, ~~providers~~providers, and care settings. The UM Program incorporates physical and behavioral health, pharmacy services, ~~long term~~Long-term care and long-term services and supports. This includes preventive, emergency, primary, specialty, home- and community-based services, as well as acute, subacute, ~~short term~~ short-term, and long-term facility and ancillary care services.

UM Process ~~ROCESS~~

The UM process includes but is not limited to the following program components: referral/prior authorization, inpatient and concurrent review, post-stabilization services, ambulatory care review, retrospective review, discharge planning, continuity of care coordination, transitions of care, and second opinions. All requests are reviewed against hierarchical guideline criteria and approved services must meet medical necessity criteria. The clinical decision process initiates upon receipt of a treatment authorization request. Request types include but are not limited to, authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services, durable medical equipment. The treatment authorization review process is complete when the requesting practitioner, rendering practitioner, and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to utilization trends and opportunities as well as identifying potential fraud, waste and abuse among practitioners and members. The UM ~~d~~Department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified. All UM team members and oversight ~~c~~Committees sign an annual attestation and are expected to abide by and uphold, CalOptima Health's policy for ensuring all medical decisions are made based within regulatory requirements and are not unduly influenced by financial considerations.

CalOptima Health provides Continuity of Care services up to 12 months to a requesting member's primary care provider~~s~~, specialists and some ancillary providers for Medi-Cal beneficiaries transitioning to CalOptima Health or transitioning from a Managed Care Plan with contracts expiring with ~~to~~ CalOptima Health or a Health Network.

UM Program Goals

The purpose of the ~~goal of the~~ UM Program is to manage appropriate utilization of medically necessary covered services and to ensure access to quality and cost-effective health care for

CalOptima Health, this is accomplished through the following goals: ~~of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima Health members. This includes but is not limited to:~~

- Assisting in the coordination of medically necessary physical health, behavioral health, Long-Term Services and Supports (LTSS), Long-~~-~~Term Care (LTC) and pharmacy services in accordance with benefit and clinical criteria and hierarchy, state and federal laws, regulations, contract requirements, NCQA standards and other evidence-based clinical criteria.
- Enhancing the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Providing a mechanism to address concerns about access, ~~availability~~availability, and timeliness of care.
- Clearly ~~defining~~define staff responsibility for activities regarding decisions based on medical necessity including non-clinical, clinical and Medical Director staff roles and responsibilities.
- Establishing and maintaining processes used to review medical and behavioral health care and pharmacy service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on medical necessity and/or benefit coverage.
- Identifying and referring members to Care Coordination, Case Management, Complex Case Management and Enhanced Care Management programs, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promoting a high level of member, ~~practitioner~~practitioner, and stakeholder satisfaction.
- Protecting the confidentiality of members health and personal information.
- Identifying and reporting potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) ~~d~~Department for further action.
- Identifying and ~~address~~addressing over- and underutilization of services. Monitoring utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.
- Promoting improved member outcomes by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- ~~The LTSS team w~~Work~~s~~ collaboratively with CalOptima Health's Health Network's to coordinate care for complex discharge needs and CalAIM services.
- Provide continuous identification of UM staffing needs including clinical, non-clinical and ~~m~~Medical D~~d~~irectors to address the needs of the members we serve.
- Provide continuous training for competency, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The CalOptima Health UM Program is designed to work in alignment with delegated entities,

for optimal health outcomes and includes but is not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community to ensure that the member receives appropriate, cost-efficient, quality-based health care.

The UM Program is reviewed, ~~evaluated and~~evaluated and revised as needed for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA), NCQA and established best practice standards/ internal benchmarks at least annually. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by ~~the~~ CalOptima Health's network. Additionally, the UM program structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization. The organization chart and the UM Program reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Health Equity Committee (QIEHC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is overseen by the Chief Medical Officer and evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team that may include but is not limited to the Deputy Chief Medical Officer; Medical Director(s) of UM; Behavioral Health Medical Director; Executive Director of Behavioral Health Integration; Executive Director, Clinical Operations; UMC; and QIHEC.

~~Delegation of UM functions~~

~~CalOptima Health delegates UM activities for a portion of the CalOptima membership to Health Networks that demonstrate the ability to meet CalOptima Health's standards, as outlined in the UM Program Description and CalOptima Health policies and procedures.~~

~~CalOptima Health retains accountabilities for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:~~

- ~~Frequent reporting of key performance metrics that are required and/or developed by CalOptima Health's Audit & Oversight department and reported to the Delegation Oversight Committee and/or Quality Improvement Committee (QIC).~~
- ~~Annual and ad hoc audits of delegated HNs' UM activities by CalOptima Health's Audit & Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA, and CalOptima Health standards and program requirements.~~
- ~~Annual approval of the delegate's UM Program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.~~

~~In the event the delegated provider does not adequately perform contractually~~

~~specified delegated duties, CalOptima Health takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation review, or de-delegation.~~

Long-Term ~~Support~~ Services and Supports (LTSS)

CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community- based nursing and sub-acute facility services for both adults and pediatrics. CalOptima Health's LTSS ~~d~~Department monitors and reviews the quality and outcomes of services provided to members in both settings.

Home- and Community-Based Services~~:~~

CalOptima Health's LTSS Department monitors member utilization, level of access and satisfaction with Community Based Adult Services (CBAS) and Multipurpose Senior Services Programs (MSSP) focusing on diverting members from institutionalization, when appropriate.

Behavioral Health Services

CalOptima Health offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, ~~emotional~~emotional, or behavioral functioning, Services include but are not limited to individual, family and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima Health also covers alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) provided to members 11 years and older, including pregnant women by providers within their scope of practice.

CalOptima Health covers medically necessary behavioral health treatment (BHT) for members 20 years and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). BHT services include applied behavior analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction.

CalOptima Health's behavioral health provider network consists of: Psychiatrists, Licensed Clinical Psychologist (PYSD), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Professional Counselor(LPCC), Nurse Practitioner, Physician Assistant, Certified Nurse Specialist, Associate Social worker, ~~Assoicate~~Associate Marriage and Family Therapist, Psychological Assistant, Associate Professional Clinical Counselor, Board Certified Behavioral Analyst (BCBA), Board Certified Associate Behavior Analyst (BCaBA), Register Behavioral Technician (RBT).

CalOptima Health does not require members, or their ~~practitioners~~practitioners, to undergo triage and referral when seeking information about or approval of BH services. Most mental health services do not

require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at **855-877-3885**. A CalOptima Health representative will conduct a brief telephonic screening to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent DHCS approved screening tool. The screening is used to make an initial determination of the member's impairment level due to a mental health condition. If the member has mild to moderate impairments, the member will be offered behavioral health providers within the CalOptima Health network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services (SMHS) through the Orange County Mental Health Plan (OCMHP) managed by the Orange County Health Care Agency.

CalOptima Health directly manages all administrative functions of the Medi-Cal behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

~~One Care (OC)~~

CalOptima Health offers the following mental health services to OC members:

- Inpatient psychiatric hospitalization
- Intensive outpatient program (IOP) and partial hospitalization program (PHP)
- ~~I~~Outpatient individual and group psychotherapy
- Outpatient medication management
- Psychological testing
- Opioid Treatment Program (OTP) services
- Electro Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT)

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at 855-877-3885. A CalOptima Health representative will conduct a brief telephonic screening to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent approved screening tool. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments due to a mental health condition, the member will be offered behavioral health practitioners within the CalOptima Health provider network. If the member has significant to severe impairments, the member will be referred to (SMHS) through the OCMHP.

CalOptima Health directly manages all administrative functions of the OC behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

Authority ~~UTHORITY~~, Boards ~~OARDS OFF~~ of Directors'~~IRECTORS'~~ Committees~~OMMITTEES~~, and~~AND~~ Responsibilities~~ESPONSIBILITIES~~

Board of Directors

CalOptima Health's Board of Directors has ultimate accountability and responsibility for overseeing the quality of care and service provided to CalOptima Health members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the Quality Improvement Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts — and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board ensures the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIEHC and the QAC on an annual basis.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the QAC to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program.

Member Advisory Committee

The Member Advisory Committee (MAC) has 175 voting members, each seat represents a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership has representatives from the following constituencies:

- Adult Beneficiaries
- Children
- ~~Consumer~~
- Family Support

- Foster Children
- ~~Long~~ Term Care Representative
- Medi-Cal Beneficiaries or Authorized Family Member (two seats)
- ~~Medical Safety Net Representative~~
- Member Advocate
- OneCare Member or Authorized Family Member (four seats))
- ~~Orange County Health Care Agency (standing seat)~~
- Orange County Social Services Agency (standing seat)
- People with Disabilities
- Behavioral/Mental Health Representative
- People with Special Needs
- Recipients of CalWORKs
- Seniors

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. PAC members represent a broad provider community that serves CalOptima Health members. The PAC meets at least quarterly and is open to the public. The members include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- Health Care Agency (HCA)
- Long Term Services and Supports ~~(LTC facilities and CBAS)~~
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) ~~when~~ since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board of Directors and staff on issues concerning the WCM program, serves as a liaison

between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

Members of WCM FAC include-

- Family representatives:
  - Authorized representatives, which include~~s~~ parents, foster parents and caregivers of ~~a~~ CalOptima Health member~~s~~ who ~~is a~~are current recipient~~s~~ of CCS services; or
  - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
  - Current CalOptima Health members over the age of 21 who transitioned from CCS services.
- Interests of children representatives:
  - Community-based organizations; or
  - Consumer advocates

CalOptima Health Officers

The CalOptima Health Officers are the senior- leaders responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations. CalOptima Health Officers include the Chief Medical Officer (CMO), Chairperson of the Utilization Management Committee (UMC), Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima Health's Chief Executive Officer (CEO) ~~are. the senior leaders responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.~~

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, ~~policies~~policies, and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the Executive Director of Quality and Population Health Management.

~~EDs of~~ **Executive Director, Quality ~~and Population Health Management~~ Improvement** ~~(Q&PHM~~(ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Medicare Stars and Quality Initiatives.~~), makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima Health's strategic plan, goals and objectives. The EDCO is expected to anticipate, continuously improve, communicate, and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.~~

Executive Director, Behavioral Health Integration (ED of BHI) is responsible for the management and oversight of CalOptima Health's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED of BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Executive Director, Population Health Management (ED PHM) is responsible for the management and oversight of CalOptima Health's disease management and health education departments. The ED PHM oversees the development and implementation of ~~company-wide~~companywide Population Health Management strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Physical and Behavioral Health Medical Directors *(hereinafter referred to "Medical Directors")*

have primary assigned roles but may provide coverage and back up to other specialties as needed. All ~~m~~Medical ~~d~~Directors are appointed by the CMO and/or DCMO and are responsible to adhere to and oversee the direction of the UM Program and objectives, as well as evaluation of the UM Program.

- The ~~m~~Medical ~~d~~Director who oversees UM ensures quality medical service delivery to members managed directly by CalOptima Health and is responsible for medical direction and clinical decision making in UM. The ~~m~~Medical ~~d~~Directors serve as the senior-level physicians designated to the implementation of the UM Program. The ~~Mecial~~Medical Directors ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and uses evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the ~~m~~Medical ~~d~~Director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. The ~~m~~Medical ~~d~~Director provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The ~~m~~Medical ~~d~~Director of UM ~~e~~ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the biweekly UM Workgroup meetings and participates in the CalOptima Health Medical Directors Forum and QIHEC.

- The ~~m~~Medical ~~d~~Director who oversees the behavioral health program is a double board-certified Psychiatrist specializing in Child and Adolescent Psychiatry and is a participating member of the UMC, QIHEC and CPRC. The ~~m~~Medical D~~d~~irector provides consultation and oversight to the UM Program, including guidance on criteria review and development to ensure parity. The ~~m~~Medical ~~d~~Director is also the chair of the Pharmacy & Therapeutics committee (P&T). The ~~m~~Medical director supports the behavioral health aspects of the UM Program. The ~~medical~~ Medical ~~d~~Director also provides leadership and program development in the creation and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima Health members. Clinical oversight is also provided for BH benefits and services provided to members. The ~~m~~Medical D~~d~~irector works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes.

- The ~~m~~Medical ~~d~~Director ~~who~~ oversees specialty programs and services, is a key member of the medical management team, and is responsible for the Medi-Medi programs, MLTSS programs, and Case Management programs. The ~~m~~Medical ~~d~~Director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima Health operational and support departments, including PHM, disease management and health education programs, while also providing clinical quality oversight of the Program of All-Inclusive Care for the Elderly (PACE) Center.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental operations. This position provides leadership and direction to the UM department, ensures ~~to ensure~~ compliance with all local, state and federal regulations. The Director, Utilization Management also ensures~~,~~ that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima Health's UM Program for CalOptima Health Community Network, CalOptima Health Direct and the delegated HNs. The Director is expected to serve as a liaison for various internal and external committees, ~~workgroups~~workgroups, and operational meetings.

Director, Behavioral Health Integration is responsible for the planning, organization monitoring, and evaluation of all activities and personnel engaged in the BH UM operations. The director ~~tracks,~~tracks and analyzes changes in the behavioral health care delivery environment and program opportunities affecting or available to assist CalOptima Health in integrating physical and BH care services. This position provides leadership and direction to the BH UM team to ensure compliance with all local, ~~state~~state, and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. This position plays a key leadership role in coordinating with all levels of CalOptima Health staff, including the Board of Directors, executive staff, members, providers, HN management, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position is also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHE Work Plan.~~assigned day-to-day operations of the QI department, including Credentialing, Facility Site Reviews consisting of FSR(Facility Site Review, Medical Record Review (MRR) for both physical and behavioral health (including onsite visits and process evaluation), and Physical Accessibility Compliance and working with the ED of Q&PHMQuality to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.~~

Director, Quality Analytics provides ~~data~~ analytical direction to support quality measurement activities for the agencywide QI Program by managing, ~~executing~~executing, and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. This position provides coordination and support to the QIBEC and other committees to support compliance with regulatory and accreditation agencies.

Director, Population Health Management (PHM) provides direction for program development and implementation for agencywide population health initiatives while ensuring linkages supporting a whole- person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position ~~provides~~ oversees ~~direct care~~ programs that promote health and wellness services ~~coordination and health education for~~

for all CalOptima Health members. ~~participating in non-delegated health programs, such as~~PHM services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and ~~Reigstered~~Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). ~~Also,~~PHM also supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director, Internal Audit ~~& Oversight~~ oversees and conducts compliance ~~independent performance~~ audits and monitoring of CalOptima Health's internal operations~~, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions~~ with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima Health policies, and industry best practices. The director validates~~ensures~~ that CalOptima Health's business areas ~~and subcontracted HNs~~ perform consistently with both CMS and state requirements for all programs. Specifically, the director leads the department in developing audit protocols for all internal ~~and delegated~~ functions to ensure adequate performance relative to both quality and timeliness. Additionally, the director is responsible ~~to ensure~~ for the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls~~., as well as delegated functions.~~ The position interacts with the Board of Directors, CalOptima Health ~~executives~~Executives, Compliance Committee, departmental management, ~~HN management~~ and legal counsel.

UM Staffing Resources

CalOptima Health uses appropriate licensed health care professionals to process and/or supervise UM activities. The ~~following~~ UM Program ~~roles~~health care professionals:

- ~~p~~Provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

Manager, Utilization Management RN/LVN (Concurrent Review [CCR]) manages the day-to-day operational activities of the ~~d~~Department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The ~~m~~Manager develops, ~~implements and~~implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Supervisor, Utilization Management RN/LVN(CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work assignment and activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The ~~s~~Supervisor is a resource to the CCR staff regarding CalOptima Health policies and procedures, as well as regulatory and accreditation agency requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The ~~s~~Supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours and during weekend/holiday on call schedules~~.~~

Manager, Utilization Management RN/LVN (Prior Authorization [PA]) manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima Health policies and procedures, and regulatory and accreditation agency requirements. The ~~m~~Manager develops, ~~implements and~~implements and maintains processes and strategies to ensure the delivery of quality health care services to members. The Manager~~, Utilization Management PA~~ also establishes ~~while establishing~~ and ~~maintaining~~ maintains collaborative working relationships with internal and external resources ~~in order to~~to ensure appropriate support for utilization activities.

Supervisor, Utilization Management RN/LVN (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The ~~s~~Supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff —regarding CalOptima Health policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing —while providing ongoing monitoring and development of staff through training activities. The ~~s~~Supervisor also ~~monitors for~~monitors documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent

application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours and during weekend/holiday on call schedules.

The following staff positions provide support for the UM ~~d~~Department's ~~o~~organizational/operational functions and activities:

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation, ~~and~~ utilization of appropriate ~~criteria, and~~criteria, and assurance that the letter is ~~and is~~ written in plain language that a layperson understands.

Medical Case Managers (RN/LVN) provide inpatient and outpatient utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria.

All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA) are responsible for interacting with practitioners, members, ~~family~~family, and other customers. Staff members who are not qualified health care professionals are under the direct supervision of a licensed clinician. Non-licensed team members process service requests that do not require application of clinical judgement ~~be~~to be ~~applied~~. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They can administratively authorize services according to departmental guidelines and under the oversight of UM nurse reviewers and ~~m~~Medical ~~d~~Directors.

~~**Manager, Utilization Management (RN/LVN)** (UM Monitoring) is responsible for management of the day-to-day monitoring of UM activities, including monitoring of UM processes of Prior Authorization and Inpatient. They eEnsure that service standards are met,, and operations are consistent with all regulatory requirements, accreditation standards and CalOptima Health policies and procedures.~~

Medical Case Managers ~~Monitoring Nurses – UM~~ (Clinical Auditors, ~~LVN))~~(LVN) ~~is~~are responsible for ~~conducts~~ conducting routine oversight, and ~~,~~ ~~monitoring~~monitoring~~,~~ and auditing of internal UM activities to ensure compliance with state, federal and accreditation standards. — Monitoring activities include but are not limited to, prior authorization and inpatient file reviews, addressing Correction Action Plans (CAPS) findings, ~~as well as identify~~and identifying ~~opportunity~~ opportunities for process improvement during the monitoring process.

Pharmacy Staffing Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements and administers all aspects of the CalOptima Health pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to- day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery~~,~~ and has frequent interaction with external contacts~~,~~ including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case- by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima Health, as well as national practice guidelines and on an ongoing basis, research, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs and~~,~~ assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T) Committee. The Manager, Clinical Pharmacist~~,~~ interacts frequently ~~and independently~~ with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interactions with external contacts, including the pharmacy benefit managers' clinical department staff.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima Health, as well as national, practice guideline. On an ongoing basis, they research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs.
~~They~~ The Clinical Pharmacists assist the Pharmacy director in preparing drug monographs and reports for the P&T Committee, interact ~~frequently and independently~~ with other department staff as needed to perform the duties of the position, and have frequent interactions with external contacts, including the pharmacy benefit managers' clinical department.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and

delivery system setting.

LTSS Staffing Resources

Director, Long- -Term ~~Support and Services~~Services and Supports develops, manages and implements LTSS programs~~,~~ including Long- Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs.

Manager, Long- -Term ~~Support and~~ Services and Supports (CBAS/LTC) develops and manages the LTSS department's work activities and team. The manager ensures that service standards are met, and operations are consistent with CalOptima Health's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima Health's members who are eligible for and/or receiving LTSS.

Supervisor, Long-T ~~T~~erm ~~Support and~~ Services and Supports (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting.

Medical Case Managers, Long- -Term ~~Support and~~ Services and Supports (MCM LTSS), are part of an advanced specialty collaborative practice responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for qualified CalOptima Health members in LTC facilities and members receiving CBAS. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The MCM LTSS acts as liaisons to Orange County community agencies, CBAS centers, skilled nursing facilities, members and providers.

~~**Program Manager, Sr., LTSS** is responsible for assisting the LTSS management with the day-to-day operations of the LTSS department.~~

Behavioral Health Integration Staffing Resources

Manager, Behavioral Health CalOptima Health manages the day-to-day operational activities of the BH UM team to ensure staff compliance with CalOptima Health policies and procedures, and regulatory and accreditation agency requirements.

Supervisor, Behavioral Health, (BH) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met.

Medical Case Managers (BH-RN/LVN or Licensed BH Clinician) provide inpatient and outpatient utilization review and authorization of services in support of members. They are

responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient psychiatric hospital and outpatient BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Care Manager (BH CM) Board Certified Behavior Analyst, BCBA.~~BH~~) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed BHT services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA BH) are responsible for interacting with practitioners or other customers, under the direction of the licensed Medical Case Manager and or Care Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions.

Qualifications and Training

CalOptima Health hires highly qualified clinical individuals with extensive experience and expertise in UM and CM for staff positions. Qualifications and educational requirements are delineated in the position job description~~s~~ of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

- CalOptima Health New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Diversity, Inclusion, and Unconscious Bias
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM and CM Program, policies/procedures, etc.
- Medical Management information system data entry
- Application of Review Criteria/Guidelines
- Appeals process
- Seniors and Persons with Disabilities (SPD) awareness training
- OneCare (OC) training

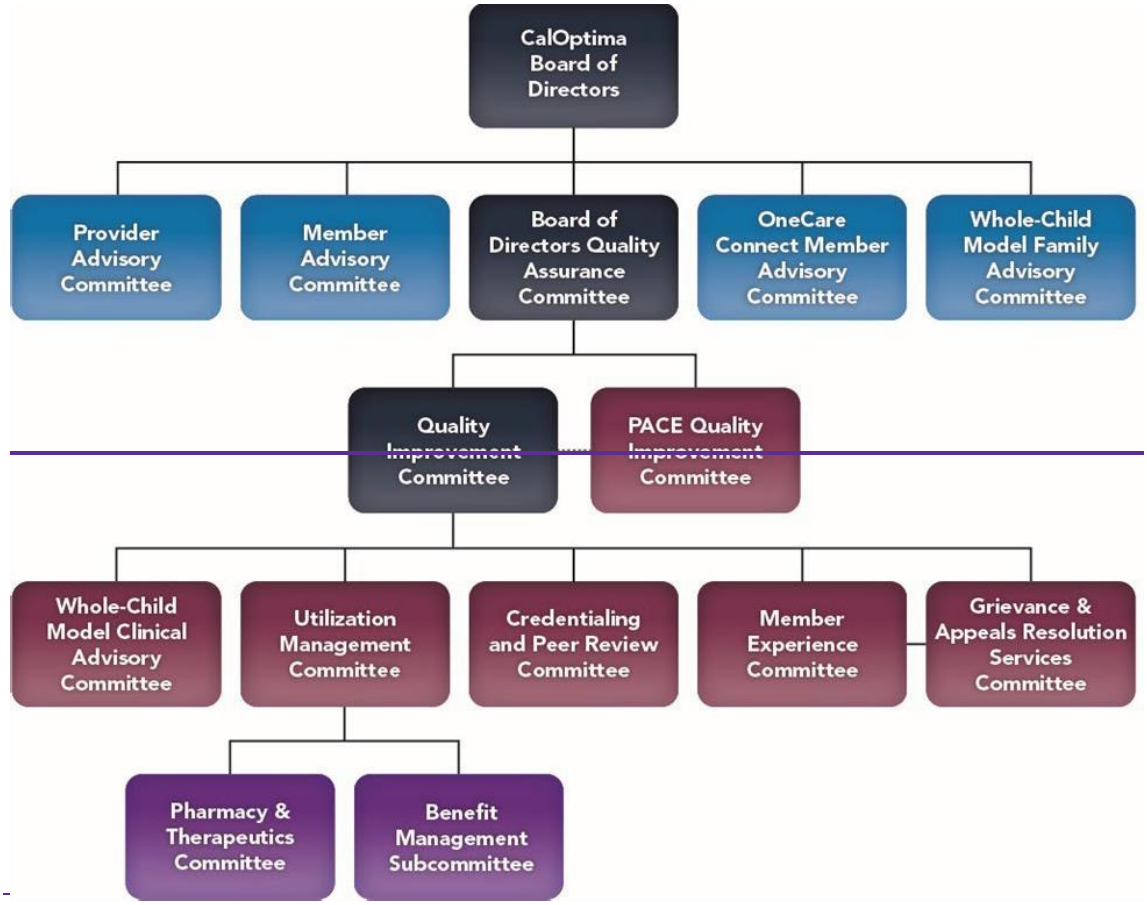
CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health.

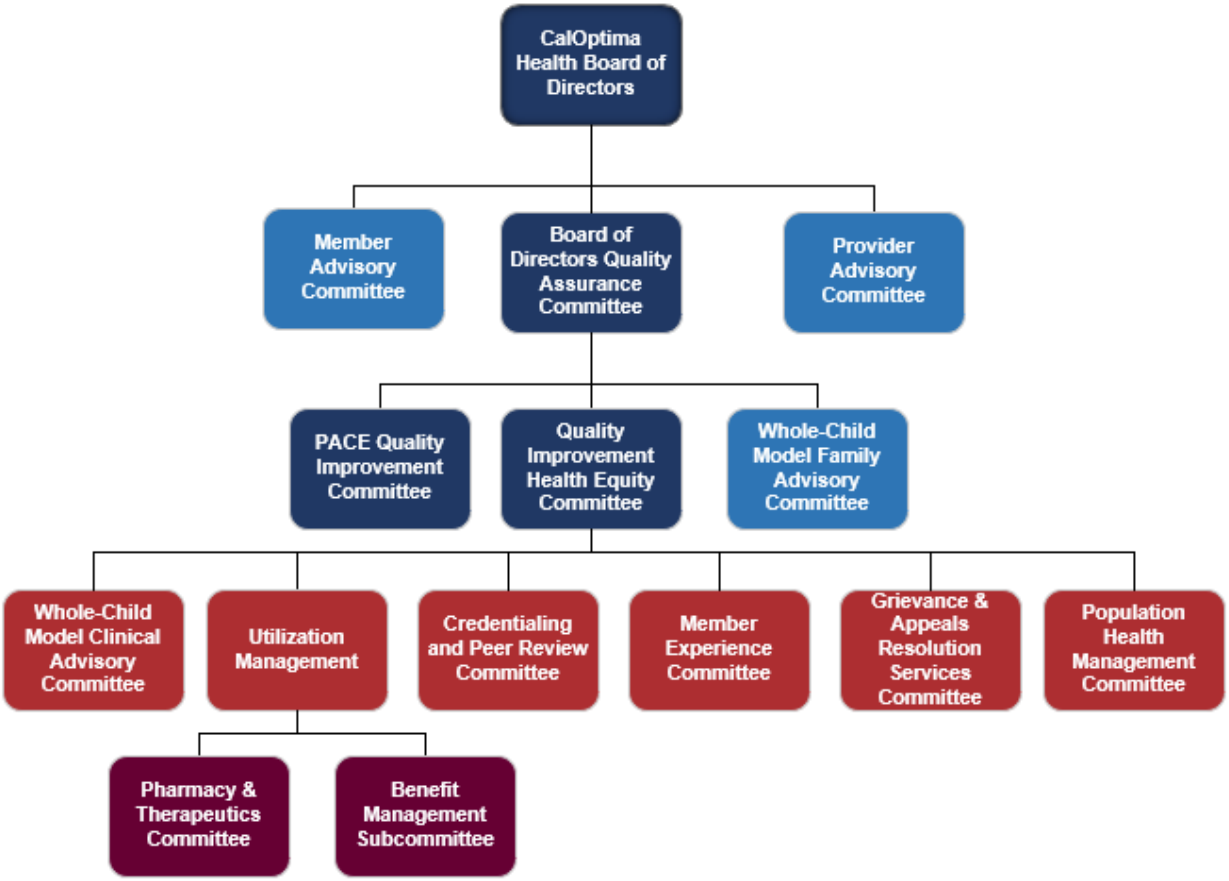
CalOptima Health and its delegated HN UM staff do not permit or provide compensation or anything of value to its employees, agents or contractors based on the percentage or the amount

by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

~~2023~~ Utilization Management Committee (UMC) ~~Committee Structure Diagram~~

Diagram representing the committee structure





UMC

The UMC is led by a CalOptima Health Medical Director. This senior level physician is involved in UM activities, including but not limited to, implementation, supervision, oversight, and evaluation of the UM Program.

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Health Direct, CalOptima Health Community Care Network and through the delegated HMOs, PHCs and SRGs, to identify areas of under or over utilization that may adversely impact member care. The UMC ~~and~~ is responsible for the annual review and approval of medical necessity criteria and protocols, and the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIHEC and QAC. With the assistance of the UM Program specialist, the ~~d~~Director of UM or designee maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIHEC. Oversight and operating authority of UM activities is delegated to the UMC, which reports up to QIHEC and ultimately to QAC and the Board of Directors.

Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy addressing the process to identify and evaluate potential social, ~~economic~~economic, and professional conflicts of interest and take appropriate actions. CalOptima Health requires that all individuals who serve on the UMC or who otherwise make decisions on UM, quality oversight and activities, disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information that are overseen by the ~~d~~Department of ~~c~~Compliance and assigned ~~p~~Privacy ~~o~~Officer. During the onboarding process, all CalOptima Health employees, including contracted professionals who have access to confidential or member information sign a written statement for maintaining confidentiality. In addition, all non-employee Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM Program, consistent with CalOptima Health's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima Health and its delegated HNs.
- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, ~~M~~medical ~~N~~necessity ~~C~~~~vriteria~~criteria, UMC Charter, UM ~~policies, and~~policies, and the UM Program Evaluation on an annual basis.
- Reviews and analyzes UM ~~O~~operational and ~~O~~outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for

further action.

- Reviews and approves annual UM ~~M~~metric targets and goals.
- Reviews progress toward UM Program ~~G~~goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM Program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, ~~assesses~~assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:
  - Benefit Management Subcommittee (BMSC)
  - P&T Committee
- Reports to the QIHEC on a quarterly basis, communicates significant findings and makes recommendations related to UM issues.

Departments Reporting Relevant Information on UM Issues:

- Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- UM Workgroup
- LTSS

UMC Membership

Voting Members in the UMC Committee include:

- CMO/Deputy Chief Medical Office (DCMO)
- Medical Director who oversees Utilization Management
- Medical Director who oversees UM Program
- Medical Director who oversees Behavioral Health Program
- Medical Director who oversees ~~Specialty~~Senior Programs
- Medical Director who oversees Whole-Child Model Program
- Medical Director who oversees Quality and Analytics
- Executive Director, Clinical Operations

- Up to six participating practitioners from the community*[1]
  - * Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

Participating members of The UMC that don't have voting rights, although presents data, program outcomes and updates to policies consists ofis supported by:

- Executive Director, Behavioral Health Integration
- Director, UM
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)

The BMSC is a subcommittee of the UMC. The BMSC iswas chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, The BMSC establishes a single source for the, and revise revisions and updates to CalOptima Health's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

BMSC Scope

The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima Health's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Voting Membership

- Medical Director who oversees UM services— Chairperson
- Medical Director who oversees Population Health and Equity
- Executive Director, Clinical Operations
- Director, UM (Alternate; Manager, Prior Authorization)
- Director, Behavioral Health Integration (Alternate: Medical Director who oversees

[1] Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

Behavioral Health)
- ~~Director, Claims Management~~
- Director, Claims (Alternate: Manager, Claims/Coding Initiatives)
- Director, Pharmacy (Alternate: Manager, Clinical Pharmacist)
- ~~Director, Coding Initiatives~~

The BMSC meets quarterly, at a minimum, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

UM Workgroup

The UM Workgroup is a sub-workgroup under the UMC. The Workgroup meets bi-monthly and includes staff members from UM, CM, BHI, and GARS. Roles and responsibilities of this Workgroup include but are not limited to:

- Provide input to the development and processes of the UM Program
- Provide input to key performance metrics, measures, and goals
- Provide input and recommend criteria and protocols for approving new technology, ~~treatment~~treatment, and diagnostic procedures.
- Review, assess, and recommend internal utilization management best practices
- Review outcome data, trend studies, and key performance indicators
- Provide input on UM Department policies and procedures and desktop procedures
- Identify opportunities to optimize UM processes

The goals of the UM Workgroup include but is not limited to:

- Ensure regulatory and accreditation compliance is met
- Provide ongoing review and input for current process improvement initiatives
- Ensure policies and procedures are current and comply with new and modified regulatory initiatives
- Ensure key performance indicators are met and/or process improvements are initiated when appropriate

Based on discussions at the UM Workgroup, other Sub Workgroups were formed in 2023 and will continue in 2024

- Brain/Spine Workgroup
- Transplant Workgroup
- UM Authorization Strategy Workgroup
- Bed Day Reduction Workgroup

Brain / Spine Workgroup

The Brain / Spine Workgroup meets monthly and consists of UM staff and UM leadership including

Medical Directors. The goal of the Brain / Spine Workgroup is to ensure member requests for neurological and spine treatment and/or surgery are provided by appropriate medical practitioners based on member need and that services are provided in a timely manner. CPT codes are reviewed to determine if prior authorization is necessary.

Transplant Workgroup

The Transplant Workgroup meets bi-monthly and consists of UM staff and UM leadership including Medical Directors. The goal of the Transplant Workgroup is to ensure members needing transplant services are case managed throughout the continuum of the transplant process (pre and post), in addition to assisting member families with lodging and meal needs.

CalOptima Health has three dedicated nurses as the point of contact for transplant cases. A UM Nurse is assigned to the pre-authorization needs of the members, one is assigned to the inpatient needs and the third is assigned to the post-transplant needs.

Transplant Workgroup team members also meet weekly with CalOptima Health's COE, UCSD. These rounding meetings allow CalOptima Health to assist UCSD with discharge and post discharge needs and the needs of the families.

UM Authorization Strategy Workgroup

The UM Authorization Strategy Workgroup consists of UM staff, UM leadership, Medical Directors, and representatives from Clinical Operations and Analytics. The workgroup supports ongoing strategic decisions and process improvement for the access and utilization of Utilization Management data.

Bed ~~d~~Day Reduction Workgroup

The Bed Day Reduction ~~w~~Workgroup is a cross-departmental ~~focus~~clinical-lead work group designed to evaluate utilization data. The workgroup is responsible for ~~and~~ development of strategies to improve outcomes for CalOptima Health members and establish bed day goals including readmission rates that will be presented to UMC ongoing. The ~~w~~Bed Day Reduction Work-group establishes data-driven interventions to reduce inpatient admissions, bed days, decrease 30-day readmission, and reduce ED utilization through collaboration between Case Management, Utilization Management, Medical Affairs.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIHEC and QAC, with final review and approval by the Board of Directors.

- The UM Program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) Director in conjunction with the Executive Director of Clinical Services, Executive Director of Behavioral Health Integration, Chief Medical Officer, and Deputy Chief Medical Director prior to submission for committee review and approval.
- Utilization data including, but not limited to, denials, unused authorizations, bed day utilization data, ED utilization data, provider preventable conditions, and trends representing potential over or underutilization, is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.

- The UMC is a subcommittee of the QIHEC and routinely reports activities to the QIHEC.
- The QIHE~~C~~C reports to the Board QAC.

Integration with Other Processes

The UM CM Integrated Program, ~~Case Management Program,~~ BH Program, LTSS Program~~s~~, P&T, QI, Credentialing, Compliance and Audit & Oversight are closely linked in function and process. The UM process uses quality indicators as a part of the review process and provides the results to the QI ~~d~~Department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima Health as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI ~~d~~Department for review and resolution. As a result, ~~the~~ utilization of services is inter- related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between ~~the~~ UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI ~~d~~Department in the format prescribed by CalOptima Health for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima Health's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting and responding to Fraud and Abuse among practitioners and members. The UM ~~d~~Department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima Health coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Review and Authorization of Services~~REVIEW AND AUTHORIZATION OF SERVICES~~

Medical Necessity Review

Medical necessity review requires consideration of the members' clinical needs, evaluation of ~~ng~~ available services within the local delivery system and ~~applying~~ application of evidenced based guidelines and CalOptima Health policies to provide quality care in the most appropriate setting.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima Health's contract with CMS and the State of California for Medi-Cal and OC. Medically necessary~~ily~~ means all covered services or supplies ~~that:~~ are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

Medical necessity for members receiving MLTSS is determined by using a member's current needs assessment and is consistent with person-centered planning.

- ~~For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.~~

~~The~~ CalOptima Health UM process~~es~~ consists of ~~uses active,~~ ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure quality medically necessary services are provided in the most appropriate setting. Appropriate to the situation, p~~Physicians, or P~~hysicians, pharmacists or psychologists ~~in appropriate situations,~~ review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior ~~authorization,~~authorization ~~may be~~is completed by a qualified physician or pharmacist.

CalOptima Health's UM ~~d~~Department is responsible for the review and authorization of health care services for CalOptima Health Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Continuity of care review
- Admission Review
- Post-stabilization review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for HN members

The following standards and considerations are applied when reviewing prior authorizations, inpatient ~~and outpatient~~ concurrent review, and retrospective review requests:

- ~~Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.~~
- Evidenced based clinical criteria or guidelines are applied consistently and~~,~~ regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:

  - Age
  - Co-morbidities
  - Complications
  - Progress of treatment
  - Psychological/Psychosocial situation
  - Home environment, when applicable

- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action.
- Clinical rationale and reasons for decisions are clearly documented in the medical management system, including the criteria used to make the determination.
- The Medical Director may be contacted by calling their direct dial number listed at the bottom of the provider denial notification or through contacting the UM ~~d~~Department during the review process. A CalOptima Health Case Manager may also coordinate communication between the CalOptima Health Medical Director and requesting practitioner. All peer-to-peer discussions are documented within the CalOptima Health clinical documentation platform.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima Health's Grievance and Appeals Resolution Services (GARS) process, and as the member's condition requires.
- Medical conditions requiring time sensitive services are reviewed in accordance with the appropriate CalOptima Health Policy and Procedure.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider may be ~~is~~ notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- ~~All~~ Medi-Cal members are notified in writing of any decision to deny, modify, or delay a service.
- OneCare members are notified in writing of any and all determinations.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action or UM Coverage letter. A provider may request a discussion with the Medical Director (Peer-to-Peer), or a copy of the specific criteria utilized.

Supporting documents used to make medical necessity determinations include~~s~~, but ~~is~~ are not limited to:

- Office and hospital records
- A documented history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- ~~A printed copy of~~Evidenced ~~criteria~~based criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

The data collection process shall not be burdensome to the member and provider.

The UMC and~~/~~ BMSC reviews the Prior Authorization List regularly, in conjunction with CalOptima Health's CMO, Medical Directors and Executive Director of ~~, and~~ Clinical Operations and UM Management, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima Health program requirements, and/or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications ~~occur~~are made.

Prior Authorization

Prior Authorization requires the provider or practitioner to submit a formal Authorization Request Form (ARF) medical necessity determination request and all relevant clinical information related to the request to CalOptima Health prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima Health website at www.caloptima.org. Clinical information submitted by the provider

justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima Health's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social, and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Health Provider Portal allows for non-urgent and urgent online authorizations to be submitted by providers and processed electronically. The provider portal functionality includes referral intelligence rules, approved by clinical leadership to auto-adjudicate when criteria is met. The referral intelligence rulesrules, and auto-adjudication trends are reviewed quarterly at a minimum to identify potential misuse or utilization issues that require follow up.
Practitioners may also submit referrals and requests to the UM dDepartment by mail, fax and/or telephone.

Second Opinions

A second opinion may be requested when there is a question concerning the diagnosis, options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising a custodialcustodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner if there is no in-network practitioner available.

Extended Specialist Services

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, CalOptima Health provides guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers

The decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to:, continuity of care, availability and location of an in-network provider of the same specialty and expertise, and lack of an in-network provider with the specialty and expertise.

Appropriate Professionals for UM Decision Process

Appropriately licensed health care professional supervises all medical necessity review decision. The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forwards the request to the appropriate qualified, licensed health practitioner for a

determination. Only practitioners or pharmacists can make decisions/determinations for denial, ~~or~~ modification, ~~reduction~~reduction, or termination of services ~~of care~~ based on medical necessity. All practitioners or pharmacists rendering decisions ~~, and~~ must have education, training, and professional experience in medical or clinical practice, and ~~and~~ must have a current unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima Health distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima Health does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima Health ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

Pharmaceutical Management ~~PHARMACEUTICAL MANAGEMENT~~

Pharmacy Management is overseen by the CMO, and CalOptima Health's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima Health related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima Health website.

The P&T Committee is responsible for development of the Medi-Cal physician-administered drug prior authorization list and the OneCare Formulary, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the Formulary are communicated to both members and providers.

Pharmacy Determinations Medi-Cal Effective January 1,2022, the outpatient pharmacy benefit moved to the Medi-Cal fee-for-service program, Medi-Cal Rx.

~~Medi-Cal/~~Medicare

CalOptima Health does not delegate OneCare Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Pharmacy Benefit Manager (PBM)

The PBM is responsible for some pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, clinical services and quality improvement functions. The PBM follows

and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity, the PBM is monitored according to the Audit & Oversight department's policies and procedures.

Behavioral Health Determinations~~BEHAVIORAL HEALTH DETERMINATIONS~~

Medi-Cal

CalOptima Health's BHI department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers and Care Managers (BCBA). All

~~D~~determinations are based on CalOptima UM hierarchical criteria. ~~from MCG Guidelines, DHCS All Plan Letters (APL) and CalOptima Health policy (approved by DHCS).~~

~~Medi-Cal/~~Medicare

CalOptima Health's BHI department performs prior authorization review functions for OC covered BH services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, psychological testing, electro convulsive therapy (ECT), and transcranial magnetic stimulation (TMS). Prior authorization requests are reviewed by BH Medical Case Managers.

~~Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL) and CalOptima Health policies.~~

- The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may be made by a Medical Director or a qualified health care profession with appropriate clinical expertise in treating the behavioral health condition. CalOptima Health's written notification of BH modifications and denials to members and their treating practitioners contains:
- A description of appeal rights, including the member's right to submit written comments, ~~documents~~documents, or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal timeframes and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima Health gives practitioners the opportunity to discuss BH UM denial decisions.

UM Hierarchical ~~CRITERIA~~Criteria

CalOptima Health conducts Utilization Review using UM hierarchical criteria for medical, BH, and pharmacy medical necessity decisions that are objective, nationally recognized,

evidence-based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Clinical guideline criteria ~~is~~are published on the CalOptima Health website to be accessible and available for members, ~~and p~~providers, and the public upon request. Such criteria and guidelines include, but are not limited to: ~~[RJ12]~~

Medi-Cal

1. Medi-Cal Provider Manual and Department of Health Care Services (DHCS) All Plan Letter's (APL)
2. National Correct Coding Initiative (NCCI) Policy Manual
3. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook

~~1. Federal and State Law Mandates (i.e., Department of Health Care Services Provider Manuals/Medi-Cal Benefits Guidelines, EPSDT)~~

~~2.~~4. ~~(e.g.,~~ MCG Care Guidelines~~, National Comprehensive Cancer Network, etc.)~~

5. National Comprehensive Cancer Network Guidelines (NCCN)
6. Other: Medical Societies, National Guidelines, and other Authoritative Publications:
    a. ~~Society~~Hayes Criteria
    b. World Professional Association for Transgender Health (WPATH)
    c. U.S. Food and Drug Administration (FDA)
    d. Centers for Disease Control and Prevention (CDC)
    e. American Board of Medical Specialties
    f. Up To Date
    g. Optum 2023 Current Procedural Coding Expert (Encoder Pro)
    h. Preventive Health Guidelines (e.gl, U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
    i. National Guideline Clearinghouse

~~3. Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, etc.)~~

~~4. Other: US Preventative Services Task Force, Guideline Central~~

~~5. CalOptima Health Policy and Procedures and/or Clinical Benefits and Guidelines~~

~~Whole Child Model/CCS (Medi-Cal)~~

~~1. CCS Numbered Letters (N.L.s) and CCS Program Information Notices for decisions related to CCS and Whole Child Model~~

~~2. Follow Medi-Cal hierarchy listed above.~~

Medicare (OneCare ~~and OneCare Connect~~)

~~1. Federal and State Law Mandates — CMS, DMHC~~

1. CMS ~~Guidelines~~ National ~~and Local~~ Coverage Determinations (~~L~~NCD~~)~~ ~~first, followed by NCD)~~
2. CMS Local Coverage Determination (LCD) (Noridian Local Contractor for California)
3. ~~CMS Local Coverage Article (LCA)~~
3.
4. CMS ~~Provider~~ Manuals (Medicare Benefit Policy Manual, Medicare National (NCD) Manual, Medicare Claims Processing Manual, etc.)
5. National Correct Coding Initiative (NCCI) Policy Manual
5.6. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
6. ~~Internet-Only Manuals (IOMs) | CMS~~
7. ~~Department of Health Care Services~~
8. ~~National Evidence-Based Guidelines (e.g., MCG, National Comprehensive Cancer Network, etc.)~~
7. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology
8. National Comprehensive Cancer Network Guidelines (NCCN)
9. MCG Care Guidelines
10. Other: Medical Societies~~y~~, National Guidelines, and other Authoritative Publications: ~~Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, Guideline Central, etc.)~~
    a. Hayes Criteria
    b. World Professional Association for Transgender Health (WPATH)
    c. U.S. Food and Drug Administration (FDA)
    d. Centers for Disease Control and Prevention (CDC)
    e. American Board of Medical Specialties
    f. Up To Date
    g. Optum 2023 Current Procedural Coding Expert (Encoder Pro)
    h. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
    i. National Guideline Clearinghouse

~~2.~~

~~3. CalOptima Health Policy and Procedures and/or Clinical Benefits and Guidelines~~

Whole Child Model (WCM)

1. California Children Services (CCS) Numbered Letters and CCS Information Notices
2. Medi-Cal Provider Manual and DHCS APLs
3. National Correct Coding Initiative (NCCI) Policy Manual
4. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook

5. MCG Care Guidelines
6. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology
7. National Comprehensive Cancer Network Guidelines (NCCN)
8. Other: Medical Societies, National Guidelines, and other Authoritative Publications:
    a. Hayes Criteria
    b. World Professional Association for Transgender Health (WPATH)
    c. U.S. Food and Drug Administration (FDA)
    d. Centers for Disease Control and Prevention (CDC)
    e. American Board of Medical Specialties
    f. Up To Date
    g. Optum 2023 Current Procedural Coding Expert (Encoder Pro)
    h. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
    i. National Guideline Clearinghouse

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines, as well as based on the member's individual needs. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

Clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are used in conjunction with national guideline criteria in review for medical necessity. Additional guidelines may include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, World Professional Association for Transgender Health (WPATH), Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Board Certified Clinical Consultants:

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts ~~outside~~outside of CalOptima Health may be contacted, when necessary to avoid a conflict of interest. CalOptima Health defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM ~~d~~Department or may discuss the UM decision with CalOptima Health's Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical

information about how and when to interact with the UM ~~d~~Department. The manual also outlines CalOptima Health's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-
service to review all required provider trainings, including operational and clinical information such as UM timeliness of decisions. In addition, Provider Relations also provides any related policies regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and on the health website at www.CalOptima-Health.org.

Inter-Rater Reliability (IRR)

At least annually, the UM Managers ~~CMO and Clinical Operations leadership assess~~ evaluate the consistency with which Medical Directors and other clinical staff involved in UM ~~decision makers~~ apply UM criteria in decision- making. ~~The assessment is performed as an annual review to compare how reviewers' decision the same case.~~ If an opportunity for improvement is identified through this process, UM and Medical Director leadership take~~s~~ corrective action(s). Newly hired UM staff are required to successfully complete IRR~~inter-rater reliability~~ testing prior to being released from training oversight. ~~The~~ IRR results are ~~is~~ reported to the UMC and QIHEC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from UMC ~~the Committee~~.

Provider and Member Communication

Members and practitioners can access UM staff ~~through a toll-free telephone number 888-587-8088~~ at least eight hours a day during normal business hours for inbound collect or toll free calls at (888) 587-8088 or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at 711. These phone numbers ~~for these~~ are included in the Member Handbook, on the CalOptima Health website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, communications received after normal business hours are returned ~~on~~ the next business day and communications received after midnight on Monday–Friday are responded to on the same business day. CalOptima Health has MD and UM coverage 24 hours a day, 7 days a week through after-hours answering services.

Inbound and outbound communications include~~s~~ directly speaking with practitioners and members, fax correspondence, electronic or telephonic communications (e.g., sending email messages or leaving voicemail messages). Staff identify themselves by name, ~~title~~title, and CalOptima Health UM ~~d~~A Department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM ~~d~~Department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. ~~The v~~Vendor staff take~~s~~ authorization information for the next business day response by CalOptima Health. In cases requiring immediate response ~~the~~ vendor staff notifies the CalOptima Health on-call nurse. CalOptima Health will review and process authorizations outside business hours, as necessary, including decisions to approve, deny or modify authorization requests which are made by CalOptima Health on-call UM MD. A log is shared daily identifying activity and follow-up needed the following day.

Access to Physician Reviewer

The CalOptima Health Medical Director or appropriate practitioner reviewer (BH and clinical pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider ~~Orientation~~Orientation, and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Health Medical Director who made a denied determination may be contacted by calling their direct ~~dial~~ number listed at the bottom of the provider denial notification or through contacting the UM ~~d~~Department. ~~during the review process.~~ A CalOptima Health Case Manager may also coordinate communication between the Medical Director and requesting practitioner. All peer-to-peer discussions are documented within the clinical documentation platform

UM Staff Access to Clinical Expertise

The CMO and Medical ~~Directors,~~Directors have the authority, accountability, and responsibility for denial determinations and follow~~ing~~ sound clinical and professional judgment. Contracted HNs that are delegated for UM responsibilities ~~,~~ utilize a Medical Director, or designee, as the sole authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

During prospective, retrospective, inpatient and concurrent review requests, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance, appeal, ~~-~~or when a potential quality of care issue is identified through the UM process Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information

CalOptima Health's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g., discharge planning, case management, PHM, health education, etc.) to avoid duplicate requests for information from members or ~~practitioners.~~practitioners. Pertinent medical records are stored in a single system which services as the source of truth for decision making.

Provider Communication to Member

CalOptima Health's UM Program does not prohibit or restrict health care professionals from acting within the lawful scope of practice or advising or advocating on behalf of a member including but not limited to the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or absence of treatment.

- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Timeliness of UM Decisions

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima Health of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner. These turnaround time requirements are dictated by regulatory bodies such as DHCS, CMS, and NCQA.

Attachment A TIMELINES FOR MEDI-CAL

UM Decision and Notification Timelines

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be eElectronic or ~~w~~Written)**	**Electronic/Written Notification of ~~ADVERSE DETERMINATIONS~~ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-urgent) Pre- Service Prior Authorization / Prospective or outpatient service requests.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request.	**Practitioner: Electronic ~~W~~w**ithin 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** ~~Notice must be postmarked~~ ~~w~~Within 2 business days of decision~~, not to exceed 14 calendar days from receipt of the request.~~ ~~calendar days from receipt of the request.~~

Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • The decision may be delayed /deferred, and the time limit extended an additional 14 calendar days from the Medical Director pend request, only where the member or member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest. • CalOptima Health will notify the member and practitioner of ~~decision~~the decision to delay / defer ~~defer~~, in writing, within 5 ~~business days of receipt of information reasonably necessary to render a decision and no longer than~~ 14 calendar days from the receipt of initial request. • Notice of delay / deferral should include the additional information needed to render the decision, the type of expert reviewe~~d~~r and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.	**Practitioner: Electronic** ~~W~~within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision~~, not to exceed 28 calendar days from the receipt of the request, for service.~~ **Practitioner/Member:** Written Notice of Action "Delay" notification within 14 calendar days ~~of~~ from the receipt of the initial request. ~~for services.~~

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	Additional information received	**Practitioner:**	**Practitioner: Electronic**

	• If requested information is received, decision must be made within 5 business days of receipt of information, not to exceed 28 calendar days from the date of initial receipt of the request ~~for service~~.	Within 24 hours of making the decision.	Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from ~~the~~ initial receipt of the request ~~for service~~.
	Additional information ~~incomplete~~ ~~or~~incomplete or not received • If after 28 calendar days from ~~the~~ receipt of the initial request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from ~~the~~ receipt of the initial request. ~~for service.~~

Working days = Monday through Friday excluding California State Holidays
https://www.ftb.ca.gov/aboutftb/holidays.shtml

Attachment A TIMELINES FOR MEDI-CAL

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be electronic or written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Expedited Authorization (Pre-Service) • Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request.	Approve, Deny, or Modify within 72 hours from receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. ~~not to exceed 72 hours from receipt of request.~~ **Member: Written** Written notice within 72 hours ~~of the receipt of the request for services~~ from receipt of the request.~~.~~

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Expediated Authorization (Pre-Service) - Extension Needed • A request ~~Extension~~ is extended when the member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	Approve, Deny, or Modify within 72 hours from receipt of the request **Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify the practitioner and member using the "Delay" written notification, and insert specifics about what has not been received,, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. **Note:** The time limit may be extended by up to 14 calendar days if the member requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. ~~not to exceed 72 hours from receipt of request.~~ **Member: Written** Written notice within 72 hours of the receipt of the request ~~for services.~~
	Additional information received • If requested information is received, decision must be made within 1 business day of receipt of information.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision

	Additional information incomplete or not received • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision.
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify, or Deny within 72 hours of ~~the~~ receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of inpatient treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify, or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. **Extension:** CalOptima Health may extend the timeframe 48 hours o~~f~~r up to 14 calendar days under the following conditions: • Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic or Oral:** Within 24 hours of receipt of the request. **Member: Written** Written notification within 2 business ~~calendar~~ days of decision. **Note:** If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 2 business ~~calendar~~ days after the oral notification.

Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request).	~~Decision within~~ Within 30 calendar days from receipt of request. ~~information~~, that is reasonably necessary to make a decision. ~~that is reasonably necessary to make a decision.~~	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 30 calendar days of receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner:** Within 24 hours of making the decision. ~~**Practitioner:** Within 24 hours of making the decision.~~	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.

[1] Working days = Monday through Friday excluding California State Holidays
https://www.ftb.ca.gov/aboutftb/holidays.shtml

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Attachment B TIMELINES FOR OneCare

OneCare Decisions and Notification Timelines		
Type of Request	**Decision**	**Notification Timeframe**
Standard Integrated Organization Determinations Prior Authorization / Prospective or outpatient service requests.	Approve, Modify or Deny no later than 14 calendar days from receipt of request. **Extensions: CalOptima Health may not extend ~~the~~ deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Written** Within 24 hours of making the decision. **Practitioner/Member: Written** Within 2 business days of decision. **Issue the Coverage Decision Notice for written notification of denial decision.**
Expedited ~~Integrated Organization~~Integrated Organization Determinations Prior Authorization / Prospective or outpatient service requests.	Approve, Modify or Deny expeditiously but no later than 72 hours from receipt of the request. CalOptima Health must request the necessary information from the noncontracted provider within 24 hours of the receipt request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Oral Notification** Within 24 hours of making the decision. **Member: Oral** Within 24 hours of determination. **Practitioner/Member: Written** Within 2 business days of making the decision. When oral notification is given, it must be followed by written notification within 3 calendar days of the oral notification.

Expedited Authorization (Pre-Service) **If Expedited Criteria are not met**	If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: • Automatically transfer the request to the standard timeframe. The 14 calendar ~~-~~day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, CalOptima Health must notify member (within 72 hours) oral notification of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notification. **Use the Expedited Criteria Not Met** template to provide written notice. The written notice must include: 1. Explain that CalOptima Health will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member. 4. Provide instructions about the expedited grievance process and its time frames.
		~~physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member.~~ ~~4. Provide instructions about the expedited grievance process and its time frames.~~

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Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify or Deny within 72 hours of the receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. **Extension:** CalOptima Health may extend the time frame 48 hours or up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner/Member: Electronic or Oral** Within 24 hours of receipt of the request. **Practitioner/Member: Written** Within 3 calendar days of decision.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	~~Decision w~~Within 30 calendar days from receipt of request information that is reasonably necessary to make a decision.	**Practitioner: Written** Within 30 calendar days of receipt of the request **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner: Electronic or Oral** Within 24 hours of making the decision **Practitioner /Member: Written** Within 2 business days of making the decision

Type of Request	Decision	Important Message (~~IM) from~~IM) from Medicare	Detailed Notice of ~~Discharge (~~Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Hospitals are responsible for delivery of the Important Message from Medicare (IM): 1. Within 2 calendar days of admission to a hospital inpatient setting. 2. No more than 2 calendar days prior to discharge from a hospital inpatient setting. 3. CalOptima Health is responsible for the delivery of the Detailed Notice of Discharge (DND) when members appeal a discharge. DND must be delivered no later than noon of the day after notification by QIO (Quality Improvement Organization)	Hospitals must issue IM within 2 calendar days of admission. Hospitals must issue IM no more than 2 calendar days prior to discharge from an inpatient stay.	CalOptima Health must issue the DND to both the member and QIO as early as possible but no later than noon of the day after notification by the QIO.

Working days = Monday through Friday excluding California State Holidays
https://www.ftb.ca.gov/aboutftb/holidays.shtml

*Medi-Cal Pharmacy Prior Authorization Determination Timelines

*Timelines for determination apply to pharmacy authorization requests managed by CalOptima Health ~~and Magellan Rx~~

Type of Request	Determination Timeline
Standard (Non-urgent) Preservice - All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 14 calendar days from receipt of the original request.
Standard (Non-urgent) Preservice – Delay Needed	- CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 14 calendar days of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS for the need for additional information and how it is in the member's interest. ▪ The delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 72 hours from receipt of the original request.

Expedited (Urgent) Preservice/Concurrent - Delay Needed	- CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 72 hours of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS for the need for additional information and how it is in the member's interest. ▪ The delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.
Post-Service/Retrospective	- A decision to approve, modify, or deny is required within 30 calendar days of receipt of the request.

~~Type of Request~~	~~Notification Timeline~~
~~**Standard (Non-urgent) Preservice** ~~ ~~All necessary information received at time of initial request.~~	~~**Provider:** Within 24 hours of receipt of the request.~~ ~~**Member (modify or deny only):** Within 24 hours of receipt of the request.~~

Type of Request	Notification Timeline
Standard (Non-urgent) Preservice - All necessary information received at time of initial request.	- **Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- **Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Standard (Non-urgent) Preservice- Delay Needed - Additional clinical information not received within initial 14 calendar days.	- **Provider:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days. - **Member:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days.

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Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- **Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- **Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Expedited (Urgent) Preservice/Concurrent - Delay Needed - Additional clinical information not received within initial 72 hours.	- **Provider:** Delay notice sent within 72 hours of receipt of the original request to delay the timeframe for up to an additional 14 calendar days. - **Member:** Delay notice sent within 72 hours of receipt of the original request to delay the timeframe for up to an additional 14 calendar days.
Post-Service/Retrospective	- **Provider:** Within 30 calendar days of receipt of the request. - **Member:** Within 30 calendar days of receipt of the request.

OneCare Pharmacy Part D Determination Timelines

Type of Request	Determination Timeline
Standard (Non-urgent) Preservice/Concurrent	A decision to approve or deny is required within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received).
Expedited (Urgent) Preservice/Concurrent	A decision to approve or deny is required within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received).
Post-service/Retrospective	A decision to approve or deny is required within 14 calendar days of the initial receipt of the request.

Type of Request	Notification Timeline (Member and Prescriber)
Standard (Non-urgent) Preservice/Concurrent	Within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from the date of the original request).

Expedited (Urgent) Preservice/Concurrent	Within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from the date of the original request).
Post-service/Retrospective	Within 14 calendar days of the initial receipt of the request.

Emergency Services

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, a person, ~~,~~ who possesses an average knowledge of health and medicine, , ~~,~~ could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. ~~Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition.~~

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima Health also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

Post stabilization services are covered services related to an emergency medical condition provided after a member is stabilized to maintain, improve, or resolve the member's condition.

In accordance with Title 28 CCR 1300.71.4, when a member is stabilized, but the Emergency Department (ED) provider believes the member requires additional medically necessary services and may not be discharged safely, CalOptima Health or the HN must approve or deny the request for post-stabilization care within 30 minutes of the request for a Medi-Cal member and within 60 minutes for a OneCare member. This requirement applies to both contracted and non-contracted providers. If CalOptima Health or a HN does not respond within the 30 ~~-~~ minute (Medi-Cal) or ~~60 minute~~60-minute timeframe (OneCare), post-stabilization inpatient services are considered approved.

A hospital is required to ~~must~~ notify ~~-~~CalOptima Health of a Post-Stabilization request for services prior to admission. ~~Once a member is stabilized after emergency services but requires additional, medically necessary inpatient services The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.~~

~~According to DHCS, the requirements of Title 28 CCR Section 1300.71.4 (the 30-minute rule) apply to both contracted and noncontracted providers in CalOptima Health's Medi-Cal program. CalOptima Health or a HN shall approve or deny a prior authorization request~~

~~for post-stabilization services if all information reasonably necessary to render a decision is received from a hospital within 30 minutes or 60 minutes for OC members. If CalOptima Health or the HN does not respond within the prescribed timeframe, medically necessary post-stabilization inpatient services are considered approved.~~

Retrospective Review

Retrospective review is an initial review of services that require prior authorization ~~and have~~for which the services have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima Health notification and/or authorization and when there was no opportunity for pre-service review. Retrospective ~~A~~authorization is only permitted in accordance with CalOptima Health Policy and Procedure GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers which ~~is as~~states the follow~~s~~ing:

The request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply ~~(CalOptima Health Utiliztion Management)~~:

1. The Member has Other Health Coverage (OHC); or
2. The Member's medical condition is such that the Provider or Practitioner was~~is~~ unable to verify the Member's eligibility for Medi-Cal, or OneCare ~~program~~, as applicable, at the time of service.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is approved~~authorized~~. If the supporting documentation is questionable, the UM Nurse Case Manager ~~Director of UM~~ or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post-service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Inpatient Review Process

Contracted facilities are required to notify CalOptima Health of all inpatient admissions within 24 hours of admission. The inpatient review process assesses the clinical status of the member and ~~,~~ verifies the need for continued hospitalization. Information assessed during the review includes but is not limited to:

- Clinical information to support the appropriateness and level of service being provided
- ~~Validating~~ Validation of the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures requested
- Reasons for extension of the treatment or service

Utilizing evidenced based clinical guidelines, inpatient and concurrent review is conducted throughout

the member's inpatient stay and, with each each approved hospital day approved based on review of the patient's condition and evaluation of medical necessity. Inpatient review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient clinical criteria, and discharge criteria are met, and/or alternative care options exist, the nNurse cCase mManager refers the case to the Medical Director for review. If the Medical Director determines the case no longer meets medical necessity for inpatient care, a Notice of Action (NOA)/UM Coverage Determination letter is issued immediately by fax and telephone to the attending physician, hospital and mailed to the member. If the member is an OC member, for OC members verbal notification is also provided.

The need for case management or discharge planning services is assessed during the admission review, and with each inpatient admission, focused onwith consideration for the most appropriate alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issue, the concern is referred to CalOptima Health QI dDepartment for investigation and resolution.

Discharge Planning Review

Discharge planning begins at the time of an inpatient admission and is designed to identify and initiate a safe, quality-driven treatment intervention for post-hospital care needs. It is a coordinated effort among the facility and CalOptima Health and includes participation from but is is not limited to the attending physician, hospital discharge planner, UM staff, complex discharge team, Case Management team, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multidisciplinary team and family members involved in the member's care.
- Communication towith the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

The UM staff obtains medical record information and, based on discharge review criteria/guidelines, identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post--hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Inpatient Review Process.

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Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, ~~denial~~denial, or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Health Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner.

Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the timeframes as noted in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The written notification is written in lay language that is easily understandable at a ~~sixth grade~~~~sixth grade~~sixth grade reading level and includes ~~the~~ member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS and CMS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Health Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to-~~-~~peer discussion. The denial letter coversheet outlines the process for a practitioner to speak to the Medical Director and this information is provided ~~This is communicated to the practitioner~~ at the time of verbal notification of the denial.~~, as applicable, and is included in the standard denial letter template.~~

Grievance and Appeal Process~~GRIEVANCE AND APPEAL PROCESS~~

CalOptima Health has a comprehensive review system to address matters when Medi-Cal~~,~~ and OC members who wish to exercise their right to contest ~~onreview~~ the UM decision to deny, delay or modify a request for services, or terminate a previously approved service. This process is initiated by contact from a member, a member's representative or treating practitioner received by phone, fax, mail, online web submission or in person submission to Grievances and a~~A~~ppeals for members enrolled in COD~~,~~ or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima Health's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.~~v~~

The grievance process is in accordance with CalOptima Health Member Complaint Policy. HH.1102: ~~CalOptima Member Complaint~~Member Grievance for our Medi-Cal line of business and Policy MA.9002 Member Grievance Process for our OneCare line of business. The appeal process is in accordance with CalOptima Health Appeal Policy GG.1510: Member Appeal Process for our Medi-Cal line of business and MA.9015: Standard Integrated Appeals for our OneCare line of business. These policies define processes ~~include but are~~including but not limited to:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication ~~to~~with the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for all of CalOptima Health Networks ~~except Kaiser~~ are handled by CalOptima Health GARS department. CalOptima Health ~~works collaboratively~~collaborates with the community provider or delegated entity ~~in gathering~~to gather the necessary information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. This process is in accordance with CalOptima Health Policy, HH.1108: State Hearing Process and Procedure. Grievances and appeals ~~can~~ may be initiated by a member, a member's representative, or a practitioner. ~~Pre-service a~~An Appeal~~s~~ may be processed as expedited or standard and will be handled as expeditiously as the member's health requires. ~~appeals, while post-service appeals will be~~are only processed as standard appeals ~~only~~.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer ~~other than~~separate from the reviewer who made the initial denial determination.

The Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-~~-~~Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is ~~now being~~under appeal~~ed~~.

CalOptima Health sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, the identified issue in the review is directed for further review ~~of the matter is indicated~~. This portion of the review is covered by a confidential and peer protected process separate ~~than~~from the grievance and appeal process.

All members have a right to access ~~to and~~ copies of all documents relevant to the member's appeal. Documentation requests may be submitted by calling the CalOptima Health Customer Service department.

Expedited Appeals and Grievances

Expedited appeals and grievances are managed in an accelerated fashion to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality. A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, risk for adverse health outcome if not decisioned quickly, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt. At the time of the request, the information is reviewed, and a decision is made regarding the expedited appeal criteria. ~~Expedited appeals and grievances are managed in an accelerated fashion to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.~~

State ~~Fair~~ Hearing

CalOptima Health Medi-Cal members have the right to request a State Hearing from the California Department of Social Services ~~after~~ once ~~exhausting~~ the appeal process has been exhausted. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima Health and delegated HNs comply with State Aid Paid Pending requirements, as applicable. Information and education on filing a State ~~Fair~~ Hearing ~~is~~ are included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Reviewww

OC members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency or a comprehensive outpatient rehabilitation facility. CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima Health is notified when a request is made by a member or member representative. CalOptima Health supports the process ~~with~~by providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima Health of the outcome of their review. If the decision is overturned, CalOptima Health complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima Health's QI department for further research and reporting to government and/or regulatory agencies.

Long-Term Services and Supports ~~LONG TERM SERVICES AND SUPPORTS~~

LTC

The LTC case management program includes authorizations for the following facilities:

- Nursing Facility Level A (NF-A) Custodial Intermediate LOC
  - Intermediate Care Level of Care (CCR Title 22 Section 51334(/)) In order to qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his ability.
  - ~~Custodial Level of Care~~
  - ~~Services include:~~
    - ~~Simple wound care or dressing changes~~
    - ~~Suctioning~~
    - ~~Routine SQ/IM injectable medications administration~~
    - ~~Catheter changes and irrigation~~
    - ~~Oxygen, three (3) liters or less, respiratory & oxygen supplies and services (nursing or respiratory therapist perform treatment)~~
    - ~~Restorative nursing care~~
    - ~~Bowel and bladder training~~
    - ~~Standard/stable tracheostomy care~~
    - ~~New colostomy/Ileostomy wound care with dressing changes every shift as needed.~~
    - ~~Diabetic education related to glucose monitoring and subcutaneous injection (insulin dependent)~~
    - ~~New ostomy education to the patient and family~~
    - ~~Foley catheter (maintenance and irrigation)~~
    - ~~IDDM patients incapable of self-injection~~
- Nursing Facility Level B~~,~~ (~~-~~NF-B)

- Skilled Level of Care ~~,~~
  - Skilled Nursing Level of Care (CCR Title 22 Section 51335 (j)) In order to qualify for skilled nursing facility services, a member shall have a medical condition which needs visits by a physician at least every 60 days, one or more physical disabilities, and constantly available skilled nursing services.

- ~~s~~Subacute care
  - Adult subacute care is a level of care that is defined as a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility.
  - Pediatric subacute care is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.
  - Subacute patients require special medical equipment, supplies, and treatments such as ventilators, tracheostomies, total parenteral nutrition, tube feeding and complex wound management care.
  - ~~o~~

Facilities are required to notify CalOptima Health of admissions within 21 days. Nurse Case Managers assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS, CalAIM or CBAS. Referrals to case management can also be made upon discharge when a member's needs indicate a referral is appropriate. In addition, the LTC staff provide~~s~~ education to facilities and their staff ~~in response to individual facility requests~~at the request of the facility~~,~~ and when new programs are implemented.

CBAS

CBAS is ~~A~~an outpatient, facility-based program offering day-time care and health and social services~~,~~ to frail seniors and adults with disabilities ~~to~~ which enable~~s~~ participants to remain living at home instead of in a nursing facility. Services offered through CBAS centers may include~~-~~ but are not limited to health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center. ~~A new benefit launched in October 2022~~In addition to the facility-based benefit, the CBAS benefit has allowance ~~allow~~ for members to receive Emergency Remote Services (ERS) in lieu of attending the center when they are experiencing an event that precludes them from attending the center in person. By allowing for ongoing support while the member is experiencing a public or personal emergency, the CBAS can continue to coordinate care and services on the member's behalf.

MSSP

CalOptima Health is an approved MSSP site through California Department of Aging (CDA)~~.~~. The MSSP program provides services and support to help people 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to, senior center programs, case management, money management and counseling, respite, housing assistance, assistive devices,

legal services, transportation, nutrition services, home health care, meals, personal care assistance with hygiene, personal safety, and activities of daily living.

Over/Under Utilization

Over/under utilization monitoring is tracked by the UM leadership team, the UM workgroup, identified stakeholders, Medical Director Team and reported to UMC. The UMC reviews the Over/Under Utilization report on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization.
Over/under utilization monitoring and performance are reported to the QIC and QAC on a quarterly basis.

Under and Over Utilization is tracked and monitored through the following areas and trends:

- ED utilization ~~R visits per 1000 member months~~
- Bed day utilization ~~s per 1000 member months~~
- ~~Admits per 1000 member months~~
- ~~Average length of stay per 1000 member months~~
- Readmission rates
- Pharmacy utilization measures
- Member and grievance~~s~~ data ~~per 1000 member months~~
- Identified Trends from Fraud, Waste and Abuse investigations
- Select HEDIS rates for selected measures
- PCP and specialist referral pattern analysis
- Member utilization patterns
- Trends in UM-related complaints
- Potential quality issues
- Behavioral health measures
- Other areas as identified

Program Evaluation

The UM Program is evaluated at least ~~annually~~annually and modifications made as necessary.
The Deputy Chief Medical Director, Executive of Clinical Operations and UM ~~Director, UM evaluate~~Director evaluate the impact of the UM Program by using:

- Member complaint, ~~grievance~~grievance, and appeal data
- ~~The r~~zResults of member satisfaction surveys

- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- DUR profiles (where applicable)

The evaluation ~~covers~~ encompasses all aspects of the UM Program. Problems and/or concerns are identified through the evaluation process, and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIHEC and QAC for approval.

Satisfaction with the UM Process

CalOptima Health provides an explanation of the GARS process, State Fair ~~Hearing~~Hearing, and Independent Medical Review (IMR) processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima Health QI ~~d~~Department for investigation and resolution.

Annually, CalOptima Health evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include but are not limited to member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates areas of dissatisfaction, CalOptima Health develops an action plan and interventions to improve the areas of concern, which may include but are not limited to staff retraining and member/provider education.

C~~C~~ASE MANAGEMENT PROCESS

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable.

Program Updates and/or Changes

——Each year, based upon the evaluation and review of member satisfaction and effectiveness data, CalOptima Health updates the Complex Case Management

(CCM) process to better address member needs. Evaluation results are shared with staff and training is provided to ensure understanding of any programmatic changes to the current process for the upcoming year.

Updates and/or changes to the CCM program and process include but are not limited to the following:

- New DHCS contract goes into effect January 1, 2024.
- Ongoing development of the clinical documentation platform to enhance functionality of assessments, care plans, and outputs and provide continued training in clinical standards of care, NCQA PHM 5: Complex Case Management Standards, and techniques for effective case management to both CalOptima Health and Health Network staff.
- Creation of additional tools to assist CalOptima Health and Health Network staff ~~in order to~~to ensure all elements of NCQA PHM 5 are addressed.
- Provide targeted outreach and case management to support members who are risk stratified as high risk. Some ~~high risk~~high-risk members may primarily be utilizinge ~~primarily~~ the emergency department for ~~care and~~care and develop best practices for outreaching to these members and improving their overall care.
- Continue development of specialized outreach and management for special populations, such as members struggling with ~~homelessness,~~ pain, ~~or~~ behavioral health issues, or who may be experiencing homelessness. Enhance training in resources and engagement to care management staff, with the goal of increasing member engagement in case management.

Program Changes

- ~~California Children's Services (CCS) managed by CalOptima through the Whole Child Model (WCM) Program went into effect in 2019.~~
- Beginning on January 1, 2022, CalOptima Health implemented two DHCS CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole- person approach to care that addresses the clinical and non-clinical circumstances of high need Medi-Cal members. As of January 1, 2024 CalOptima Health operates all 14 Community supports and continues to identify members for enhanced care management through a fully integrated approach.
- Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx. CalOptima continues to coordinate and support members clinical pharmacy needs through program integration and advocacy. The OneCare program and medical pharmacy benefit continues to be managed by CalOptima Health.
- ~~The OneCare Connect program ended effective December 31, 20222022, and members transitioned to the OneCare (D-SNP) program effective January 1, 2023.~~
- Another component of CalAIM, Population Health Management (PHM) was launched effective January 1, ~~2023~~2023, with a phased implementation. Components of the PHM program ~~include~~includes Risk Stratification and Segmentation, Assessments and Transitional Care Services (TCS). CalOptima Health continues to support members through transitions in care settings through outreach and interventions coordinated with hospital

partners. Health Networks continue to be trained on TCS components to ensure all members receive coordinated care during a transition event.

Team Composition and Roles

The Case Management Department consists of functional teams that focus on specific program activities. The teams are multidisciplinary, and are composed of nurse Case Managers, Social Workers, Medical Assistants, Personal Care Coordinators, and Member Liaison Specialists, as appropriate, to meet the needs of the member. Case Managers are assigned caseloads that are variable in volume depending on the complexity of the cases managed. The Case Management Teams include a Triage Team, Health Risk Assessment Team, Health Network Liaison Team, an Oversight Clinical Team and a Direct Clinical Team.

The following staff positions provide support for organizational/operational CM Department's functions and activities:

Sr. Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima Health to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct. The incumbent is responsible for programmatic oversight, strategic planning and ongoing compliance with all local, state and federal regulations and accreditation standards according to the CalOptima Health mission and vision.

Director of Care Management directs all Case Management programs for CalOptima Health ~~-~~members to ensure that ~~these functions~~case management functions are properly and ~~implemented~~consistently implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct. The incumbent is responsible for all departmental compliance with all local, state, and federal regulations and ensures that accreditation standards are current, and all policies and procedures meet current requirements.

Manager of Case Management provides shared responsibility for the daily operations, activities, and projects for the Case Management department. The incumbent works under the general direction of the Director of Case Management and in partnership with the other department managers to provide performance management and development of the case management staff and projects associated with the department. The incumbent ~~to~~ ensures compliance with department policies and procedures and supports ~~, along with~~ the implementation of ~~assigned~~ departmental projects. The incumbent may be required to attend joint operational and community meetings. The incumbent is responsible for ~~monitoring of~~monitoring case management reports and reporting to management or committees.

Case Management Supervisor is responsible for the daily operation of case management activities, the implementation of new programs and compliance with regulations. The incumbent ~~will~~ provides guidance to staff ~~or will~~and directly handles complex case management referrals. The incumbent ~~will be~~is accountable for establishing quality and productivity standards for the team and ensuring compliance with department policies and

procedures in collaboration with the manager. The incumbent ~~will~~ serves as a resource for CalOptima Health's providers, health networks and community partners.

Medical Case Manager (Ambulatory) **/ Care Manager** is responsible for providing ongoing case management services for CalOptima Health's members. The Medical Case Manager ~~will~~ facilitates communication and coordination among all participants of the health care team and the member to ensure the services provided promote quality and cost-effective outcomes.

~~**Medical Case Manager (Oversight)**~~**Health Network Liaison** is responsible for providing ongoing case management services for CalOptima Health members. The position facilitates communication and coordination among all participants of the health care team and the ~~member~~members to ensure that the services are provided to promote quality, cost-effective outcomes. The ~~Oversight Case Manager~~Health Network Liaison completes intensive investigation of cases that are referred to the Case Management Team. The position serves as a resource for members, delegated plan case managers, Personal Care Coordinators (PCCs) and community partners to address medical, behavior, and psychosocial concerns. In conjunction with other team members, the incumbent may make recommendations for a comprehensive individualized care plan at all levels of care.

Medical Assistants are responsible ~~for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager or the Gerontology Resource Coordinator. The Medical Assistant~~to performs medical and administrative routine tasks specific to the assigned unit, and office support functions. ~~The Medical Assistant may also authorize requested services according to departmental guidelines.~~

Social Worker provides administrative case management and coordination of benefits for carved-out services. The Medical Social Worker serves as a departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. The Medical Social Worker also serves as a liaison to Orange County based community agencies.

Personal Care Coordinators support CalOptima Health members in completing a Health Risk Assessment (HRA) and ensure communication of the HRA and care plan with the member, Primary Care Provider (PCP) and health care team. The PCC will identify barriers to members' care and assists ~~in~~ in improving these barriers for all levels of care. The incumbent ~~will~~ works closely with the PCP and health care team to ensure members have access to timely services and coordination of care.

Program Assistant provides support to staff, including but not limited to preparing meeting materials, maintaining minutes, routing documents, conducting data entry and handling of incoming and outgoing correspondence per administrative policy. Provides administrative support for specific and/or ongoing projects, such as generating reports, logs, calendars, and mailings, applying general business practices, as well as CalOptima Health policies and procedures under the direction of the Director.

Data Analyst performs analysis and reports data related to Case Management ~~projects, and~~projects and ensures that case management goals and objectives are accomplished within specified time frames, through the judicious and efficient use of CalOptima Health resources.

QI Nurse Specialist is responsible for overseeing regulatory reports and audits for the entire Case Management department to ensure regulatory compliance, implementing and monitoring policy changes to case management reporting, and providing quality review of submitted health network data to meet Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) requirements. In addition, the incumbent performs analysis and reports data related to the Case Management projects and ensures that Case Management goals and objectives are accomplished within specified time frames. The incumbent interacts with other internal CalOptima Health departments, health networks, and external agencies.

While CalOptima Health enjoys a robust array of internal case management resources, case management activities are also performed by the Health Networks. The Health Networks utilize their own case management staff to manage CalOptima Health's members who are assigned to them. Case management departments at the Health Networks are staffed with Licensed Case Managers, Social Workers, Pharmacists, and unlicensed support staff. While these staff are supervised by the Health Networks, they participate in CalOptima Health specific training and are overseen by CalOptima Health.

Staff Training/Education

CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in Case Management for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive orientation and job specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job description:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Workplace Harassment Prevention training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training
- Seniors and Persons with Disabilities Awareness Training
- OneCare Model of Care Training
- CM Program: policies/procedures and desk top processes, etc.

- Medical Information System data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- QI Referral Process

~~CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for continuing education for each licensed CM employee.~~

Licensed nursing staff ~~is~~ are monitored for appropriate application of Review Criteria/Guidelines, NCQA requirements, and case management documentation. Training opportunities are identified through regular administration of proficiency evaluations and addressed as immediately as they are identified ~~identified through regular administration of proficiency evaluations~~. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, ~~are~~is provided to all Case Management staff on an annual basis. Delegated Health Network staff participates annually in CalOptima Health model of care training.

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for continuing education for each licensed CM employee.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medi-Cal is always the payer of last resort, CalOptima Health must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima Health. CalOptima Health assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, continuity of care may also be explored to continue treatment with the provider in certain situations. CalOptima Health also coordinates continuity of care with other Managed Care Plans when a new member comes into CalOptima ~~Health~~Health, or a member terminates from CalOptima Health to a new health plan.

CalOptima Health uses the following data sources to identify a member for case management:

- Pharmacy data

- Health Risk/Needs Assessment
- Claims or encounter data
- Hospital Discharge data
- Utilization Management data
- Laboratory results
- Data supplied by purchasers
- Data supplied by member or caregiver
- Data supplied by practitioners
- Risk Sstratification and Segmentation (RSS)process or Predictive Modeling Tool
- Health Information Form (HIF) or Member Evaluation Tool (MET), if available

The avenues for referring a member for case management are:

- Member self-referral
- Member's authorized representative/family referral
- Practitioner/Provider referral
- Customer Service referral
- Discharge Planner referral
- Disease Management program referral
- Community Agency referral
- HN/SRG/PMG referral
- Utilization Management referral
- Long TermLong-term Services and Supports referral

The case management program includes:

- Documented process to assess the needs of member population.
- Development of the program through use of evidenced based guidelines.
- Defined program goals.
- Standardized mechanisms for member identification through use of data.
- Multiple avenues for referrals to case management.
- Following members across the continuum of health care from outpatient or ambulatory to inpatient settings.
- Process to inform eligible members of case management services, and the ability to elect or decline services.
- Documentation in a case management system that supports automatic documentation of case manager's name, date, time of action and prompts for required follow up.
- Use of evidenced-based clinical practice guidelines or algorithms.
- Initial assessment and ongoing management process.

- Developing, ~~implementing and~~implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the provider, member and/or their family/caregiver.
- Developing prioritized goals that consider the member or caregiver's goals and preferences.
- Developing member self-management plans.
- Coordinating services for members for appropriate levels of care and resources.
- Documenting all findings.
- Monitoring, reassessing, and modifying the plan of care to ensure quality, timeliness, and effectiveness of services.
- Analyzing data and member feedback to identify opportunities for improvement.
- Mechanism for identification and referral of quality-of-care issues to QI Department.
- Coordination of carved out services, such as Denti-Cal
- Identification of mental health needs and referral to Behavioral Health
- Identification of educational needs and referral to Population Health Management
- Referral to LTSS
- Assess and identify continuity of care needs and work collaboratively with UM department

Initial assessment of member's health care status and needs, including condition-specific issues:

- Member's right to accept or decline case management services
- Review of past medical history and co-morbidities
- Medication reconciliation and compliance
- Assessing member's support systems/caregiver resources and involvement
- Evaluation of behavioral health, cognitive function, and substance use disorder
- Evaluation of cultural and linguistic needs, ~~preferences~~preferences, or limitations
- Member's motivational status or readiness to learn
- Assessment of visual and hearing needs, ~~preferences~~preferences, or limitations
- Assessment of life-planning activities
- Assessment of functional status - activities of daily living (ADLs) and instrumental activities of daily living (iADLs)
- Assessment of social drivers of health (SDOH)
- Review ~~current status~~status and treatment plan
- Identifies barriers to quality, cost-effective care and fulfilling the treatment plan
- Determines implications of resources, and availability and limitations of benefit coverage
- Assessment of need for referrals to community resources
- Evidence-based clinical guidelines or algorithms to conduct assessment and management

Upon acceptance of a member into the CM Program, the Case Manager will develop a Case Management Plan that identifies the interventions required to provide appropriate care to the member.

A Case Management Plan includes ~~the following:~~

- Development of prioritized SMART goals ~~that take into account~~with consideration for:
  - Member or caregiver's goals or preferences
  - Member or caregiver's desired level of involvement in case management plan
  - Barriers to meeting goals and complying with self-management plan
  - Scheduled time frame for follow-up and communication with members
  - Assessment of progress towards goal, with modifications as needed
  - Resources to be utilized, including the appropriate level of care
  - Planning for continuity of care, including transition of care and transfer
  - Collaborative approaches to be used, including family/caregiver participation

Coordination of Carved Out Services

CalOptima Health provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits.

Memorandum of Understanding (MOU) with other community agencies and programs, such as the HCA/California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The CM staff and delegated entity practitioners are responsible for identification of such cases and coordination of referrals to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The Case Management Department assists members with the transition to other care, if necessary, when benefits end. This may include informing ~~the member~~members about ways to obtain continued care through other sources, such as community resources.

Case Management Programs include identification and referral of a member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

- Specialty Mental Health Services
- California Children's Services (CCS) (for intercounty transfers)
- Regional Center of Orange County (RCOC)
- Local Education Agency (LEA)
- Genetically Handicapped Persons Program (GHPP)
- AIDS Waiver Program
- 1915 (c) Home and Community Based Services
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternative (HCBA) Waiver (formerly NF/AH Waiver)
- Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver

- Multipurpose Senior Services Program (MSSP)
- Tuberculosis Program (Direct Observation Therapy)
- Targeted Case Management (TCM)
- Collaborate with the HCA/PDS TB Control Officer

Clinical Protocols

CalOptima Health is committed to serving the needs of all members assigned and places additional emphasis on the coordination of care for the vulnerable population. Approved clinical practice guidelines and nationally recognized protocols are used to guide treatment and care provided to the members. The use of clinical practice guidelines or nationally recognized protocols is challenging for the CalOptima Health membership as many of their needs are socioeconomic in nature. These guidelines do not address many of the supplemental benefits or community-based resources that may be critical to a comprehensive care plan for these individuals. ~~Members with end stage renal disease (ESRD) and a comorbid condition of prostate cancer may not meet criteria for transplant based on guidelines.~~ Lack of transportation may create obstacles to care, yet the member may not meet criteria for non-emergency medical transportation. Members who are at the end-of-life may be inappropriate for certain preventive care screenings.

When use of a clinical practice guideline or nationally recognized protocol is challenging or inappropriate for an individual member the following steps may be taken:

- ICT is convened with the member, PCP, and specialists (if appropriate).
- Participants of the ICT review the case and mutually develop an ICP, prioritized per member's preferences.
- PCP or Case Manager facilitates referrals and linkages to identified supplemental benefits, community referrals and resources.

When a member's specific clinical requirements indicate the need for an alternative approach, decisions to modify clinical practice guidelines or nationally recognized protocols are made by the member, PCP or specialists, in consultation with other members of the health care team. The care team members review the member's current health status, limitations, social support, barriers, and treatment approach, which include any modifications needed in the clinical practice guidelines that support the ICP. Timeframes are established for each of the action items of the ICP to ensure successful completion of these tasks, identification of barriers, and attainment of goals. Updated ICP is shared with the care team members including but not limited to the ~~member~~members, caregivers, and PCP.

To address the unique needs of our members, CalOptima Health offers supplemental benefits, which can be accessed either through self-referral or via referral by a treating practitioner. These benefits are intended to aid members in maintaining optimal health status, either by providing health care services not covered by Medicare or Medi-Cal (e.g., vision care), by addressing barriers to access to care (e.g., Non-Medical Transportation), or by promoting regular physical activity (gym benefit).

Types of Case Management Services

Basic Case Management

Basic case management activities by the primary care practitioner may include, but are not limited to:

- A health assessment of member's current acute, chronic and preventive health needs
- Development of the member's treatment plan
- Communication between the practitioner and member/authorized representative to ensure compliance with established treatment plan
- Identification of the need for medical, specialty or ancillary referrals
- Referrals to case management and/or disease management

Care Coordination

CalOptima Health or a Health Network may provide a Member with Care Coordination Case Management, to include an assessment and creation of a care plan, if the Member does not qualify for Complex Case Management but would benefit from case management support. Care Coordination Case Management shall include:

- Assistance with access to care issues;
- Health and disease-specific education;
- Referral to resources; and
- Coordination of care with all Providers.

Complex Case Management

Complex Case Management Services are provided by CalOptima Health, in collaboration with the Primary Care Provider, and includes, at minimum:

1. Basic Case Management Services
2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3. Intense coordination of resources to ensure member regains optima health or improved functionality
4. With member and PCP input, development of care plans specific to individual needs, and updating of the care plans at least annually

Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

The members in Complex Case Management usually:

1. Are at high risk; or
2. Have medically complex or frequently managed conditions or diseases, including, but are not limited to, the following:
    3. Spinal Injuries

4. Transplants
5. Cancer
6. Serious Trauma
7. AIDS
8. Multiple chronic illnesses
9. Chronic illnesses that result in high utilization

10. Have a complex social situation that affects the medical management of their care; or
11. Require extensive use of resources; or
12. Have an illness or condition that is severe, and the level of management necessary is very intensive.

CalOptima Health uses ~~this criteria~~this criterion when data mining and as a guideline for internal and external referral sources to identify appropriate CCM cases.

Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are those who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition. They may have a disability or chronic medical condition due to complications of prematurity, metabolic disorder, chromosomal abnormalities, or congenital abnormalities. They require health and related services of a type or amount beyond that required by children generally.

Case Management staff ensures coordination of care with other entities that provide services for Children with Special Health Care Needs (~~e.g.~~e.g., mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency).

The goals of CSHCN Case Management are to:

- Collaborate with family and providers to develop an Individualized Care Plan
- Facilitate member access to needed services and resources
- Prevent duplication of services
- Optimize member's physical and emotional health and well-being
- Improve member's quality of life

Whole Child Model

The Whole-Child Model is a program that aims to help California Children's Services (CCS) children and their families get better care coordination, access to care, and health results. The WCM program combines a qualified member's Medi-Cal and CCS benefits under CalOptima Health. CCS is a statewide program that arranges and pays for medical care, equipment and other services for children and young adults under 21 years of age who have certain serious medical conditions.

Provides access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth,

when it is time to call a specialist, primary, urgent care, or emergency room, what an Interdisciplinary Care Team (ICT) is, and what the community resources are.

The Whole Child Model program includes:

- Personal Care Coordinator (PCC) will be assigned to each CCS-eligible Member.
- Perform initial and periodic outreach to assist the Member with Care Coordination
- Provide information, education and support continuously, as appropriate
- Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.
- Improve coordination of services to meet the needs of the child and family
- Maintain existing patient-provider relationships when possible
- Retain CCS program standards
- Improve overall health results

Transitional Care Services (TCS)

DHCS has outlined a phased approach in the Population Health Management (PHM) Policy Guide to provide Transitions of Care Services starting January 1, 2023. ~~Transitional Care Services (~~TCS~~)~~ are provided to members transitioning from levels of care, including hospitalizations and skilled nursing facility. Beginning in 2023, members identified as TCS High Risk, per DHCS definition, received outreach from Case Management staff. The ~~G~~goal of outreach is to ensure all needs are met post hospitalization, including follow up visit with PCP, medication review and resolution of discharge summary follow up items.

~~For members enrolled with Case Management, Case Managers will support recently discharged members with tools and support to encourage and sustain self-management skills to help minimize the potential of a readmission and optimize the member's quality of life. TCS is provided to ensure members are supported from discharge planning until they have been successfully connected to all needed services and supports.~~

The TCS Case Management staff~~r~~ is responsible for coordinating and verifying that assigned members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. The ~~C~~TCS Case Management staff~~r~~ is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the TCS Case Management staff~~r~~ does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services.

For members enrolled with Case Management or ECM, the assigned Case Manager~~s~~ will support recently discharged members with tools and support to encourage and sustain self-management skills to help minimize the potential of a readmission and optimize the member's quality of life. TCS is provided to ensure members are supported from discharge planning until they have been successfully connected to all needed services and supports.

Special Programs

Transplant Program

The CalOptima Health Transplant Program is coordinated by the Medical Director, UM Department and CM Department staff. ~~and Medi-Cal members are managed in collaboration with the Case Management department. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan.~~

The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management ~~d~~Department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence or CMS certified Centers for OneCare. Case Management ~~will~~ follows the member and assists as needed through the transplant evaluation process, while the~~y~~ member is ~~are~~ awaiting to procure an organ, and post-transplant for one year.

Members are monitored on an inpatient and outpatient basis and followed through the transplant continuum. The member, physician and facilities are assisted in order to assure timely, efficient and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the ~~member~~members, the community of transplant staff and the facilities. CalOptima Health monitors and maintains oversight of the Transplant Program and reports to the UM Committee to oversee the accessibility, timeliness, and quality of the transplant protocols.~~–~~

Transplants for Medi-~~-~~ Cal members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan.

Palliative Care Services

The CalOptima Health Case Management and Utilization Management teams work collaboratively to ensure access to Palliative Care services. Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the and the member and their family.

Palliative care is provided by a trained team of doctors, nurses and other specialists who work together with the members other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

2024
INTEGRATED UTILIZATION MANAGEMENT AND CASE MANAGEMENT PROGRAM DESCRIPTION

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2024 UTILIZATON MANAGEMENT PROGRAM
SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Dabbah, Zeinab, M.D. ***Date***
Deputy Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. ***Date***

Board of Directors Chair:

Clayton M. Corwin **Date:**

_____ _____

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We Are CalOptima Health

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. Our Medicaid (Medi-Cal) and Medicare members deserve the highest quality of care and service across the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision.

Our Mission

To serve members' 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.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In 2022, CalOptima Health's Board of Directors and Executive Team worked together to develop the 2023 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved by the CalOptima Health Board of Directors in June 2022 and will continue to be reviewed and updated, at a minimum of annually, based on CalOptima Health Board of Directors and Executive Team input. The core strategy of the Strategic Plan is an inter-agency co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision. Our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima Health.
The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking

Future Growth - What Is CalOptima Health?

Our Unique Dual Role

CalOptima Health operates as both a public agency and a community health plan.

In this dual role, CalOptima Health must:

- Provide quality health care to ensure optimal health outcomes for our members.

- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

What We Offer

Medi-Cal

In California, Medicaid is known as Medi-Cal. Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, Affordable Care Act (ACA) expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Health Medi-Cal. On January 1, 2024, a new law in California now allows adults ages 26 through 49 to qualify for full Medi-Cal regardless of immigration status. Other Medi-Cal eligibility rules, including income limits, still apply. This latest expansion of Medi-Cal means that all Californians now have access to coverage; prior expansions extended coverage to undocumented children, young adults and people over 50.

Scope of Services

CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019.

Certain services are not covered by CalOptima Health but may be provided by a different agency, but coordinated by CalOptima Health are indicated below:

- Specialty mental health and substance use disorder services are administered by the Orange County Health Care Agency (HCA).
- Dental services are provided through the Medi-Cal Dental Program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima Health has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through a specific Memoranda of Understanding (MOU) with certain community agencies, including the HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, the Department of Health Care Services (DHCS) has integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members into the scope of benefits provided by CalOptima Health. CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO D-SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima Health has been offering OC to low- income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled and dual eligible members in Orange County.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B and reside in Orange County. Enrollment in OC is by member choice and voluntary. OC has an innovative Model of Care, which is the structure for supporting consistent provision of quality of care. Each member has a Case Management single point of contact, a Case Manager or a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the Case Management team works with our members and their doctors (PCP. specialists, behavioral health provider) to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

Quality Program Initiatives

CalOptima Health's QIHE Priority Areas and Goals align with CalOptima Health's 2022–25 Strategic Goals and DHCS Bold Goals

1) Maternal Health
    - Close racial/ethnic disparities in well-child visits and immunizations by 50%
    - Close maternity care disparity for Black and Native American persons by 50%
2) Children's Preventive Care
    - Exceed the 50th percentile for all children's preventive care measures
3) Behavioral Health Care

- Improve maternal and adolescent depression screening by 50%
- Improve follow-up for mental health substance disorder by 50%

4) Program Goals
    - Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set MCAS)
    - OneCare: Attain a Four-Star Rating for Medicare

Comprehensive Community Cancer Screening and Support Program

The Comprehensive Community Cancer Screening and Support Program was approved by the CalOptima Health Board of Directors in December 2022. The program aims to create a health ethos with respect to breast cancer, cervical cancer, colorectal cancer and lung cancer. CalOptima Health strives to be the health care exemplar for all Orange County residents.

The goal of the program is to create a culture of cancer prevention, early detection and collaboration with partners such as physicians, Cancer Centers and the community to work towards dramatically decreasing late-stage cancer incidence and ensuring CalOptima Health Medi-Cal members have equitable access to high quality care. Increasing cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs.

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among MediCal members.

The program will use a phased-in approach to invest over the next five years in the following three pillars:

1. Community and member awareness and engagement
2. Access to cancer screening
3. Improved member experience throughout cancer treatment

The measurement of this program will evaluate the comparison of newly diagnosed cancer rates to baseline rates. As of October 2, 2023, 3,718 CalOptima Health members were newly diagnosed with cancer this year.

Five-Year Hospital Quality Program

Five-Year Hospital Quality Program 2023-2027. CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience, and patient safety. Hospitals may earn annual incentives based on achievement of benchmarks.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy, and financial assistance. As of July 1, 2019, through SB 586, the state integrated CCS services into CalOptima Health's Medi-Cal managed care plan benefit, now called Whole Child Model (WCM). The goal of this transition and integration was to improve health care coordination by providing all needed care (CCS and non-CCS services including utilization management, transportation, care coordination, case management and complex case management) into a managed care plan (MCP), rather than providing CCS services separately. The WCM services successfully transitioned to CalOptima Health in 2019 as the 5th MCP awarded this pilot program. The HCA in Orange County continues to have the CCS program operate the medical eligibility determination processes, the Medical Therapy Unit and Program and CCS service authorizations for non- CalOptima Health enrollees. CalOptima Health works closely with the county CCS office to align protocols and ensure continuity of care for CCS-eligible members.

California Advancing and Innovating Medi-Cal (CalAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reforms across Medi-Cal.

CalOptima Health implemented CalAIM on 1/1/2022 and continues to work on expanding member access to services and supports. CalOptima Health's CalAIM program was established based upon three primary goals:

1. Identification and management of member risk and need through whole person care approaches and addressing social determinants of health.
2. Development of a consistent and seamless delivery of care and services through reduction of complexity and increase flexibility.
3. Improved member outcomes, reduction of health disparities, improved health equity and innovation through value-based initiatives, modernization of payment reform.

Enhanced Care Management and Community Supports

In a phased approach since January 2022, CalOptima Health has launched Enhanced Care Management (ECM) as well as all 14 Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Members are identified to participate in ECM services through either a risk stratification approach that proactively identifies members as falling into one of the 10 DHCS identified Populations of Focus (POF) or members who meet the DHCS eligibility criteria can be referred in so that they can receive the services.

ECM providers are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and Engagement
2. Comprehensive Assessment and Care Management Plan

3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

CalOptima Health has partnered with several local Community Based Organizations to provide the 14 Community Supports to our members in a medically appropriate, community-rooted, cost-effective manner. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits, and discharge delays.

The 14 Community Supports are:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications) includes Personal Emergency Response Systems (PERS)
12. Medically Tailored Meals/Medically Supportive Foods
13. Sobering Centers
14. Asthma Remediation

Authorizations for ECM and Community Supports can be requested through the CalOptima Health Connect Portal and are managed by CalOptima Health's LTSS CalAIM team to determine eligibility.

Pharmacy Administration Changes

Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances are the responsibility of Medi-Cal Rx.

CalOptima Health Pharmacy Management staff continue to assist members with medication-related access issues. CalOptima Health-retained responsibilities to include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management,

and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect OneCare or PACE.

Population Health Management (PHM) Program

CalOptima Health's PHM Program aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Program integrates physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. PHM services include basic population health management, care management, complex care management, ECM, and transitional care services.

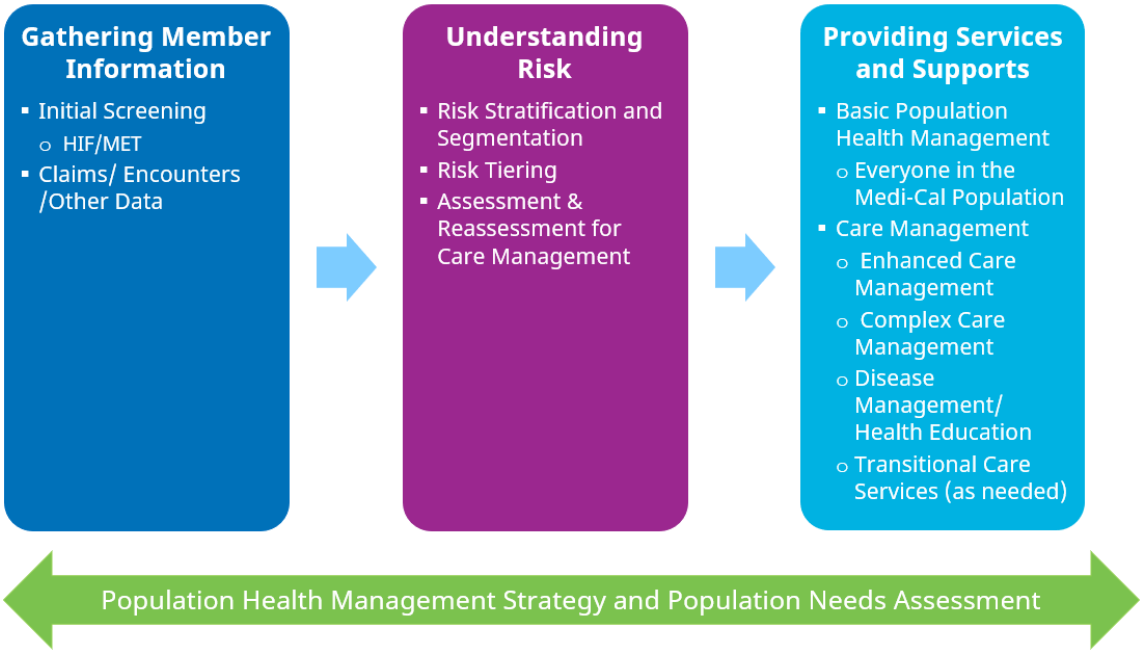
CalOptima Health's PHM Program address the following four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Considering patient safety or outcomes across settings
4. Managing multiple chronic conditions

The PHM Framework outlines four key components for operationalizing the program:

1. Population Health Management Strategy and Population Needs Assessment;
2. Gathering member information;
3. Understanding risk; and
4. Providing services.

PHM Framework



The goals of the PHM program are to establish:

- Trust and meaningful engagement with members
- Data-driven risk stratification and predictive analytics to address gaps in care
- Revisions to standardize assessment processes
- Care management services for all high-risk members
- Robust transitional care services (TCS)
- Effective strategies to address health disparities, Social Determinants of Health (SDOH) and upstream drivers of health
- Interventions to support health and wellness for all members

CalOptima Health analyzes the PHM Program annually and uses key performance indicators such as Primary Care, ambulatory care, ED visit and inpatient utilization and quality measures, such as HEDIS, to measure the effectiveness of the PHM Program.

CalOptima Health Direct Network and Health Network Entities

Direct Network and Contracted Health Networks Entities

Providers have several options for participating in CalOptima Health's programs providing health care to CalOptima Health members. Providers can participate through the CalOptima Health Direct (COD) network, CalOptima Health Community Network (CCN), or through a Health Network (HN) affiliation.

CalOptima Health members can choose a Primary Care Provider (PCP) in CalOptima's Community Network (CCN) or one of 10 HNs, representing more than 10,000 practitioners.

CalOptima Health members that do not choose a PCP are provisionally assigned to CalOptima Health's Direct Administrative network for forty-five (45) days until they choose a HN and PCP.

CalOptima Health Direct (COD)

CalOptima Health Direct (COD) network is composed of two elements: CalOptima Health Direct- Administrative (COD-A) and the CalOptima Health Community Network (CCN).

- CalOptima Health Direct-Administrative (COD-A) is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima Health's OneCare program), share of cost members, newly eligible members transitioning to a HN from CCN, and members residing outside of Orange County.
- CalOptima Health Community Network (CCN) - provides doctors with an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and is available for HN eligible members, supplementing the existing HN delivery model and creating additional capacity for access for certain covered services that are not the financial risk of the HN.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with HNs that are delegated to perform certain clinical and administrative functions on behalf of CalOptima Health through a variety of risk models to provide care to members. The following contract risk models are currently in place with HNs:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to 1,260 primary care providers (PCPs), 9,053 specialists, 44 hospitals, 52 Community Health Centers clinics and 107 long-term care facilities.

Provider Network Data (as of October 31, 2023)

	Number of Providers
Primary Care Providers	**1,260**
Specialists	**9,053**
Pharmacies	**553**
Acute and Rehab Hospitals	**44**
Community Health Centers	**52**
Long-Term Care Facilities	**107**

CalOptima Health contracts with the following Health Networks as Shared Risk Group (SRG),

Physician-Hospital Consortia (PHC), or Health Maintenance Organization (HMO):

Health Network/Delegate	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI Care Medical Group	PHC	PHC
CHOC Health Alliance	PHC	
Family Choice Medical Group		SRG
Family Choice Health Services	HMO	
HPN – Regal Medical Group	HMO	HMO
Optum Care Network	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG

CalOptima Health delegates UM activities for a portion of the CalOptima Health membership to HNs that demonstrate the ability to meet CalOptima Health's standards, as outlined in the UM Program Description and CalOptima Health policies and procedures. Delegated clinical functions may include but are not limited to Utilization Management, Basic and Complex Case Management and navigation and referrals to CalAIM community supports, ECM, and community organizations.

CalOptima Health retains accountabilities for all delegated functions and services, and monitors the performance of the delegated HN through the following processes:

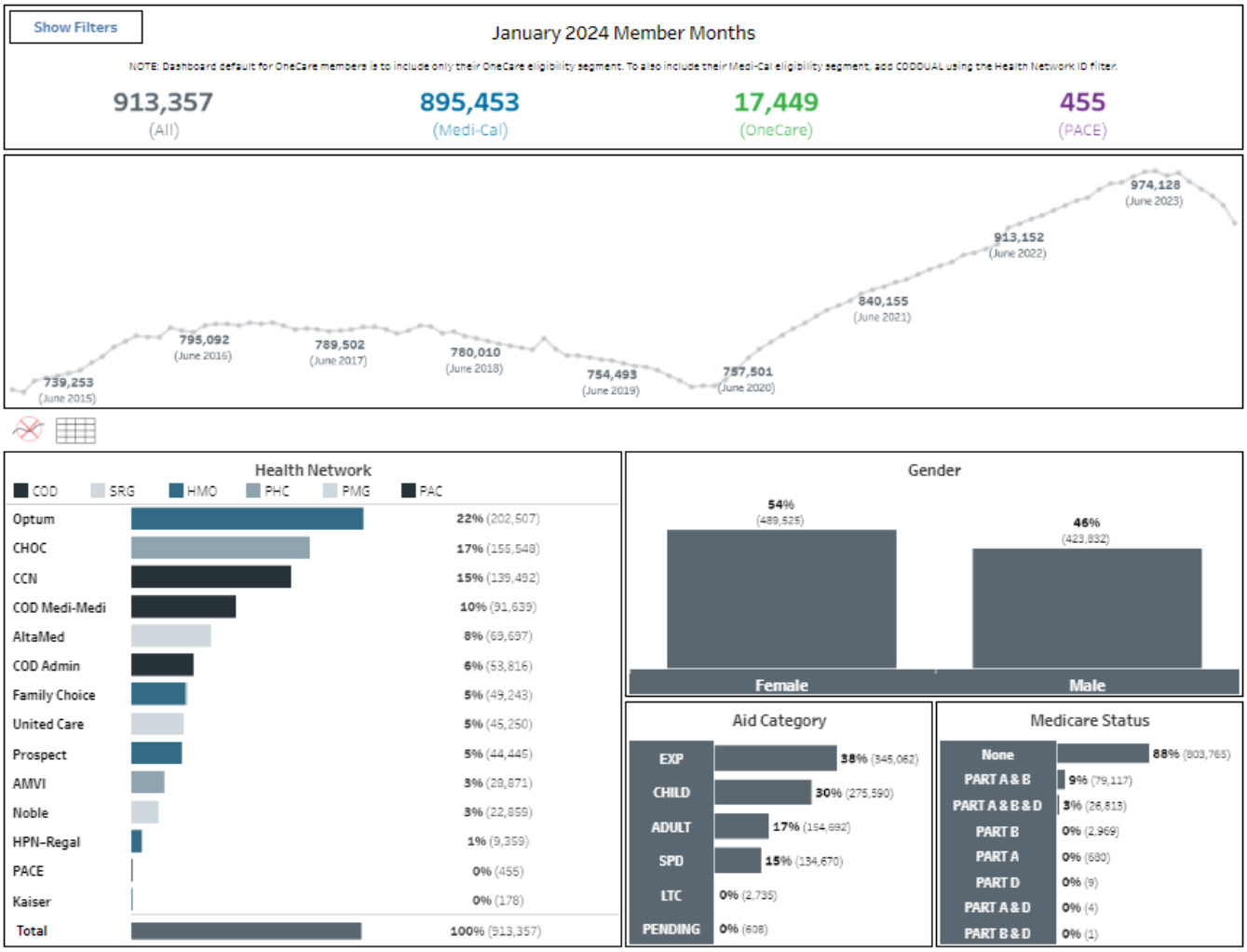
- Frequent reporting of key performance metrics that are required and/or developed by CalOptima Health's Internal Audit Department and reported to the Delegation Oversight Committee (DOC) and/or Quality Improvement Health Equity Committee (QIHEC).
- Annual and ad hoc audits of UM activities by CalOptima Health's Internal Audit Department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Center for Medicare & Medicaid Services (CMS), NCQA, and CalOptima Health standards and program requirements.
- Annual approval of the HNs UM Program (or portions of the program that are delegated), as well as any significant changes that occur during the contract year.

In the event the HN does not adequately perform contractually specified delegated duties, CalOptima Health takes further action, including increasing the frequency or number of focused audits, requiring the HN to implement corrective actions, imposing sanctions, capitation review, or de-delegation.

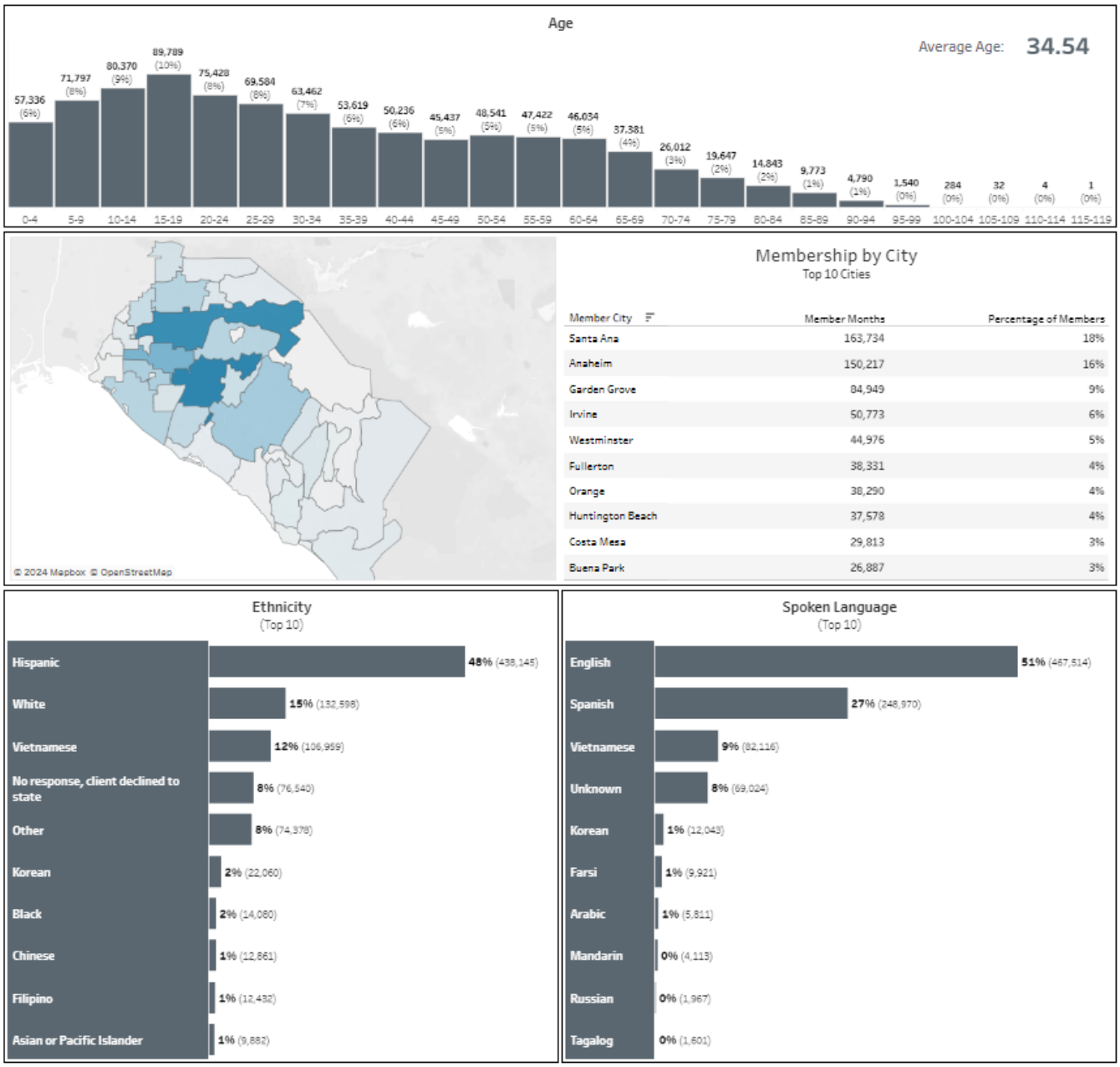
Health Network Forum

Lead by Executive Director of Clinical Operations and Medical Director Liaison, the forum includes representation from Health Networks and CalOptima Health who come together to discuss programmatic enhancements and changes to the implementation and operation of medical management

programs. This forum allows all Health Networks the opportunity to provide feedback and discuss how to improve operations establishing a cohesive and unified approach to managing CalOptima Health members, regardless of who is managing the care of the member.



Source: Membership Dashboard tableau, *data pulled 1/5/2024*



Source: Membership Dashboard tableau, *data pulled 1/5/2024*

UTILIZATION MANAGEMENT PROGRAM

Utilization Management Purpose

The purpose of the Utilization Management (UM) Program is to define the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic approach to review health care services, treatment, and supplies, and provide quality, coordinated health care services to CalOptima Health members. The UM Program includes review and analysis of utilization trends including identification of under and over-utilization to determine members are receiving appropriate services. All health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an effective, and timely manner by delegated and non-delegated providers.

UM Scope

The UM Program is comprehensive with a scope that encompasses all eligible members across all product types, age categories and range of diagnoses within CalOptima Health's membership. In addition, the UM program scope includes oversight of continuity of care and assurances for access to appropriate services, providers, and care settings. The UM Program incorporates physical and behavioral health, pharmacy services, Long-term care and long-term services and supports. This includes preventive, emergency, primary, specialty, home- and community-based services, as well as acute, subacute, short-term, and long-term facility and ancillary care services.

UM Process

The UM process includes but is not limited to the following program components: referral/prior authorization, inpatient and concurrent review, post-stabilization services, ambulatory care review, retrospective review, discharge planning, continuity of care coordination, transitions of care, and second opinions. All requests are reviewed against hierarchical guideline criteria and approved services must meet medical necessity criteria. The clinical decision process initiates upon receipt of a treatment authorization request. Request types include but are not limited to, authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services, durable medical equipment. The treatment authorization review process is complete when the requesting practitioner, rendering practitioner, and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to utilization trends and opportunities as well as identifying potential fraud, waste and abuse among practitioners and members. The UM Department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified. All UM team members and oversight Committees sign an annual attestation and are expected to abide by and uphold, CalOptima Health's policy for ensuring all medical decisions are made based within regulatory requirements and are not unduly influenced by financial considerations.

CalOptima Health provides Continuity of Care services up to 12 months to a requesting member's primary care provider, specialists and some ancillary providers for Medi-Cal beneficiaries transitioning to CalOptima Health or transitioning from a Managed Care Plan with contracts expiring with CalOptima Health or a Health Network.

UM Program Goals

The purpose of the UM Program is to manage appropriate utilization of medically necessary covered services and to ensure access to quality and cost-effective health care for CalOptima Health, this is accomplished through the following goals: Assisting in the coordination of medically necessary physical health, behavioral health, Long-Term Services and Supports (LTSS), Long-Term Care (LTC) and pharmacy services in accordance with benefit and clinical criteria and hierarchy, state and federal laws, regulations, contract requirements, NCQA standards and other evidence-based clinical criteria.

- Enhancing the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Providing a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity including non-clinical, clinical and Medical Director staff roles and responsibilities.
- Establishing and maintaining processes used to review medical and behavioral health care and pharmacy service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on medical necessity and/or benefit coverage.
- Identifying and referring members to Care Coordination, Case Management, Complex Case Management and Enhanced Care Management programs, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promoting a high level of member, practitioner, and stakeholder satisfaction.
- Protecting the confidentiality of members health and personal information.
- Identifying and reporting potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) Department for further action.
- Identifying and addressing over and underutilization of services. Monitoring utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.
- Promoting improved member outcomes by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Work collaboratively with CalOptima Health's Health Network's to coordinate care for complex discharge needs and CalAIM services.
- Provide continuous identification of UM staffing needs including clinical, non-clinical and

Medical Directors to address the needs of the members we serve.

- Provide continuous training for competency, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The CalOptima Health UM Program is designed to work in alignment with delegated entities, for optimal health outcomes and includes but is not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community to ensure that the member receives appropriate, cost-efficient, quality-based health care.

The UM Program is reviewed, evaluated and revised as needed for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA), NCQA and established best practice standards/ internal benchmarks at least annually. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by CalOptima Health's network. Additionally, the UM program structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization. The organization chart and the UM Program reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Health Equity Committee (QIEHC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is overseen by the Chief Medical Officer and evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team that may include but is not limited to the Deputy Chief Medical Officer; Medical Director(s) of UM; Behavioral Health Medical Director; Executive Director of Behavioral Health Integration; Executive Director, Clinical Operations; UMC; and QIHEC.

Long-Term Services and Supports (LTSS)

CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community- based nursing and sub-acute facility services for both adults and pediatrics. CalOptima Health's LTSS Department monitors and reviews the quality and outcomes of services provided to members in both settings.

Home- and Community-Based Services

CalOptima Health's LTSS Department monitors member utilization, level of access and satisfaction with Community Based Adult Services (CBAS) and Multipurpose Senior Services Programs (MSSP) focusing on diverting members from institutionalization, when appropriate.

Behavioral Health Services

CalOptima Health offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, emotional, or behavioral functioning, Services include but are not limited to individual, family and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima Health also covers alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) provided to members 11 years and older, including pregnant women by providers within their scope of practice.

CalOptima Health covers medically necessary behavioral health treatment (BHT) for members 20 years and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). BHT services include applied behavior analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction.

CalOptima Health's behavioral health provider network consists of: Psychiatrists, Licensed Clinical Psychologist (PYSD), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Professional Counselor(LPCC), Nurse Practitioner, Physician Assistant, Certified Nurse Specialist, Associate Social worker, Associate Marriage and Family Therapist, Psychological Assistant, Associate Professional Clinical Counselor, Board Certified Behavioral Analyst (BCBA), Board Certified Associate Behavior Analyst (BCaBA), Register Behavioral Technician (RBT).

CalOptima Health does not require members, or their practitioners, to undergo triage and referral when seeking information about or approval of BH services. Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at **855-877-3885**. A CalOptima Health representative will conduct a brief telephonic screening to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent DHCS approved screening tool. The screening is used to make an initial determination of the member's impairment level due to a mental health condition. If the member has mild to moderate impairments, the member will be offered behavioral health providers within the CalOptima Health network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services (SMHS) through the Orange County Mental Health Plan (OCMHP) managed by the Orange County Health Care Agency.

CalOptima Health directly manages all administrative functions of the Medi-Cal behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

CalOptima Health offers the following mental health services to OC members:

- Inpatient psychiatric hospitalization
- Intensive outpatient program (IOP) and partial hospitalization program (PHP)
- Outpatient individual and group psychotherapy
- Outpatient medication management
- Psychological testing

- Opioid Treatment Program (OTP) services
- Electro Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT)

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at 855-877-3885. A CalOptima Health representative will conduct a brief telephonic screening to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent approved screening tool. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments due to a mental health condition, the member will be offered behavioral health practitioners within the CalOptima Health provider network. If the member has significant to severe impairments, the member will be referred to (SMHS) through the OCMHP.

CalOptima Health directly manages all administrative functions of the OC behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

Authority, Boards of Directors' Committees, and Responsibilities

Board of Directors

CalOptima Health's Board of Directors has ultimate accountability and responsibility for overseeing the quality of care and service provided to CalOptima Health members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the Quality Improvement Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts — and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board ensures the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIEHC and the QAC on an annual basis.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the QAC to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program.

Member Advisory Committee

The Member Advisory Committee (MAC) has 17 voting members, each seat represents a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership has representatives from the following constituencies:

- Adult Beneficiaries
- Children
- Family Support
- Foster Children
- Medi-Cal Beneficiaries or Authorized Family Member (two seats)
- Member Advocate
- OneCare Member or Authorized Family Member (four seats))
- Orange County Social Services Agency (standing seat)
- People with Disabilities
- Behavioral/Mental Health Representative
- People with Special Needs
- Recipients of CalWORKs
- Seniors

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. PAC members represent a broad provider community that serves CalOptima Health members. The PAC meets at least quarterly and is open to the public. The members include:

- Health networks
- Hospitals

- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- Health Care Agency (HCA)
- Long Term Services and Supports
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board of Directors and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

Members of WCM FAC include-

- Family representatives:
  - Authorized representatives, which include parents, foster parents and caregivers of CalOptima Health members who are current recipients of CCS services; or
  - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
  - Current CalOptima Health members over the age of 21 who transitioned from CCS services.
- Interests of children representatives:
  - Community-based organizations; or
  - Consumer advocates

CalOptima Health Officers

The CalOptima Health Officers are the senior leaders responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations. CalOptima Health Officers include the Chief Medical Officer (CMO), Chairperson of the Utilization Management Committee (UMC), Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima Health's Chief Executive Officer (CEO).

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies, and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the Executive Director of Quality and Population Health Management.

Executive Director, Quality Improvement(ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Medicare Stars and Quality Initiatives.

Executive Director, Behavioral Health Integration (ED of BHI) is responsible for the management and oversight of CalOptima Health's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED of BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Executive Director, Population Health Management (ED PHM) is responsible for the management and oversight of CalOptima Health's disease management and health education departments. The ED PHM oversees the development and implementation of companywide

Population Health Management strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Physical and Behavioral Health Medical Directors *(hereinafter referred to "Medical Directors")* have primary assigned roles but may provide coverage and back up to other specialties as needed. All Medical Directors are appointed by the CMO and/or DCMO and are responsible to adhere to and oversee the direction of the UM Program and objectives, as well as evaluation of the UM Program.

- The Medical Director who oversees UM ensures quality medical service delivery to members managed directly by CalOptima Health and is responsible for medical direction and clinical decision making in UM. The Medical Directors serve as the senior-level physicians designated to the implementation of the UM Program. The Medical Directors ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and uses evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the Medical Director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. The Medical Director provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The Medical Director of UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the biweekly UM Workgroup meetings and participates in the CalOptima Health Medical Directors Forum and QIHEC.

- The Medical Director who oversees the behavioral health program is a double board-certified Psychiatrist specializing in Child and Adolescent Psychiatry and is a participating member of the UMC, QIHEC and CPRC. The Medical Director provides consultation and oversight to the UM Program, including guidance on criteria review and development to ensure parity. The Medical Director is also the chair of the Pharmacy & Therapeutics committee (P&T). The Medical director supports the behavioral health aspects of the UM Program. The Medical Director also provides leadership and program development in the creation and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima Health members. Clinical oversight is also provided for BH benefits and services provided to members. The Medical Director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes.

- The Medical Director oversees specialty programs and services, is a key member of the medical management team, and is responsible for the Medi-Medi programs, MLTSS programs, and Case Management programs. The Medical Director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima Health operational and support departments, including PHM, disease management and health education programs, while also providing clinical quality oversight of the Program of All-Inclusive Care for the Elderly (PACE) Center.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental operations. This position provides leadership and direction to the UM department, ensures compliance with all local, state and federal regulations. The Director, Utilization Management also ensures that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima Health's UM Program for CalOptima Health Community Network, CalOptima Health Direct and the delegated HNs. The Director is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.

Director, Behavioral Health Integration is responsible for the planning, organization monitoring, and evaluation of all activities and personnel engaged in the BH UM operations. The director tracks and analyzes changes in the behavioral health care delivery environment and program opportunities affecting or available to assist CalOptima Health in integrating physical and BH care services. This position provides leadership and direction to the BH UM team to ensure compliance with all local, state, and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. This position plays a key leadership role in coordinating with all levels of CalOptima Health staff, including the Board of Directors, executive staff, members, providers, HN management, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position is also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHE Work Plan.

Director, Quality Analytics provides analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing, and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. This position provides coordination and support to the QIBEC and other committees to support compliance with regulatory and accreditation agencies.

Director, Population Health Management (PHM) provides direction for program development and implementation for agencywide population health initiatives while ensuring linkages supporting a whole- person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position oversees programs that promote health and wellness services for all CalOptima Health members. PHM services

include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). PHM also supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director, Internal Audit oversees and conducts compliance audits and monitoring of CalOptima Health's internal operations with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima Health policies, and industry best practices. The director validates that CalOptima Health's business areas perform consistently with both CMS and state requirements for all programs. Specifically, the director leads the department in developing audit protocols for all internal functions to ensure adequate performance relative to both quality and timeliness. Additionally, the director is responsible for the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls. The position interacts with the Board of Directors, CalOptima Health Executives, Compliance Committee, departmental management, and legal counsel.

UM Staffing Resources

CalOptima Health uses appropriate licensed health care professionals to process and/or supervise UM activities. The UM Program health care professionals:

- Provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

Manager, Utilization Management RN/LVN (Concurrent Review [CCR]) manages the day-to-day operational activities of the Department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Supervisor, Utilization Management RN/LVN(CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work assignment and activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The Supervisor is a resource to the CCR staff regarding CalOptima Health policies and procedures, as well as regulatory and accreditation agency requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The Supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours and during weekend/holiday on call schedules

Manager, Utilization Management RN/LVN (Prior Authorization [PA]) manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima Health policies and procedures, and regulatory and accreditation agency requirements. The Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members. The Manager also establishes and maintains collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Supervisor, Utilization Management RN/LVN (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The Supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff regarding CalOptima Health policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing while providing ongoing monitoring and development of staff through training activities. The Supervisor also monitors documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours and during weekend/holiday on call schedules.

The following staff positions provide support for the UM Department's organizational/operational functions and activities:

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation, utilization of appropriate criteria, and assurance that the letter is written in plain language that a layperson understands.

Medical Case Managers (RN/LVN) provide inpatient and outpatient utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria.

All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA) are responsible for interacting with practitioners, members, family, and other customers. Staff members who are not qualified health care professionals are under the direct supervision of a licensed clinician. Non-licensed team members process service requests that do not require application of clinical judgement. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They can administratively authorize services according to departmental guidelines and under the oversight of UM nurse reviewers and Medical Directors.

Medical Case Managers (Clinical Auditors,(LVN) are responsible for conducting routine oversight, and monitoring and auditing of internal UM activities to ensure compliance with state,

federal and accreditation standards. Monitoring activities include but are not limited to, prior authorization and inpatient file reviews, addressing Correction Action Plans (CAPS) findings, and identifying opportunities for process improvement during the monitoring process.

Pharmacy Staffing Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements and administers all aspects of the CalOptima Health pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to- day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery and has frequent interaction with external contacts including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case- by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima Health, as well as national practice guidelines and on an ongoing basis, research, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs and assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T) Committee. The Manager, Clinical Pharmacist interacts frequently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interactions with external contacts, including the pharmacy benefit managers' clinical department staff.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima Health, as well as national, practice guideline. On an ongoing basis, they research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs.
The Clinical Pharmacists assist the Pharmacy director in preparing drug monographs and reports for the P&T Committee, interact with other department staff as needed to perform the duties of the position, and have frequent interactions with external contacts, including the pharmacy benefit managers' clinical department.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

LTSS Staffing Resources

Director, Long-Term Services and Supports develops, manages and implements LTSS programs including Long- Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs.

Manager, Long-Term Services and Supports (CBAS/LTC) develops and manages the LTSS department's work activities and team. The manager ensures that service standards are met, and operations are consistent with CalOptima Health's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima Health's members who are eligible for and/or receiving LTSS.

Supervisor, Long-Term Services and Supports (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting.

Medical Case Managers, Long-Term Services and Supports (MCM LTSS), are part of an advanced specialty collaborative practice responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for qualified CalOptima Health members in LTC facilities and members receiving CBAS. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The MCM LTSS acts as liaisons to Orange County community agencies, CBAS centers, skilled nursing facilities, members and providers.

Behavioral Health Integration Staffing Resources

Manager, Behavioral Health CalOptima Health manages the day-to-day operational activities of the BH UM team to ensure staff compliance with CalOptima Health policies and procedures, and regulatory and accreditation agency requirements.

Supervisor, Behavioral Health, (BH) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met.

Medical Case Managers (BH-RN/LVN or Licensed BH Clinician) provide inpatient and outpatient utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient psychiatric hospital and outpatient BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Care Manager (BH CM) Board Certified Behavior Analyst, BCBA.) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed BHT services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA BH) are responsible for interacting with practitioners or other customers, under the direction of the licensed Medical Case Manager and or Care Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions.

Qualifications and Training

CalOptima Health hires highly qualified clinical individuals with extensive experience and expertise in UM and CM for staff positions. Qualifications and educational requirements are delineated in the position job description of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

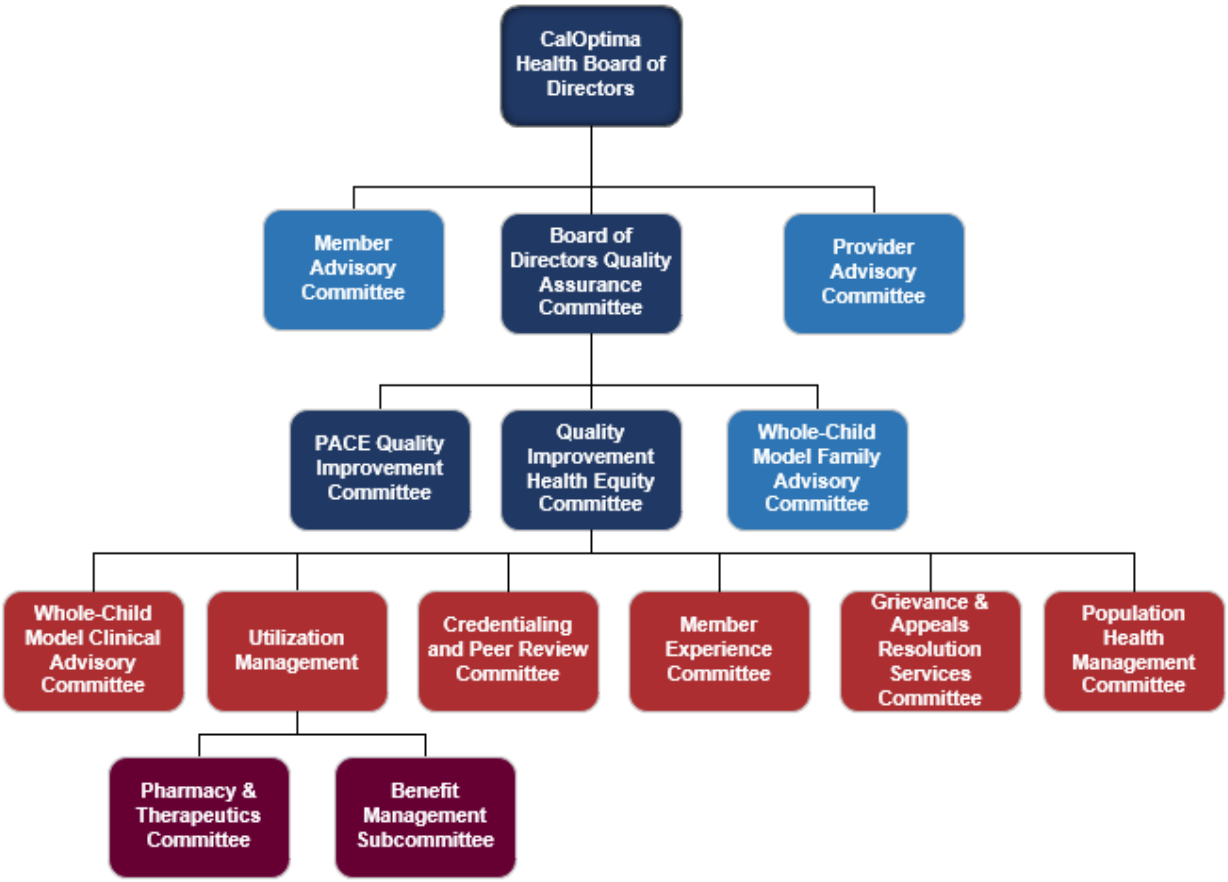
- CalOptima Health New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Diversity, Inclusion, and Unconscious Bias
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM and CM Program, policies/procedures, etc.
- Medical Management information system data entry
- Application of Review Criteria/Guidelines
- Appeals process
- Seniors and Persons with Disabilities (SPD) awareness training
- OneCare (OC) training

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health.

CalOptima Health and its delegated HN UM staff do not permit or provide compensation or anything of value to its employees, agents or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

Utilization Management Committee (UMC)

Diagram representing the committee structure



UMC

The UMC is led by a CalOptima Health Medical Director. This senior level physician is involved in UM activities, including but not limited to, implementation, supervision, oversight, and evaluation of the UM Program.

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support

the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Health Direct, CalOptima Health Community Care Network and through the delegated HMOs, PHCs and SRGs, to identify areas of under or over utilization that may adversely impact member care. The UMC is responsible for the annual review and approval of medical necessity criteria and protocols, and the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIHEC and QAC. With the assistance of the UM Program specialist, the Director of UM or designee maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIHEC. Oversight and operating authority of UM activities is delegated to the UMC, which reports up to QIHEC and ultimately to QAC and the Board of Directors.

Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy addressing the process to identify and evaluate potential social, economic, and professional conflicts of interest and take appropriate actions. CalOptima Health requires that all individuals who serve on the UMC or who otherwise make decisions on UM, quality oversight and activities, disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information that are overseen by the Department of Compliance and assigned Privacy Officer. During the onboarding process, all CalOptima Health employees, including contracted professionals who have access to confidential or member information sign a written statement for maintaining confidentiality. In addition, all non-employee Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM Program, consistent with CalOptima Health's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima Health and its delegated HNs.
- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, medical necessity criteria, UMC Charter, UM policies, and the UM Program Evaluation on an annual basis.
- Reviews and analyzes UM operational and outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM metric targets and goals.
- Reviews progress toward UM Program goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM Program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:
    - Benefit Management Subcommittee (BMSC)
    - P&T Committee
- Reports to the QIHEC on a quarterly basis, communicates significant findings and makes recommendations related to UM issues.

Departments Reporting Relevant Information on UM Issues:

- Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- UM Workgroup
- LTSS

UMC Membership

Voting Members in the UMC Committee include:

- CMO/Deputy Chief Medical Office (DCMO)
- Medical Director who oversees Utilization Management

- Medical Director who oversees UM Program
- Medical Director who oversees Behavioral Health Program
- Medical Director who oversees Senior Programs
- Medical Director who oversees Whole-Child Model Program
- Medical Director who oversees Quality and Analytics
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community[1]

Participating members of the UMC that don't have voting rights, although presents data, program outcomes and updates to policies consists of:

- Director, UM
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)

The BMSC is a subcommittee of the UMC. The BMSC is chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, The BMSC establishes a single source for the revisions and updates to CalOptima Health's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

BMSC Scope

The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima Health's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Voting Membership

- Medical Director who oversees UM services— Chairperson

[1] Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

- Medical Director who oversees Population Health and Equity
- Executive Director, Clinical Operations
- Director, UM (Alternate; Manager, Prior Authorization)
- Director, Behavioral Health Integration (Alternate: Medical Director who oversees Behavioral Health)
- Director, Claims (Alternate: Manager, Claims/Coding Initiatives)
- Director, Pharmacy (Alternate: Manager, Clinical Pharmacist)

The BMSC meets quarterly, at a minimum, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

UM Workgroup

The UM Workgroup is a sub-workgroup under the UMC. The Workgroup meets bi-monthly and includes staff members from UM, CM, BHI, and GARS. Roles and responsibilities of this Workgroup include but are not limited to:

- Provide input to the development and processes of the UM Program
- Provide input to key performance metrics, measures, and goals
- Provide input and recommend criteria and protocols for approving new technology, treatment, and diagnostic procedures.
- Review, assess, and recommend internal utilization management best practices
- Review outcome data, trend studies, and key performance indicators
- Provide input on UM Department policies and procedures and desktop procedures
- Identify opportunities to optimize UM processes

The goals of the UM Workgroup include but is not limited to:

- Ensure regulatory and accreditation compliance is met
- Provide ongoing review and input for current process improvement initiatives
- Ensure policies and procedures are current and comply with new and modified regulatory initiatives
- Ensure key performance indicators are met and/or process improvements are initiated when appropriate

Based on discussions at the UM Workgroup, other Sub Workgroups were formed in 2023 and will continue in 2024

- Brain/Spine Workgroup
- Transplant Workgroup
- UM Authorization Strategy Workgroup
- Bed Day Reduction Workgroup

Brain / Spine Workgroup

The Brain / Spine Workgroup meets monthly and consists of UM staff and UM leadership including Medical Directors. The goal of the Brain / Spine Workgroup is to ensure member requests for neurological and spine treatment and/or surgery are provided by appropriate medical practitioners based on member need and that services are provided in a timely manner. CPT codes are reviewed to determine if prior authorization is necessary.

Transplant Workgroup

The Transplant Workgroup meets bi-monthly and consists of UM staff and UM leadership including Medical Directors. The goal of the Transplant Workgroup is to ensure members needing transplant services are case managed throughout the continuum of the transplant process (pre and post), in addition to assisting member families with lodging and meal needs.

CalOptima Health has three dedicated nurses as the point of contact for transplant cases. A UM Nurse is assigned to the pre-authorization needs of the members, one is assigned to the inpatient needs and the third is assigned to the post-transplant needs.

Transplant Workgroup team members also meet weekly with CalOptima Health's COE, UCSD. These rounding meetings allow CalOptima Health to assist UCSD with discharge and post discharge needs and the needs of the families.

UM Authorization Strategy Workgroup

The UM Authorization Strategy Workgroup consists of UM staff, UM leadership, Medical Directors, and representatives from Clinical Operations and Analytics. The workgroup supports ongoing strategic decisions and process improvement for the access and utilization of Utilization Management data.

Bed Day Reduction Workgroup

The Bed Day Reduction Workgroup is a cross-departmental clinical-lead work group designed to evaluate utilization data. The workgroup is responsible for development of strategies to improve outcomes for CalOptima Health members and establish bed day goals including readmission rates that will be presented to UMC ongoing. The Bed Day Reduction Workgroup establishes data-driven interventions to reduce inpatient admissions, bed days, decrease 30-day readmission, and reduce ED utilization through collaboration between Case Management, Utilization Management, Medical Affairs.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIHEC and QAC, with final review and approval by the Board of Directors.

- The UM Program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) Director in conjunction with the Executive Director of Clinical Services, Executive Director of Behavioral Health Integration, Chief Medical Officer, and Deputy Chief Medical Director prior to submission for committee review and approval.
- Utilization data including, but not limited to, denials, unused authorizations, bed day utilization data, ED utilization data, provider preventable conditions, and trends representing potential over or underutilization, is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions

during utilization review activities. These issues are referred to the QI staff for evaluation.

- The UMC is a subcommittee of the QIHEC and routinely reports activities to the QIHEC.
- The QIHEC reports to the Board QAC.

Integration with Other Processes

The UM CM Integrated Program, BH Program, LTSS Program, P&T, QI, Credentialing, Compliance and Audit & Oversight are closely linked in function and process. The UM process uses quality indicators as a part of the review process and provides the results to the QI Department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima Health as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI Department for review and resolution. As a result, utilization of services is inter- related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI Department in the format prescribed by CalOptima Health for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima Health's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting and responding to Fraud and Abuse among practitioners and members. The UM Department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima Health coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Review and Authorization of Services

Medical Necessity Review

Medical necessity review requires consideration of the members' clinical needs, evaluation of available services within the local delivery system and application of evidenced based guidelines and CalOptima Health policies to provide quality care in the most appropriate setting.
Covered services are those medically necessary health care services provided to members as outlined in CalOptima Health's contract with CMS and the State of California for Medi-Cal and OC. Medically necessary means all covered services or supplies are reasonable and necessary to protect life, prevent

illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

Medical necessity for members receiving MLTSS is determined by using a member's current needs assessment and is consistent with person-centered planning.

CalOptima Health UM processes consists of ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure quality medically necessary services are provided in the most appropriate setting. Appropriate to the situation, physicians, pharmacists or psychologists review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization is completed by a qualified physician or pharmacist.

CalOptima Health's UM Department is responsible for the review and authorization of health care services for CalOptima Health Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Continuity of care review
- Admission Review
- Post-stabilization review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for HN members

The following standards and considerations are applied when reviewing prior authorizations, inpatient concurrent review, and retrospective review requests:

- Evidenced based clinical criteria or guidelines are applied consistently and regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological/Psychosocial situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved

criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action.

- Clinical rationale and reasons for decisions are clearly documented in the medical management system, including the criteria used to make the determination.
- The Medical Director may be contacted by calling their direct dial number listed at the bottom of the provider denial notification or through contacting the UM Department during the review process. A CalOptima Health Case Manager may also coordinate communication between the CalOptima Health Medical Director and requesting practitioner. All peer-to-peer discussions are documented within the CalOptima Health clinical documentation platform.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima Health's Grievance and Appeals Resolution Services (GARS) process, and as the member's condition requires.
- Medical conditions requiring time sensitive services are reviewed in accordance with the appropriate CalOptima Health Policy and Procedure.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider may be notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- Medi-Cal members are notified in writing of any decision to deny, modify, or delay a service.
- OneCare members are notified in writing of any and all determinations.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action or UM Coverage letter. A provider may request a discussion with the Medical Director (Peer-to-Peer), or a copy of the specific criteria utilized.

Supporting documents used to make medical necessity determinations include, but are not limited to:

- Office and hospital records
- A documented history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider

- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- Evidenced based criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

The data collection process shall not be burdensome to the member and provider.

The UMC and BMSC reviews the Prior Authorization List regularly, in conjunction with CalOptima Health's CMO, Medical Directors and Executive Director of Clinical Operations and UM Management, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima Health program requirements, and/or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications are made.

Prior Authorization

Prior Authorization requires the provider or practitioner to submit a formal Authorization Request Form (ARF) medical necessity determination request and all relevant clinical information related to the request to CalOptima Health prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima Health website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima Health's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social, and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Health Provider Portal allows for non-urgent and urgent online authorizations to be submitted by providers and processed electronically. The provider portal functionality includes referral intelligence rules, approved by clinical leadership to auto-adjudicate when criteria is met. The referral

intelligence rules, and auto-adjudication trends are reviewed quarterly at a minimum to identify potential misuse or utilization issues that require follow up. Practitioners may also submit referrals and requests to the UM Department by mail, fax and/or telephone.

Second Opinions

A second opinion may be requested when there is a question concerning the diagnosis, options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner if there is no in-network practitioner available.

Extended Specialist Services

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, CalOptima Health provides guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers

The decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to: continuity of care, availability and location of an in-network provider of the same specialty and expertise, and lack of an in-network provider with the specialty and expertise.

Appropriate Professionals for UM Decision Process

Appropriately licensed health care professional supervises all medical necessity review decision. The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) forwards the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial, modification, reduction, or termination of services based on medical necessity. All practitioners or pharmacists rendering decisions must have education, training, and professional experience in medical or clinical practice, and must have a current unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima Health distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima Health does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima Health ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical

needs, and benefit coverage.

Pharmaceutical Management

Pharmacy Management is overseen by the CMO, and CalOptima Health's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima Health related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima Health website.

The P&T Committee is responsible for development of the Medi-Cal physician-administered drug prior authorization list and the OneCare Formulary, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the Formulary are communicated to both members and providers.

Pharmacy Determinations Medi-Cal Effective January 1,2022, the outpatient pharmacy benefit moved to the Medi-Cal fee-for-service program, Medi-Cal Rx.

Medicare

CalOptima Health does not delegate OneCare Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Pharmacy Benefit Manager (PBM)

The PBM is responsible for some pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, clinical services and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity, the PBM is monitored according to the Audit & Oversight department's policies and procedures.

Behavioral Health Determinations

Medi-Cal

CalOptima Health's BHI department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers and Care Managers (BCBA). All determinations are based on CalOptima UM hierarchical criteria.

Medicare

CalOptima Health's BHI department performs prior authorization review functions for OC covered BH services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, psychological testing, electro convulsive therapy (ECT), and transcranial magnetic stimulation (TMS). Prior authorization requests are reviewed by BH Medical Case Managers.

- The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may be made by a Medical Director or a qualified health care profession with appropriate clinical expertise in treating the behavioral health condition. CalOptima Health's written notification of BH modifications and denials to members and their treating practitioners contains:
- A description of appeal rights, including the member's right to submit written comments, documents, or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal timeframes and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima Health gives practitioners the opportunity to discuss BH UM denial decisions.

UM Hierarchical Criteria

CalOptima Health conducts Utilization Review using UM hierarchical criteria for medical, BH, and pharmacy medical necessity decisions that are objective, nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Clinical guideline criteria are published on the CalOptima Health website to be accessible and available for members, providers, and the public upon request. Such criteria and guidelines include, but are not limited to:

Medi-Cal

1. Medi-Cal Provider Manual and Department of Health Care Services (DHCS) All Plan Letter's (APL)
2. National Correct Coding Initiative (NCCI) Policy Manual
3. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
4. MCG Care Guidelines
5. National Comprehensive Cancer Network Guidelines (NCCN)
6. Other: Medical Societies, National Guidelines, and other Authoritative Publications:
    a. Hayes Criteria
    b. World Professional Association for Transgender Health (WPATH)
    c. U.S. Food and Drug Administration (FDA)
    d. Centers for Disease Control and Prevention (CDC)

e. American Board of Medical Specialties
f. Up To Date
g. Optum 2023 Current Procedural Coding Expert (Encoder Pro)
h. Preventive Health Guidelines (e.gl, U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
i. National Guideline Clearinghouse

Medicare (OneCare)

1. CMS National Coverage Determinations (NCD)
2. CMS Local Coverage Determination (LCD) (Noridian Local Contractor for California)
3. CMS Local Coverage Article (LCA)
4. CMS Manuals (Medicare Benefit Policy Manual, Medicare National (NCD) Manual, Medicare Claims Processing Manual, etc.)
5. National Correct Coding Initiative (NCCI) Policy Manual
6. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
7. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology
8. National Comprehensive Cancer Network Guidelines (NCCN)
9. MCG Care Guidelines
10. Other: Medical Societies, National Guidelines, and other Authoritative Publications:
    a. Hayes Criteria
    b. World Professional Association for Transgender Health (WPATH)
    c. U.S. Food and Drug Administration (FDA)
    d. Centers for Disease Control and Prevention (CDC)
    e. American Board of Medical Specialties
    f. Up To Date
    g. Optum 2023 Current Procedural Coding Expert (Encoder Pro)
    h. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
    i. National Guideline Clearinghouse

Whole Child Model (WCM)

1. California Children Services (CCS) Numbered Letters and CCS Information Notices
2. Medi-Cal Provider Manual and DHCS APLs
3. National Correct Coding Initiative (NCCI) Policy Manual
4. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
5. MCG Care Guidelines
6. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology

7. National Comprehensive Cancer Network Guidelines (NCCN)
8. Other: Medical Societies, National Guidelines, and other Authoritative Publications:
    a. Hayes Criteria
    b. World Professional Association for Transgender Health (WPATH)
    c. U.S. Food and Drug Administration (FDA)
    d. Centers for Disease Control and Prevention (CDC)
    e. American Board of Medical Specialties
    f. Up To Date
    g. Optum 2023 Current Procedural Coding Expert (Encoder Pro)
    h. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
    i. National Guideline Clearinghouse

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines, as well as based on the member's individual needs. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

Clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are used in conjunction with national guideline criteria in review for medical necessity. Additional guidelines may include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, World Professional Association for Transgender Health (WPATH), Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Board Certified Clinical Consultants:

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside of CalOptima Health may be contacted, when necessary to avoid a conflict of interest. CalOptima Health defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM Department or may discuss the UM decision with CalOptima Health's Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM Department. The manual also outlines CalOptima Health's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as UM timeliness of decisions. In addition, Provider Relations also provides any related policies

regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and on the health website at www.CalOptimaHealth.org.

Inter-Rater Reliability (IRR)

At least annually, the UM Managers evaluate the consistency with which Medical Directors and other clinical staff involved in UM apply UM criteria in decision- making. If an opportunity for improvement is identified through this process, UM and Medical Director leadership take corrective action(s). Newly hired UM staff are required to successfully complete IRR testing prior to being released from training oversight. IRR results are reported to the UMC and QIHEC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from UMC .

Provider and Member Communication

Members and practitioners can access UM staff at least eight hours a day during normal business hours for inbound collect or toll free calls at (888) 587-8088 or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at 711. These phone numbers are included in the Member Handbook, on the CalOptima Health website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, communications received after normal business hours are returned the next business day and communications received after midnight on Monday–Friday are responded to on the same business day. CalOptima Health has MD and UM coverage 24 hours a day, 7 days a week through after-hours answering services.

Inbound and outbound communications include directly speaking with practitioners and members, fax correspondence, electronic or telephonic communications (e.g., sending email messages or leaving voicemail messages). Staff identify themselves by name, title, and CalOptima Health UM A Department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM Department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. Vendor staff take authorization information for the next business day response by CalOptima Health. In cases requiring immediate response vendor staff notifies the CalOptima Health on-call nurse. CalOptima Health will review and process authorizations outside business hours, as necessary, including decisions to approve, deny or modify authorization requests which are made by CalOptima Health on-call UM MD. A log is shared daily identifying activity and follow-up needed the following day.

Access to Physician Reviewer

The CalOptima Health Medical Director or appropriate practitioner reviewer (BH and clinical pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation, and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Health Medical Director who made a denied determination may be contacted by calling their direct number listed at the bottom of the provider denial notification or through contacting the UM Department. A

CalOptima Health Case Manager may also coordinate communication between the Medical Director and requesting practitioner. All peer-to-peer discussions are documented within the clinical documentation platform

UM Staff Access to Clinical Expertise

The CMO and Medical Directors have the authority, accountability, and responsibility for denial determinations and follow sound clinical and professional judgment. Contracted HNs that are delegated for UM responsibilities utilize a Medical Director, or designee, as the sole authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

During prospective, retrospective, inpatient and concurrent review requests, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance, appeal, or when a potential quality of care issue is identified through the UM process Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information

CalOptima Health's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g., discharge planning, case management, PHM, health education, etc.) to avoid duplicate requests for information from members or practitioners. Pertinent medical records are stored in a single system which services as the source of truth for decision making.

Provider Communication to Member

CalOptima Health's UM Program does not prohibit or restrict health care professionals from acting within the lawful scope of practice or advising or advocating on behalf of a member including but not limited to the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Timeliness of UM Decisions

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima Health of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner. These turnaround time requirements are

dictated by regulatory bodies such as DHCS, CMS, and NCQA.

Attachment A TIMELINES FOR MEDI-CAL

UM Decision and Notification Timelines

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-urgent) Pre- Service Prior Authorization / Prospective or outpatient service requests.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request.	**Practitioner: Electronic** within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of decision

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Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • The decision may be delayed /deferred, and the time limit extended an additional 14 calendar days from the Medical Director pend request, only where the member or member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest. • CalOptima Health will notify the member and practitioner of the decision to delay / defer , in writing, within 5 14 calendar days from the receipt of initial request. • Notice of delay / deferral should include the additional information needed to render the decision, the type of expert reviewer and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.	**Practitioner: Electronic** within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision **Practitioner/Member:** Written Notice of Action "Delay" notification within 14 calendar days from the receipt of the initial request.

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	Additional information received	**Practitioner:**	**Practitioner: Electronic**

	• If requested information is received, decision must be made within 5 business days of receipt of information, not to exceed 28 calendar days from the date of initial receipt of the request.	Within 24 hours of making the decision.	Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from initial receipt of the request.
	Additional information incomplete or not received • If after 28 calendar days from receipt of the initial request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from receipt of the initial request.

Working days = Monday through Friday excluding California State Holidays
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Attachment A TIMELINES FOR MEDI-CAL

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be electronic or written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Expedited Authorization (Pre-Service) • Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request.	Approve, Deny, or Modify within 72 hours from receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Written notice within 72 hours from receipt of the request.

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Expedited Authorization (Pre-Service) - Extension Needed • A request is extended when the member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	Approve, Deny, or Modify within 72 hours from receipt of the request **Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify the practitioner and member using the "Delay" written notification, and insert specifics about what has not been received,, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. **Note:** The time limit may be extended by up to 14 calendar days if the member requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Written notice within 72 hours of the receipt of the request.
	Additional information received • If requested information is received, decision must be made within 1 business day of receipt of information.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision

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	Additional information incomplete or not received • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision.
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify, or Deny within 72 hours of receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of inpatient treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify, or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. **Extension:** CalOptima Health may extend the timeframe 48 hours or up to 14 calendar days under the following conditions: • Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic or Oral:** Within 24 hours of receipt of the request. **Member: Written** Written notification within 2 business days of decision. **Note:** If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 2 business days after the oral notification.

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Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request).	Within 30 calendar days from receipt of request. , that is reasonably necessary to make a decision	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 30 calendar days of receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.

[1] Working days =Monday through Friday excluding California State Holidays
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Attachment B TIMELINES FOR OneCare

OneCare Decisions and Notification Timelines		
Type of Request	**Decision**	**Notification Timeframe**
Standard Integrated Organization Determinations Prior Authorization / Prospective or outpatient service requests.	Approve, Modify or Deny no later than 14 calendar days from receipt of request. **Extensions: CalOptima Health may not extend deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Written** Within 24 hours of making the decision. **Practitioner/Member: Written** Within 2 business days of decision. **Issue the Coverage Decision Notice for written notification of denial decision.**
Expedited Integrated Organization Determinations Prior Authorization / Prospective or outpatient service requests.	Approve, Modify or Deny expeditiously but no later than 72 hours from receipt of the request. CalOptima Health must request the necessary information from the noncontracted provider within 24 hours of the receipt request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Oral Notification** Within 24 hours of making the decision. **Member: Oral** Within 24 hours of determination. **Practitioner/Member: Written** Within 2 business days of making the decision. When oral notification is given, it must be followed by written notification within 3 calendar days of the oral notification.

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Expedited Authorization (Pre-Service) **If Expedited Criteria are not met**	If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: • Automatically transfer the request to the standard timeframe. The 14 calendar day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, CalOptima Health must notify member (within 72 hours) oral notification of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notification. **Use the Expedited Criteria Not Met** template to provide written notice. The written notice must include: 1. Explain that CalOptima Health will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member. 4. Provide instructions about the expedited grievance process and its time frames.

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Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify or Deny within 72 hours of the receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. **Extension:** CalOptima Health may extend the time frame 48 hours or up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner/Member: Electronic or Oral** Within 24 hours of receipt of the request. **Practitioner/Member: Written** Within 3 calendar days of decision.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt of request information that is reasonably necessary to make a decision.	**Practitioner: Written** Within 30 calendar days of receipt of the request **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner: Electronic or Oral** Within 24 hours of making the decision **Practitioner /Member: Written** Within 2 business days of making the decision

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Type of Request	Decision	Important Message (IM) from Medicare	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Hospitals are responsible for delivery of the Important Message from Medicare (IM): 1. Within 2 calendar days of admission to a hospital inpatient setting. 2. No more than 2 calendar days prior to discharge from a hospital inpatient setting. 3. CalOptima Health is responsible for the delivery of the Detailed Notice of Discharge (DND) when members appeal a discharge. DND must be delivered no later than noon of the day after notification by QIO (Quality Improvement Organization)	Hospitals must issue IM within 2 calendar days of admission. Hospitals must issue IM no more than 2 calendar days prior to discharge from an inpatient stay.	CalOptima Health must issue the DND to both the member and QIO as early as possible but no later than noon of the day after notification by the QIO.

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*Medi-Cal Pharmacy Prior Authorization Determination Timelines

*Timelines for determination apply to pharmacy authorization requests managed by CalOptima Health

Type of Request	Determination Timeline
Standard (Non-urgent) Preservice - All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 14 calendar days from receipt of the original request.
Standard (Non-urgent) Preservice – Delay Needed	- CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 14 calendar days of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS for the need for additional information and how it is in the member's interest. ▪ The delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 72 hours from receipt of the original request.

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Expedited (Urgent) Preservice/Concurrent - Delay Needed	- CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 72 hours of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS for the need for additional information and how it is in the member's interest. ▪ The delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.
Post-Service/Retrospective	- A decision to approve, modify, or deny is required within 30 calendar days of receipt of the request.

Type of Request	Notification Timeline
Standard (Non-urgent) Preservice - All necessary information received at time of initial request.	- **Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- **Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Standard (Non-urgent) Preservice- Delay Needed - Additional clinical information not received within initial 14 calendar days.	- **Provider:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days. - **Member:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- **Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.

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Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- **Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Expedited (Urgent) Preservice/Concurrent - Delay Needed - Additional clinical information not received within initial 72 hours.	- **Provider:** Delay notice sent within 72 hours of receipt of the original request to delay the timeframe for up to an additional 14 calendar days. - **Member:** Delay notice sent within 72 hours of receipt of the original request to delay the timeframe for up to an additional 14 calendar days.
Post-Service/Retrospective	- **Provider:** Within 30 calendar days of receipt of the request. - **Member:** Within 30 calendar days of receipt of the request.

OneCare Pharmacy Part D Determination Timelines

Type of Request	Determination Timeline
Standard (Non-urgent) Preservice/Concurrent	A decision to approve or deny is required within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received).
Expedited (Urgent) Preservice/Concurrent	A decision to approve or deny is required within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received).
Post-service/Retrospective	A decision to approve or deny is required within 14 calendar days of the initial receipt of the request.

Type of Request	Notification Timeline (Member and Prescriber)
Standard (Non-urgent) Preservice/Concurrent	Within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from the date of the original request).
Expedited (Urgent) Preservice/Concurrent	Within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from the date of the original request).
Post-service/Retrospective	Within 14 calendar days of the initial receipt of the request.

Emergency Services

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, a person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima Health also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

Post stabilization services are covered services related to an emergency medical condition provided after a member is stabilized to maintain, improve, or resolve the member's condition.

In accordance with Title 28 CCR 1300.71.4, when a member is stabilized, but the Emergency Department (ED) provider believes the member requires additional medically necessary services and may not be discharged safely, CalOptima Health or the HN must approve or deny the request for post-stabilization care within 30 minutes of the request for a Medi-Cal member and within 60 minutes for a OneCare member. This requirement applies to both contracted and non-contracted providers. If CalOptima Health or a HN does not respond within the 30-minute (Medi-Cal) or 60-minute timeframe (OneCare), post-stabilization inpatient services are considered approved.

A hospital is required to notify CalOptima Health of a Post-Stabilization request for services prior to admission.

Retrospective Review

Retrospective review is an initial review of services that require prior authorization for which the services have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima Health notification and/or authorization and when there

was no opportunity for pre-service review. Retrospective authorization is only permitted in accordance with CalOptima Health Policy and Procedure GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers which states the following:

The request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply:

1. The Member has Other Health Coverage (OHC); or
2. The Member's medical condition is such that the Provider or Practitioner was unable to verify the Member's eligibility for Medi-Cal, or OneCare , as applicable, at the time of service.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is approved. If the supporting documentation is questionable, the UM Nurse Case Manager or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post-service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Inpatient Review Process

Contracted facilities are required to notify CalOptima Health of all inpatient admissions within 24 hours of admission. The inpatient review process assesses the clinical status of the member and verifies the need for continued hospitalization. Information assessed during the review includes but is not limited to:

- Clinical information to support the appropriateness and level of service being provided
- Validation of the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures requested
- Reasons for extension of the treatment or service

Utilizing evidenced based clinical guidelines, inpatient and concurrent review is conducted throughout the member's inpatient stay and with each approved hospital day based on review of the patient's condition and evaluation of medical necessity. Inpatient review can occur on-site or telephonically. The frequency of review is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity.

If, at any time, services cease to meet inpatient clinical criteria and discharge criteria are met and/or alternative care options exist, the Nurse Case Manager refers the case to the Medical Director for review. If the Medical Director determines the case no longer meets medical necessity for inpatient care, a Notice of Action (NOA)/UM Coverage Determination letter is issued immediately by fax and telephone to the hospital and mailed to the member. If the member is an OC member, verbal notification is also provided.

The need for case management or discharge planning services is assessed during the admission review, and with each inpatient admission, with consideration for the most appropriate alternative to inpatient care. If at any time UM staff become aware of potential quality of care issue, the concern is referred to CalOptima Health QI Department for investigation and resolution.

Discharge Planning Review

Discharge planning begins at the time of an inpatient admission and is designed to identify and initiate a safe, quality-driven treatment intervention for post-hospital care needs. It is a coordinated effort among the facility and CalOptima Health and includes participation from but is not limited to the attending physician, hospital discharge planner, UM staff, complex discharge team, Case Management team, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multidisciplinary team and family members involved in the member's care.
- Communication with the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

UM staff obtain medical record information and, based on discharge review criteria/guidelines, identifies the need for discharge to a lower level of care. If the attending physician orders discharge to a lower level of care, UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Inpatient Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial, or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Health Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner.

Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the timeframes as noted in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The written notification is written in lay language that is easily understandable at a sixth grade reading level and includes member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS and CMS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Health Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to-peer discussion. The denial letter coversheet outlines the process for a practitioner to speak to the Medical Director and this information is provided at the time of verbal notification of the denial.

Grievance and Appeal Process

CalOptima Health has a comprehensive review system to address matters when Medi-Cal and OC members who wish to exercise their right to contest the UM decision to deny, delay or modify a request for services, or terminate a previously approved service. This process is initiated by contact from a member, a member's representative or treating practitioner received by phone, fax, mail, online web submission or in person submission to Grievances and appeals for members enrolled in COD or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima Health's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Health Member Complaint Policy. HH.1102: Member Grievance for our Medi-Cal line of business and Policy MA.9002 Member Grievance Process for our OneCare line of business. The appeal process is in accordance with CalOptima Health Appeal Policy GG.1510: Member Appeal Process for our Medi-Cal line of business and MA.9015: Standard Integrated Appeals for our OneCare line of business. These policies define processes including but not limited to:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication with the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for all of CalOptima Health Networks are handled by CalOptima Health GARS department. CalOptima Health collaborates with the community provider or delegated entity to gather the necessary information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social

Services. This process is in accordance with CalOptima Health Policy, HH.1108: State Hearing Process and Procedure. Grievances and appeals may be initiated by a member, a member's representative, or a practitioner. An Appeal may be processed as expedited or standard and will be handled as expeditiously as the member's health requires.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer separate from the reviewer who made the initial denial determination.

The Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is under appeal.

CalOptima Health sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, the identified issue in the review is directed for further review. This portion of the review is covered by a confidential and peer protected process separate from the grievance and appeal process.

All members have a right to access copies of all documents relevant to the member's appeal. Documentation requests may be submitted by calling the CalOptima Health Customer Service department.

Expedited Appeals and Grievances

Expedited appeals and grievances are managed in an accelerated fashion to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality. A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, risk for adverse health outcome if not decisioned quickly, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt. At the time of the request, the information is reviewed, and a decision is made regarding the expedited appeal criteria.

State Hearing

CalOptima Health Medi-Cal members have the right to request a State Hearing from the California Department of Social Services once the appeal process has been exhausted. A member may file a

request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima Health and delegated HNs comply with State Aid Paid Pending requirements, as applicable. Information and education on filing a State Hearing are included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency or a comprehensive outpatient rehabilitation facility. CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima Health is notified when a request is made by a member or member representative. CalOptima Health supports the process by providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima Health of the outcome of their review. If the decision is overturned, CalOptima Health complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima Health's QI department for further research and reporting to government and/or regulatory agencies.

Long-Term Services and Supports

LTC

The LTC case management program includes authorizations for the following facilities:

- Nursing Facility Level A (NF-A) Custodial Intermediate LOC
    - Intermediate Care Level of Care (CCR Title 22 Section 51334(/)) In order to qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or

delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his ability.

- Nursing Facility Level B (NF-B)
    - Skilled Level of Care
        - Skilled Nursing Level of Care (CCR Title 22 Section 51335 (j)) In order to qualify for skilled nursing facility services, a member shall have a medical condition which needs visits by a physician at least every 60 days, one or more physical disabilities, and constantly available skilled nursing services.
- Subacute care
    - Adult subacute care is a level of care that is defined as a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility.
    - Pediatric subacute care is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

      Subacute patients require special medical equipment, supplies, and treatments such as ventilators, tracheostomies, total parenteral nutrition, tube feeding and complex wound management care.

Facilities are required to notify CalOptima Health of admissions within 21 days. Nurse Case Managers assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS, CalAIM or CBAS. Referrals to case management can also be made upon discharge when a member's needs indicate a referral is appropriate. In addition, the LTC staff provide education to facilities and their staff at the request of the facility and when new programs are implemented.

CBAS

CBAS is an outpatient, facility-based program offering day-time care and health and social services to frail seniors and adults with disabilities which enables participants to remain living at home instead of in a nursing facility. Services offered through CBAS centers may include but are not limited to health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center. In addition to the facility-based benefit, the CBAS benefit has allowance for members to receive Emergency Remote Services (ERS) in lieu of attending the center when they are experiencing an event that precludes them from attending the center in person. By allowing for ongoing support while the member is experiencing a public or personal emergency, the CBAS can continue to coordinate care and services on the member's behalf.

MSSP

CalOptima Health is an approved MSSP site through California Department of Aging (CDA). The MSSP program provides services and support to help people 65 and older who have a disability that puts

them at risk of going to a nursing home. Services include, but are not limited to, senior center programs, case management, money management and counseling, respite, housing assistance, assistive devices, legal services, transportation, nutrition services, home health care, meals, personal care assistance with hygiene, personal safety, and activities of daily living.

Over/Under Utilization

Over/under utilization monitoring is tracked by the UM leadership team, the UM workgroup, identified stakeholders, Medical Director Team and reported to UMC. The UMC reviews the Over/Under Utilization report on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization.
Over/under utilization monitoring and performance are reported to the QIC and QAC on a quarterly basis.

Under and Over Utilization is tracked and monitored through the following areas and trends:

- ED utilization
- Bed day utilization
- Readmission rates
- Pharmacy utilization measures
- Member and grievance data
- Identified Trends from Fraud, Waste and Abuse investigations
- Select HEDIS rates for selected measures
- PCP and specialist referral pattern analysis
- Member utilization patterns
- Trends in UM-related complaints
- Potential quality issues
- Behavioral health measures
- Other areas as identified

Program Evaluation

The UM Program is evaluated at least annually and modifications made as necessary. The Deputy Chief Medical Director, Executive of Clinical Operations and UM Director evaluate the impact of the UM Program by using:

- Member complaint, grievance, and appeal data
- Results of member satisfaction surveys

- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- DUR profiles (where applicable)

The evaluation encompasses all aspects of the UM Program. Problems and/or concerns are identified through the evaluation process, and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIHEC and QAC for approval.

Satisfaction with the UM Process

CalOptima Health provides an explanation of the GARS process, State Fair Hearing, and Independent Medical Review (IMR) processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima Health QI Department for investigation and resolution.

Annually, CalOptima Health evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include but are not limited to member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates areas of dissatisfaction, CalOptima Health develops an action plan and interventions to improve the areas of concern, which may include but are not limited to staff retraining and member/provider education.

CASE MANAGEMENT PROCESS

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable.

Program Updates and/or Changes

Each year, based upon the evaluation and review of member satisfaction and effectiveness data, CalOptima Health updates the Complex Case Management (CCM) process to better address member

needs. Evaluation results are shared with staff and training is provided to ensure understanding of any programmatic changes to the current process for the upcoming year. Updates and/or changes to the CCM program and process include but are not limited to the following:

- New DHCS contract goes into effect January 1, 2024.
- Ongoing development of the clinical documentation platform to enhance functionality of assessments, care plans, and outputs and provide continued training in clinical standards of care, NCQA PHM 5: Complex Case Management Standards, and techniques for effective case management to both CalOptima Health and Health Network staff.
- Creation of additional tools to assist CalOptima Health and Health Network staff to ensure all elements of NCQA PHM 5 are addressed.
- Provide targeted outreach and case management to support members who are risk stratified as high risk. Some high-risk members may primarily be utilizing the emergency department for care and develop best practices for outreaching to these members and improving their overall care.
- Continue development of specialized outreach and management for special populations, such as members struggling with pain, behavioral health issues, or who may be experiencing homelessness. Enhance training in resources and engagement to care management staff, with the goal of increasing member engagement in case management.

Program Changes

- Beginning on January 1, 2022, CalOptima Health implemented two DHCS CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole- person approach to care that addresses the clinical and non-clinical circumstances of high need Medi-Cal members. As of January 1, 2024 CalOptima Health operates all 14 Community supports and continues to identify members for enhanced care management through a fully integrated approach.
- Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx. CalOptima continues to coordinate and support members clinical pharmacy needs through program integration and advocacy. The OneCare program and medical pharmacy benefit continues to be managed by CalOptima Health.
- Another component of CalAIM, Population Health Management (PHM) was launched effective January 1, 2023, with a phased implementation. Components of the PHM program includes Risk Stratification and Segmentation, Assessments and Transitional Care Services (TCS). CalOptima Health continues to support members through transitions in care settings through outreach and interventions coordinated with hospital partners. Health Networks continue to be trained on TCS components to ensure all members receive coordinated care during a transition event.

Team Composition and Roles

The Case Management Department consists of functional teams that focus on specific program

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activities. The teams are multidisciplinary, and are composed of nurse Case Managers, Social Workers, Medical Assistants, Personal Care Coordinators, and Member Liaison Specialists, as appropriate, to meet the needs of the member. Case Managers are assigned caseloads that are variable in volume depending on the complexity of the cases managed. The Case Management Teams include a Triage Team, Health Risk Assessment Team, Health Network Liaison Team, an Oversight Clinical Team and a Direct Clinical Team.

The following staff positions provide support for organizational/operational CM Department's functions and activities:

Sr. Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima Health to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct. The incumbent is responsible for programmatic oversight, strategic planning and ongoing compliance with all local, state and federal regulations and accreditation standards according to the CalOptima Health mission and vision.

Director of Care Management directs all Case Management programs for CalOptima Health members to ensure that case management functions are properly and consistently implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct. The incumbent is responsible for all departmental compliance with all local, state, and federal regulations and ensures that accreditation standards are current, and all policies and procedures meet current requirements.

Manager of Case Management provides shared responsibility for the daily operations, activities, and projects for the Case Management department. The incumbent works under the general direction of the Director of Case Management and in partnership with the other department managers to provide performance management and development of the case management staff and projects associated with the department. The incumbent ensures compliance with department policies and procedures and supports the implementation of departmental projects. The incumbent may be required to attend joint operational and community meetings. The incumbent is responsible for monitoring case management reports and reporting to management or committees.

Case Management Supervisor is responsible for the daily operation of case management activities, the implementation of new programs and compliance with regulations. The incumbent provides guidance to staff and directly handles complex case management referrals. The incumbent is accountable for establishing quality and productivity standards for the team and ensuring compliance with department policies and procedures in collaboration with the manager. The incumbent serves as a resource for CalOptima Health's providers, health networks and community partners.

Medical Case Manager (Ambulatory) / Care Manager is responsible for providing ongoing case management services for CalOptima Health's members. The Medical Case Manager facilitates communication and coordination among all participants of the health care team and the member to ensure the services provided promote quality and cost-effective outcomes.

Health Network Liaison is responsible for providing ongoing case management services for CalOptima Health members. The position facilitates communication and coordination among all participants of the health care team and the members to ensure that the services are provided to promote quality, cost-effective outcomes. The Health Network Liaison completes intensive investigation of cases that are referred to the Case Management Team. The position serves as a resource for members, delegated plan case managers, Personal Care Coordinators (PCCs) and community partners to address medical, behavior, and psychosocial concerns. In conjunction with other team members, the incumbent may make recommendations for a comprehensive individualized care plan at all levels of care.

Medical Assistants are responsible to perform medical and administrative routine tasks specific to the assigned unit, and office support functions.

Social Worker provides administrative case management and coordination of benefits for carved-out services. The Medical Social Worker serves as a departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. The Medical Social Worker also serves as a liaison to Orange County based community agencies.

Personal Care Coordinators support CalOptima Health members in completing a Health Risk Assessment (HRA) and ensure communication of the HRA and care plan with the member, Primary Care Provider (PCP) and health care team. The PCC will identify barriers to members' care and assists in improving these barriers for all levels of care. The incumbent works closely with the PCP and health care team to ensure members have access to timely services and coordination of care.

Program Assistant provides support to staff, including but not limited to preparing meeting materials, maintaining minutes, routing documents, conducting data entry and handling of incoming and outgoing correspondence per administrative policy. Provides administrative support for specific and/or ongoing projects, such as generating reports, logs, calendars, and mailings, applying general business practices, as well as CalOptima Health policies and procedures under the direction of the Director.

Data Analyst performs analysis and reports data related to Case Management projects and ensures that case management goals and objectives are accomplished within specified time frames, through the judicious and efficient use of CalOptima Health resources.

QI Nurse Specialist is responsible for overseeing regulatory reports and audits for the entire Case Management department to ensure regulatory compliance, implementing and monitoring policy changes to case management reporting, and providing quality review of submitted health network data to meet Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) requirements. In addition, the incumbent performs analysis and reports data related to the Case Management projects and ensures that Case Management goals and objectives are accomplished within specified time frames. The incumbent interacts with other internal CalOptima Health departments, health networks, and external agencies.

While CalOptima Health enjoys a robust array of internal case management resources, case management activities are also performed by the Health Networks. The Health Networks utilize their own case management staff to manage CalOptima Health's members who are assigned to them. Case management departments at the Health Networks are staffed with Licensed Case Managers, Social Workers, Pharmacists, and unlicensed support staff. While these staff are supervised by the Health Networks, they participate in CalOptima Health specific training and are overseen by CalOptima Health.

Staff Training/Education

CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in Case Management for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive orientation and job specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job description:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Workplace Harassment Prevention training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training
- Seniors and Persons with Disabilities Awareness Training
- OneCare Model of Care Training
- CM Program: policies/procedures and desk top processes, etc.
- Medical Information System data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- QI Referral Process

Licensed nursing staff are monitored for appropriate application of Review Criteria/Guidelines, NCQA requirements, and case management documentation. Training opportunities are identified through regular administration of proficiency evaluations and addressed as immediately as they are identified. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, is provided to all Case Management staff on an annual basis. Delegated Health Network staff participates annually in CalOptima Health model of care training.

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within

CalOptima Health. Each year, a specific budget is set for continuing education for each licensed CM employee.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medi-Cal is always the payer of last resort, CalOptima Health must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima Health. CalOptima Health assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, continuity of care may also be explored to continue treatment with the provider in certain situations. CalOptima Health also coordinates continuity of care with other Managed Care Plans when a new member comes into CalOptima Health, or a member terminates from CalOptima Health to a new health plan.

CalOptima Health uses the following data sources to identify a member for case management:

- Pharmacy data
- Health Risk/Needs Assessment
- Claims or encounter data
- Hospital Discharge data
- Utilization Management data
- Laboratory results
- Data supplied by purchasers
- Data supplied by member or caregiver
- Data supplied by practitioners
- Risk Stratification and Segmentation (RSS)
- Health Information Form (HIF) if available

The avenues for referring a member for case management are:

- Member self-referral
- Member's authorized representative/family referral
- Practitioner/Provider referral
- Customer Service referral

- Discharge Planner referral
- Disease Management program referral
- Community Agency referral
- HN referral
- Utilization Management referral
- Long-term Services and Supports referral

The case management program includes:

- Documented process to assess the needs of member population.
- Development of the program through use of evidenced based guidelines.
- Defined program goals.
- Standardized mechanisms for member identification through use of data.
- Multiple avenues for referrals to case management.
- Following members across the continuum of health care from outpatient or ambulatory to inpatient settings.
- Process to inform eligible members of case management services, and the ability to elect or decline services.
- Documentation in a case management system that supports automatic documentation of case manager's name, date, time of action and prompts for required follow up.
- Use of evidenced-based clinical practice guidelines or algorithms.
- Initial assessment and ongoing management process.
- Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the provider, member and/or their family/caregiver.
- Developing prioritized goals that consider the member or caregiver's goals and preferences.
- Developing member self-management plans.
- Coordinating services for members for appropriate levels of care and resources.
- Documenting all findings.
- Monitoring, reassessing, and modifying the plan of care to ensure quality, timeliness, and effectiveness of services.
- Analyzing data and member feedback to identify opportunities for improvement.
- Mechanism for identification and referral of quality-of-care issues to QI Department.
- Coordination of carved out services, such as Denti-Cal
- Identification of mental health needs and referral to Behavioral Health
- Identification of educational needs and referral to Population Health Management
- Referral to LTSS
- Assess and identify continuity of care needs and work collaboratively with UM department

Initial assessment of member's health care status and needs, including condition-specific issues:

- Member's right to accept or decline case management services
- Review of past medical history and co-morbidities
- Medication reconciliation and compliance
- Assessing member's support systems/caregiver resources and involvement
- Evaluation of behavioral health, cognitive function, and substance use disorder
- Evaluation of cultural and linguistic needs, preferences, or limitations
- Member's motivational status or readiness to learn
- Assessment of visual and hearing needs, preferences, or limitations
- Assessment of life-planning activities
- Assessment of functional status - activities of daily living (ADLs) and instrumental activities of daily living (iADLs)
- Assessment of social drivers of health (SDOH)
- Review status and treatment plan
- Identifies barriers to quality, cost-effective care and fulfilling the treatment plan
- Determines implications of resources, and availability and limitations of benefit coverage
- Assessment of need for referrals to community resources
- Evidence-based clinical guidelines or algorithms to conduct assessment and management

Upon acceptance of a member into the CM Program, the Case Manager will develop a Case Management Plan that identifies the interventions required to provide appropriate care to the member.

A Case Management Plan includes Development of prioritized SMART goals with consideration for:

- Member or caregiver's goals or preferences
- Member or caregiver's desired level of involvement in case management plan
- Barriers to meeting goals and complying with self-management plan
- Scheduled time frame for follow-up and communication with members
- Assessment of progress towards goal, with modifications as needed
- Resources to be utilized, including the appropriate level of care
- Planning for continuity of care, including transition of care and transfer
- Collaborative approaches to be used, including family/caregiver participation

Coordination of Carved Out Services

CalOptima Health provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits.

Memorandum of Understanding (MOU) with other community agencies and programs, such as the HCA/California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The CM staff and delegated entity practitioners are responsible for identification of such cases and coordination of referrals to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The Case Management Department assists members with the transition to other care, if necessary, when benefits end. This may include informing members about ways to obtain continued care through other sources, such as community resources.

Case Management Programs include identification and referral of a member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

- Specialty Mental Health Services
- California Children's Services (CCS) (for intercounty transfers)
- Regional Center of Orange County (RCOC)
- Local Education Agency (LEA)
- Genetically Handicapped Persons Program (GHPP)
- AIDS Waiver Program
- 1915 (c) Home and Community Based Services
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternative (HCBA) Waiver (formerly NF/AH Waiver)
- Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver
- Multipurpose Senior Services Program (MSSP)
- Tuberculosis Program (Direct Observation Therapy)
- Targeted Case Management (TCM)
- Collaborate with the HCA/PDS TB Control Officer

Clinical Protocols

CalOptima Health is committed to serving the needs of all members assigned and places additional emphasis on the coordination of care for the vulnerable population. Approved clinical practice guidelines and nationally recognized protocols are used to guide treatment and care provided to the members. The use of clinical practice guidelines or nationally recognized protocols is challenging for the CalOptima Health membership as many of their needs are socioeconomic in nature. These guidelines do not address many of the supplemental benefits or community-based resources that may be critical to a comprehensive care plan for these individuals. Lack of transportation may create obstacles to care, yet the member may not meet criteria for non-emergency medical transportation. Members who are at the end-of-life may be inappropriate for certain preventive care screenings.

When use of a clinical practice guideline or nationally recognized protocol is challenging or inappropriate for an individual member the following steps may be taken:

- ICT is convened with the member, PCP, and specialists (if appropriate).
- Participants of the ICT review the case and mutually develop an ICP, prioritized per

member's preferences.

- PCP or Case Manager facilitates referrals and linkages to identified supplemental benefits, community referrals and resources.

When a member's specific clinical requirements indicate the need for an alternative approach, decisions to modify clinical practice guidelines or nationally recognized protocols are made by the member, PCP or specialists, in consultation with other members of the health care team. The care team members review the member's current health status, limitations, social support, barriers, and treatment approach, which include any modifications needed in the clinical practice guidelines that support the ICP. Timeframes are established for each of the action items of the ICP to ensure successful completion of these tasks, identification of barriers, and attainment of goals. Updated ICP is shared with the care team members including but not limited to the members, caregivers, and PCP.

To address the unique needs of our members, CalOptima Health offers supplemental benefits, which can be accessed either through self-referral or via referral by a treating practitioner. These benefits are intended to aid members in maintaining optimal health status, either by providing health care services not covered by Medicare or Medi-Cal (e.g., vision care), by addressing barriers to access to care (e.g., Non-Medical Transportation), or by promoting regular physical activity (gym benefit).

Types of Case Management Services

Basic Case Management

Basic case management activities by the primary care practitioner may include, but are not limited to:

- A health assessment of member's current acute, chronic and preventive health needs
- Development of the member's treatment plan
- Communication between the practitioner and member/authorized representative to ensure compliance with established treatment plan
- Identification of the need for medical, specialty or ancillary referrals
- Referrals to case management and/or disease management

Care Coordination

CalOptima Health or a Health Network may provide a Member with Care Coordination Case Management, to include an assessment and creation of a care plan, if the Member does not qualify for Complex Case Management but would benefit from case management support. Care Coordination Case Management shall include:

- Assistance with access to care issues;
- Health and disease-specific education;
- Referral to resources; and
- Coordination of care with all Providers.

Complex Case Management

Complex Case Management Services are provided by CalOptima Health, in collaboration with the Primary Care Provider, and includes, at minimum:

- Basic Case Management Services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
- Intense coordination of resources to ensure member regains optima health or improved functionality
- With member and PCP input, development of care plans specific to individual needs, and updating of the care plans at least annually

Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

The members in Complex Case Management usually:

- Are at high risk; or
- Have medically complex or frequently managed conditions or diseases, including, but are not limited to, the following:
    - Spinal Injuries
    - Transplants
    - Cancer
    - Serious Trauma
    - AIDS
    - Multiple chronic illnesses
    - Chronic illnesses that result in high utilization
- Have a complex social situation that affects the medical management of their care; or
- Require extensive use of resources; or
- Have an illness or condition that is severe, and the level of management necessary is very intensive.

CalOptima Health uses this criterion when data mining and as a guideline for internal and external referral sources to identify appropriate CCM cases.

Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are those who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition. They may have a disability or chronic medical condition due to complications of prematurity, metabolic disorder, chromosomal abnormalities, or congenital abnormalities. They require health and related services of a type or amount beyond that required by children generally.

Case Management staff ensures coordination of care with other entities that provide services for Children with Special Health Care Needs (e.g., mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency).

The goals of CSHCN Case Management are to:

- Collaborate with family and providers to develop an Individualized Care Plan
- Facilitate member access to needed services and resources
- Prevent duplication of services
- Optimize member's physical and emotional health and well-being
- Improve member's quality of life

Whole Child Model

The Whole-Child Model is a program that aims to help California Children's Services (CCS) children and their families get better care coordination, access to care, and health results. The WCM program combines a qualified member's Medi-Cal and CCS benefits under CalOptima Health. CCS is a statewide program that arranges and pays for medical care, equipment and other services for children and young adults under 21 years of age who have certain serious medical conditions.

Provides access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an Interdisciplinary Care Team (ICT) is, and what the community resources are.

The Whole Child Model program includes:

- Personal Care Coordinator (PCC) will be assigned to each CCS-eligible Member.
- Perform initial and periodic outreach to assist the Member with Care Coordination
- Provide information, education and support continuously, as appropriate
- Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.
- Improve coordination of services to meet the needs of the child and family
- Maintain existing patient-provider relationships when possible
- Retain CCS program standards
- Improve overall health results

Transitional Care Services (TCS)

DHCS has outlined a phased approach in the Population Health Management (PHM) Policy Guide to provide Transitions of Care Services starting January 1, 2023. TCS are provided to members transitioning from levels of care, including hospitalizations and skilled nursing facility. Beginning in 2023, members identified as TCS High Risk, per DHCS definition, received outreach from Case Management staff. The goal of outreach is to ensure all needs are met post hospitalization, including follow up visit with PCP, medication review and resolution of discharge summary follow up items.

The TCS Case Management staff is responsible for coordinating and verifying that assigned members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. The TCS Case Management staff is also

responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the TCS Case Management staff does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services.

For members enrolled with Case Management or ECM, the assigned Case Manager will support recently discharged members with tools and support to encourage and sustain self-management skills to help minimize the potential of a readmission and optimize the member's quality of life. TCS is provided to ensure members are supported from discharge planning until they have been successfully connected to all needed services and supports.

Special Programs

Transplant Program

The CalOptima Health Transplant Program is coordinated by the Medical Director, UM Department and CM Department staff.

The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management Department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence or CMS certified Centers for OneCare. Case Management follows the member and assists as needed through the transplant evaluation process, while the member is waiting to procure an organ, and post-transplant for one year.

Members are monitored on an inpatient and outpatient basis and followed through the transplant continuum. The member, physician and facilities are assisted in order to assure timely, efficient and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the members, the community of transplant staff and the facilities. CalOptima Health monitors and maintains oversight of the Transplant Program and reports to the UM Committee to oversee the accessibility, timeliness, and quality of the transplant protocols. Transplants for Medi- Cal members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan.

Palliative Care Services

The CalOptima Health Case Management and Utilization Management teams work collaboratively to ensure access to Palliative Care services. Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the and the member and their family.

Palliative care is provided by a trained team of doctors, nurses and other specialists who work together with the members other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

Annual Review:
2023 UM Program Evaluation and 2024 UM/CM Integrated Program Description

Quality Assurance Committee Meeting
March 13, 2024

Kelly Giardina, MSG, CCM Executive Director Clinical Operations
Stacie Oakley, RN Director Utilization Management

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.

2023 Utilization Management and Case Management Program Evaluation and

2024 Utilization Management and Case Management Integrated Program Description

Kelly Giardina, MSG, CCM, Executive Director, Clinical Operations

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CalOptima Health

Utilization Management (UM) Program Description and Program Evaluation Purpose

- UM Program Evaluation lookback period: Q4 2022 – Q3 2023
- Program description is revised for the following year based on the previous year's evaluation outcomes to ensure ongoing alignment with evolving healthcare stands and optimize UM performance.
- The UM Program is reviewed and approved by the UM Committee (UMC), the Quality Improvement Health Equity Committee (QIHEC) and the Quality Assurance Committee (QAC)

Utilization Management (UM) Program Description and Program Evaluation Purpose

- CalOptima Health annually evaluates the effectiveness of the UM program & evaluation:
  - Program Structure and Process
  - Program Scope Impact
  - UM statistics and performances
  - Member's satisfaction
  - Responsibility for the UM program
  - Medical Director's responsibilities
  - Significant changes, new initiatives and programs
  - Upcoming goals, projects and implementations

2023 UM Program Evaluation Improvements & Enhancements

(Q4 2022 – Q3 2023) Accomplishments

- **Medical Director** team additions
  - Internal Medicine
  - Emergency Medicine & Trauma
  - Child/ adolescent psychiatry and pharmacy
  - Family/ Addiction medicine
- Improved **reporting/ workflows** to prioritize treatment authorizations to exceed turnaround time
- Provider **portal enhancements** to automation and capabilities
- Design, configuration, and preparation for the new **medical management clinical documentation platform "JIVA"** for implementation **February 2024**

2023 UM Program Evaluation Improvements & Enhancements

- Refinement of **hospital utilization measurement** including bed days goals
- Launched **Brain/Spine/Pain** care coordination workgroup
- **Continuity of Care** protocol refinements
- Transplant program enhancements including COE to UCSD
  - Inpatient rounds
  - Out of Area supports such as lodging and meal assistance to member, family/caretakers of transplant members.
- **Pediatric inpatient rounds (NICU and PICU)** and coordination of **CCS eligibility** and needs.
- UM Temp personnel coverage and planning for role vacancies
- Enhanced out of network LOA protocols and oversight for opportunities to coordinate member care

2023 UM Program Evaluation
Over & Under Utilization

- Over/Under Utilization Review
  - CalOptima Health continues to monitor the trends revolving over and under utilizations of authorizations
  - Dedicated Medical Director to review and discuss utilization patterns and outlier trends with Health Network partners
  - Implementation of the **Quarterly Health Network Clinical Oversight and Support team** to discuss utilization trends, interventions to support members and compare KPIs and Health Network workplans

2023 UM Program Evaluation
Over & Under Utilization

- Over/Under Utilization Metrics:
  - Physical, behavioral health (BH) and pharmacy prior authorization
  - Physical and BH inpatient
  - Appeal/ overturn rates
  - Member grievances
  - Potential quality issues (PQI)
  - Adult and children's access to PCP services
  - Appropriate RX utilization
  - Data from Compliance Department regarding fraud, waste and abuse

2023 UM Program Evaluation
Member Satisfaction

- The UM Program continues to enhance protocols based on opportunities identified through Grievances and Appeals Resolutions (GARs), Member and Provider Experience Surveys
  - GARS outcomes reviewed such as Authorizations and access to care :
    - Non-contracted providers with CalOptima Health
    - Providers who are not accepting new patients
    - Providers who are not under the specialty or service that member is seeking care for
    - Providers who are only able to members with affiliated organization
- CAHPS results:
  - Increase from 71.3% to 78.1% of adult members reported they usually or always got an appointment with a specialist as soon as needed.
  - Decrease from 90.5% to 81.3% of adult members felt it was usually or always easy to get the care, tests, or treatment needed
  - Increase from 80.8% to 84.77% of child members felt it was usually or always easy to get the care, tests, or treatment a child needed

CAHPS Source: Member Feedback from the 2023 CAHPS Survey reporting measurement year 2022

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Inpatient Medi-Cal Utilization

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	60.2 ↓	62.1 ↓	105.9 ↓	103.5 ↓
Days/1000 PTMPY	358	315.2 ↓	321.4 ↓	553.1 ↑	518.1 ↑
ALOS	4.3	5.24 ↑	5.18 ↑	5.22 ↑	5.01 ↑
Readmit %	25.00%	17.54% ↓	18.85% ↓	18.27% ↓	18.65% ↓

- **Bed Day/1000 Per Year (PTMPY):**
  Bed days/100 fell below the goal of 358 in Q4 2022 and 2023 YTD
- **Average Length of Stay (ALOS):**
  The ALOS for this population remained above the goal of 4.3 in Q4 2022 and 2023 YTD

↑	**Denotes comparison to goal**

CCN only, Duals, LTC/Acute Rehab, & WCM excluded
Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

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CalOptima Health

Prior Authorization Turn Around Time

Prior Authorization Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023						
Year	**Goal**	**Quarter**	**LOB**	**Prospective Routine**	**Prospective Urgent**	**Retro/ Post Service**
2022	**95%**	**Qtr. 4**	Medi-Cal	99.62% ↑	99.71% ↑	100.00% ↑
			One Care	N/A	N/A	N/A
2023	**95%**	**Qtr. 1**	Medi-Cal	99.67% ↑	99.67% ↑	98.86% ↑
			One Care	99.43% ↑	100.00% ↑	100.00% ↑
		Qtr. 2	Medi-Cal	99.92% ↑	99.90% ↑	99.64% ↑
			One Care	99.83% ↑	98.65% ↑	100.00% ↑
		Qtr. 3	Medi-Cal	99.94% ↑	99.86% ↑	100.00% ↑
			One Care	99.97% ↑	100.00% ↑	98.63% ↑

Prior authorization turnaround time compliance remained compliant since Q4 2022, trending in the 98th percentile and above and has continued to meet quarter over quarter goal of 95%.

↑	**Denotes comparison to goal**

Source: CORE report Authorization Turn Around Summary (CC0003A_GC). Data Q4 2022-Q3 2023. Data pulled 11/3/2023

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CalOptima Health

Inpatient Turn Around Time

Inpatient Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023 (CCN/COD)					
Year	**Goal**	**Quarter**	**LOB**	**Urgent**	**Retro / Post Service**
2022	**95%**	**Qtr 4**	Medi-Cal	96.47% ↑	84.54% ↓
			One Care	N/A	N/A
2023	**95%**	**Qtr 1**	Medi-Cal	98.22% ↑	84.47% ↓
			One Care	99.13% ↑	100.00% ↑
		Qtr 2	Medi-Cal	99.41% ↑	88.62% ↓
			One Care	99.14% ↑	100.00% ↑
		Qtr 3	Medi-Cal	98.68% ↑	85.28% ↓
			One Care	98.55% ↑	90.91% ↓

A delay was identified in the UM assignment for retro post services cases due to pended claims and/or provider dispute resolutions (PDR).

UM continues to ensure expedited review and continued process improvements to communicate retro case assignments in real time.

↑	**Denotes comparison to goal**

Source: Authorization Turn Around Summary (CC0003I_GC). Data Q4 2022 – Q3 2023. Data pulled 11/3/2023

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Prior Authorization Referrals Processed

Referrals Processed Q4 2022 - Q3 2023(CCN/COD)					
Year	**Quarter**	**LOB**	**Prospective Routine**	**Prospective Urgent**	**Retro/ Post Service**
2022	**Qtr 4**	Medi-Cal	25,073	6,576	1,780
		One Care	N/A	N/A	N/A
2023	**Qtr 1**	Medi-Cal	28,022 ↑	6,935 ↑	3,075 ↑
		One Care	1,927	368	78
	Qtr 2	Medi-Cal	31,422 ↑	8,138 ↑	2,760 ↓
		One Care	2,972 ↑	443 ↑	120 ↑
	Qtr 3	Medi-Cal	32,427 ↑	7,756 ↓	3,707 ↑
		One Care	3,141 ↑	476 ↑	146 ↑

Medi-Cal referrals continued to increase across all quarters from Q4 2022 – Q3 2023, with the exception retrospective referrals in Q2 2022.

OneCare was effective January 1, 2023, there was an increase quarter over quarter in 2023

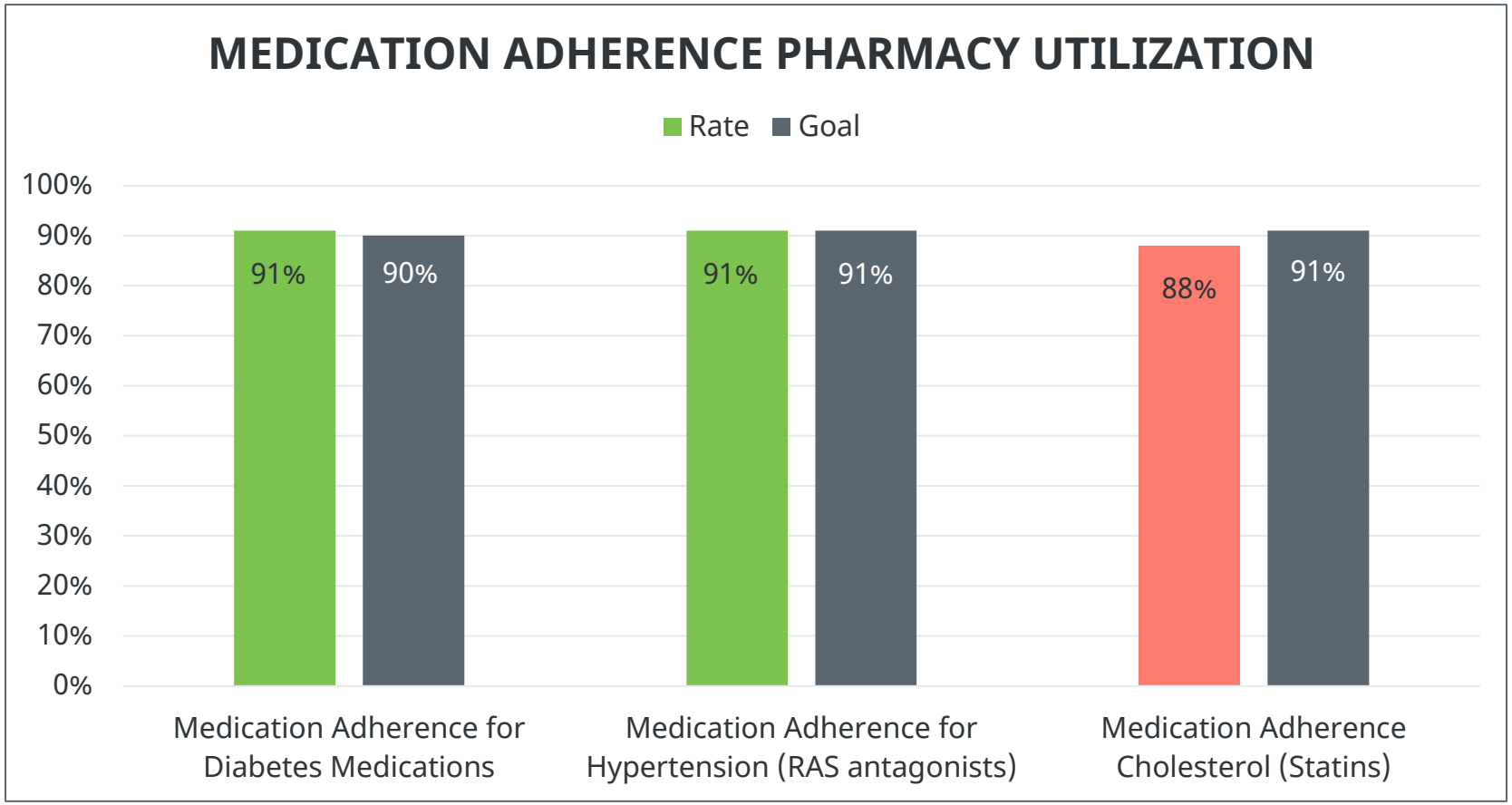
↑	**Denotes comparison to prior quarter**

Referrals Processed Source: CORE report Authorization Turn Around Summary CC0003A_GC. Data Q42022-Q32023. Data pulled 11/3/2023

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Pharmacy Utilization



Goals were met for two of the three adherence measures for year to date through the third quarter. Interventions include provider faxes, member educational materials, medication therapy management-eligible member education, and individual member refill reminders phone calls.

CBAS Turn Around Time

Denotes comparison to goal

CBAS Turnaround Time Compliance (TAT) Q1 2023 - Q3 2023				
Year	**Goal**	**Quarter**	**TAT Compliance**	**Volume**
2023	**95%**	**Qtr. 1**	51.06% ↓	1,731
		Qtr. 2	34.08% ↓	1,815
		Qtr. 3	79.72% ↓	2,141

CBAS Turnaround Time Compliance (TAT) Q1 2023 - Q3 2023				
Year	**Quarter**	**Days Used / Days Authorized**	**% Used**	**Change From Previous Qtr.**
2022	**Qtr. 4**	81,160 / 165,447	49.05%	-27.79%
2023	**Qtr. 1**	90,699 / 158,990	57.04%	7.99%
	Qtr. 2	103,577 / 159,725	64.84%	7.80%
	Qtr. 3	N/A*		

During Q1 and Q2 2023 there was not a clear mechanism to report the CBAS TAT. In addition, additional centers were opening resulting in an increase in volume and an impact in Turnaround time. In August 2023 an incident of TAT was reported to CalOptima Health leading to a SWAT analysis of the process and inventory. Approximately 335 aged inventory requests were identified and resolved within 2 days of identification. Processes were developed to support improved efficiency for staff, and additional support was implemented to monitor and control the Turnaround time for CBAS authorizations. The current TAT is 2.42 days with a 99.8% compliance rate.

CBAS Turnaround Time Compliance Source: Authorization Inventory (Tableau)

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LTC Nursing Facility Members Transition to the Community

LTC Nursing Facility Members Transition to the Community					
Year	**Quarter**	**LOB**	**LTC Nursing Facility Members / Transition to Community**	**% Transitioned**	**Change From Previous Qtr.**
2022	**Qtr. 4**	Medi-Cal	220 / 4,918	4.47%	0.36%
		One Care	9 / 173	5.20%	-1.94%
2023	**Qtr. 1**	Medi-Cal	177 / 5,433	3.26%	-1.21%
		One Care	7 / 157	4.46%	-0.74%
	Qtr. 2	Medi-Cal	231 / 5,525	4.18%	0.92%
		One Care	4 / 193	2.07%	-1.19%
	Qtr. 3 *	Medi-Cal	224 / 5,602	3.99%	0.19%

**Discontinued reporting this metric*

Source: LTC Discharge Tracking (LT0040)

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CalOptima Health

Inter-rater Reliability (IRR)

Department	Goal	IRR Score
UM Clinical Staff: Prior Authorization	90%	99% ↑
UM Clinical Staff: Concurrent Review		100% ↑
Utilization Management		100% ↑
Medical Directors		100% ↑
Pharmacy: RPh		99% ↑
LTSS: LTC		98% ↑
LTSS: CBAS		97% ↑
LTSS: MSSP		99% ↑
CalAIM		100% ↑
Behavioral Health		97% ↑

UM Prior Authorization passed IRR testing, there was 1 staff member that didn't pass with a score of 90% or greater.

Staff that didn't pass will undergo additional MCG training and may be assigned additional cases for review.

↑	Denotes comparison to goal

Source: https://learn.mcg.com/local/mcg_reports/index.php?c=report&a=completion

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UM and CM Integrated Program Description 2024

Stacie Oakley, RN, Director, Utilization Management

UM Program Goals and Initiatives

- Goal UM Program is to manage appropriate utilization of medically necessary covered services and to ensure access to quality and cost-effective health care for CalOptima Health members through:
  - Timely and efficient treatment authorizations
  - Coordination and continuity of care
  - Support of member through transitions of care including addressing complex discharge needs
  - Oversight and support of access, availability, and timeliness of care.
  - Member and provider satisfaction
  - Identifying and addressing over and under-utilization of care
  - Promotion of health literacy, prevention and improved member outcomes

Integration of Quality Program Initiatives

Comprehensive Community Cancer Screening and Support Program

- Program was launched in January 2023 to lead Orange County in achieving the lowest late-stage cancer incidence rate for breast, cervical, colon, and lung cancer in certain smokers in the nation.
- As of October 2, 2023, 3,718 CalOptima Health members were newly diagnosed with cancer this year.

Five-Year Hospital Quality Program 2023-2027

CalOptima Health has developed a hospital quality program to improve the quality of care to members through increased patient safety efforts and performance-driven processes. Hospitals may earn annual incentives based on the achievement of benchmarks.

Integration of Quality Program Initiatives

CalOptima Health and DHCS combined Strategic Goals

1. Maternal Health

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%

2. Children's Preventive Care

- Exceed the 50th percentile for all children's preventive care measures

3. Behavioral Health Care

- Improve maternal and adolescent depression screening by 50%
- Improve follow-up for mental health substance disorder by 50%

CalOptima Health Direct Network and Health Network Entities

Direct Network and Contracted Health Networks Entities

Health Network/Delegate	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI Care Medical Group	PHC	PHC
CHOC Health Alliance	PHC	
Family Choice Medical Group		SRG
Family Choice Health Services	HMO	
HPN – Regal Medical Group	HMO	HMO
Optum Care Network - Monarch	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG

CalOptima Health Direct Network and Health Network Forum

Health Networks and CalOptima Health joint discussion on programmatic enhancements and changes to the implementation and operation of medical management programs.

Topics reviewed in 2023 include but are not limited to:

- DHCS and CMS changes
- Modifications to the Prior Auth process
- Transitional Care Services
- NCQA Accreditation updates and changes
- Post Stabilization Care Services process
- Population Health Management
- Enhanced Care Management
- Integrated Care Planning
- Health Risk Assessment protocols
- NEMT
- Facility Rounds
- Audit outcomes and recommendations
- Reporting protocols
- Case Management updates
- UM Delegation Support and Oversight
- UM Peer to Peer practices
- Workplan goal alignment for Plan All-Cause Readmission (PCR) and Transitional Care Services (TCS)
- Post Discharge practices
- Model of Care
- California Children's Services (CCS) support requirements
- Transplant Care program
- Palliative Care / Hospice Program
- Continuity of Care
- Monitoring for over and under-utilization

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California Advancing and Innovating Medi-Cal (CalAIM) Care and Integration

Full care integration into care and goals:

1. Whole-person care
2. Consistent and seamless delivery of care and services
3. Improved member outcomes, reduction of health disparities, improved health equity

Enhanced Care Management (ECM)

Seven ECM Core Service Components:

1. Outreach and Engagement
2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Support
7. Coordination of and Referral to Community and Social Support Services

California Advancing and Innovating Medi-Cal (CalAIM) Care and Integration

Enhanced Care Management (ECM) and Community Support

14 Community Supports:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications) includes Personal Emergency Response Systems (PERS)
12. Medically Tailored Meals/Medically Supportive Foods
13. Sobering Centers
14. Asthma Remediation

UM Workgroup

Bi-monthly workgroup and integration of UM, CM, BHI, and GARs.

Roles and responsibilities:

- Evaluate and support the development of operational UM Program and protocols overseen by UMC
- Discuss and inform Key performance metrics, measures, and goals
- Recommend criteria and protocols for approving new technology, treatment, and diagnostic procedures

Goals:

- Ensure regulatory and accreditation compliance is met
- Provide ongoing review and input for current process improvement initiatives
- Ensure policies and procedures are current and comply with new and modified regulatory initiatives

UM Sub Workgroups

- **Brain/Spine Workgroup:** To ensure member requests for neurological and spine treatment and/or surgery are provided by appropriate medical practitioners based on the member's need and that services are provided.
- **Transplant Workgroup:** To ensure members needing transplant services are case-managed throughout the continuum of the transplant process (pre and post).
- **UM Authorization Strategy Workgroup:** To support ongoing strategic decisions and process improvement for the access and utilization of Utilization Management data.
- **Bed Day Reduction Workgroup:** To reduce inpatient admissions, decrease 30-day readmission, and reduce ED utilization through collaboration between Case Management, Utilization Management, and Medical Affairs.
- **Gender Affirming Care Workgroup**: To promote expansion of Gender affirming care options, coordination and care and access to care management.

UM Criteria

Access to Physician Reviewer

The CalOptima Health Medical Director or appropriate practitioner reviewer (BH and clinical pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process.

UM Staff Access to Clinical Expertise

The CMO and Medical Directors have the authority, accountability, and responsibility for denial determinations and follow sound clinical and professional judgment.

Requesting Copies of Medical Records

During prospective, retrospective, inpatient, and concurrent review requests, copies of medical records are required to validate the medical necessity for the requested service.

Sharing Information to coordinate care for members

CalOptima Health's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g., discharge planning, case management, PHM, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Case Management Program

Updates and/or changes to the CCM program and process include but are not limited to the following:

- Enhanced Care Management (ECM) and Community Supports operation of all 14 Community supports and continual identification of members for enhanced care management through a fully integrated approach.
- New DHCS contract 2024
- Clinical documentation platform enhancements and new system JIVA configuration decisions to enhance functionality of assessments, care plans, and other clinical workflows
- Ongoing communication and training in clinical protocols/standards of care for both CalOptima Health and Health Network staff.
- Creation of additional tools to assist CalOptima Health and Health Network staff to ensure all aspects of member care are addressed.
- Targeted outreach and case management support to members experiencing transitions
- Case Management program enhancements for outreach to members with specialized needs, such as members experiencing; pain, behavioral health needs, or homelessness.
- Enhanced training in clinical protocols, resources and engagement to care management teams
- Continued coordination and support of members clinical pharmacy needs through program integration and advocacy
- Enhance programmatic supports through transitions in care settings through outreach and interventions coordinated with hospital partners.

Case Management Program

Coordination of Care

Specialized Care Management Programs

- **Transplant Program**
  Enhanced Resources and programmatic design led by Transplant medical director for Case Managers to support members from listing to post Transplant.

- **Palliative Care Program**
  Collaborative approach between UM and CM to ensure access to palliative care services on the continuum of care.

- **Emergency Department interventions and workgroup**
  Develop CM protocols to address members with high emergency department utilization led by Medical Director and case management clinical leadership

- **UCI ED Pilot #2**
  Microsoft Teams channel to launch a Telephonic Emergency Department resource room where nursing staff, Medical Directors, UM team, CM and UCI ED team are unified and can access communication, resources and support in real time.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 13, 2024
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

5 Receive and File 2023 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Contacts

Javier Sanchez, Executive Director Operational Management, (714) 986-6115
Donna Frisch, M.D., PACE Medical Director, (714) 714-8974
Monica Macias-Garcia, LCSW, PACE Director, (714) 468-1077

Recommended Actions

- Receive and File 2023 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation, and
- Recommend that the CalOptima Health Board of Directors approve the 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan.

Background

The Program of All-Inclusive Care for the Elderly (PACE) is viewed as a natural extension of CalOptima Health's commitment to integration of acute and long-term care services for its members. This program provides the link between healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. As of December 31, 2023, CalOptima Health PACE had 442 active members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes and participant satisfaction.

PACE organizations are required to have a written Quality Improvement (QI) Plan that is evaluated annually. The results of the evaluation can directly lead to the revisions to the following year's QI Plan. The QI Plan reflects the full range of services furnished by CalOptima Health PACE. The goal of the QI Plan is to improve future performance through effective improvement activities driven by identifying and tracking key objective performance measures and reliably reporting them to decision-making and caregiving staff.

The 2023 PACE QI Plan Evaluation analyzes the core clinical and service indicators to determine if the 2023 Plan achieved its key performance goals for the year. In 2024, CalOptima Health PACE continues to expand participant services, update quality element goals, and continue efforts to ensure comprehensive care. The 2024 PACE QI Plan reflects CalOptima

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Health's efforts to continue a high level of quality while also focusing on improving health outcomes and access for PACE participants.

Discussion

CalOptima Health PACE has updated the 2024 QI Work Plan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner. The 2024 PACE QI Plan, created through a collaboration of the PACE QI Committee members, refines the PACE quality elements based on the current population's health needs. The 2024 PACE QI Plan challenges the PACE team to strive for improvement in areas of treatment, service, and health outcomes.

In 2024 PACE proposes:

1. To add new quality elements that focus on cancer screening, blood pressure monitoring, and diabetic blood sugar monitoring of older adults.
2. To ensure that eligible participants receive the most up to date COVID-19 vaccines to prevent infection and hospitalization.
3. To assist participants in completing advanced health care directives utilizing newly trained in-house notaries.
4. To continue to provide excellent service to participants in areas of transportation, meals, and overall satisfaction with the PACE program to maintain goals at or above the national averages.

Fiscal Impact

The recommended action to approve the 2024 PACE QI Plan has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2023-24 Operating Budget. Staff will include expenditures for the period of July 1, 2024, through December 31, 2024, in the FY 2024-25 Operating Budget.

Rationale for Recommendation

The Centers for Medicare & Medicaid Services requires PACE organizations to develop, implement, maintain, and evaluate an effective, data-driven QI program. PACE organizations must have a written QI Plan that is collaborative and interdisciplinary in nature. The PACE governing body must review the QI Plan annually and revise it if necessary.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

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Attachments

1. 2023 PACE QI Work Plan Evaluation
2. PowerPoint Presentation: 2023 PACE QI Work Plan Evaluation
3. 2024 Proposed PACE QI Work Plan (Redline version)
4. 2024 Proposed PACE QI Work Plan (Clean version)
5. PowerPoint Presentation: 2024 Proposed PACE QI Work Plan

/s/ Michael Hunn *03/08/2024*
Authorized Signature **Date**

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CalOptima Health Program of All-Inclusive Care for the Elderly

2023

Quality Improvement Plan

Annual Evaluation

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2023 CalOptima Health PACE

Quality Improvement (QI) Plan Annual Evaluation

Executive Summary

As the COVID-19 pandemic persisted into 2023, challenges continued to impact all areas of life. CalOptima Health PACE faced these challenges head-on and continued to provide direct care to hundreds of our county's frail and senior population who are most at risk of contracting the COVID-19 virus.

Understanding the importance of continuing to provide preventive health services, we continued intensive COVID-19 testing and follow up throughout 2023. A collaboration between the PACE clinic, the Quality Improvement department and the PACE scheduling team led to increased COVID booster vaccination numbers at the beginning of the year. The Centers for Disease Control and Prevention (CDC) vaccine recommendations changed in September 2023, and we were able to end 2023 with 42.6% of enrollees being actively *up to date* with the new one-dose 2023-2024 Updated COVID-19 vaccine. We are now able to provide this new vaccine directly within the PACE clinic, eliminating the need for additional resources such as transportation and scheduling to pharmacies outside of PACE.

PACE Day center attendance continued to increase throughout 2023 with all infection control and safety protocols being followed. Despite several small COVID-19 surges throughout 2023, we were able to provide increased face-to face services for participants with their providers, clinic, and rehabilitation staff. We have worked diligently to provide as many in-person services to our participants as possible, while also assessing risk factors for spread of disease and implementing processes to mitigate these risks. While the Federal COVID-19 Public Health Emergency officially ended on May 11, 2023, PACE continues to diligently monitor COVID-19 cases. All new COVID-19 cases are tracked and trended for potential center-wide outbreaks and participants who test positive are treated following the latest CDC guidelines for treatment and isolation to prevent spread.

Despite the continuing challenges of COVID-19 we continued to enroll new participants and saw our highest ever enrollment numbers by the close of 2023. When CalOptima Health PACE first opened for operations on October 1, 2013, we had 13 enrolled participants. We have seen sustained growth in enrollment throughout the past 10 years and at the end of 2023, we had 442 participants enrolled. As an acknowledgement of "10 Years Of PACE", in October 2023 a weeklong celebration was held for the participants which included entertainment, games, activities and speeches from CalOptima Health executive staff and the PACE leadership team.

The multicultural background and the diversity of our participant population provides a very vibrant and engaging environment at PACE. Among our PACE participants, the primary languages are 67% Spanish, 14% English, and 11% Vietnamese. Other languages spoken include Tagalog, Arabic, Chinese, Hindi, Persian, Urdu and Korean. CalOptima Health PACE ensures that participants are always provided with opportunities to communicate in their preferred language using professional interpreter services and that PACE staff provide culturally competent care for each of our members.

The purpose of the CalOptima Health PACE QI Plan is to improve the quality of health care for participants, improve on the patient experience, ensure appropriate use of resources, provide oversight to contracted services, communicate quality and process improvement activities and outcomes, and reduce the potential risk to health and safety of PACE participants through ongoing risk management. This is done via data-driven assessment of the program which in turn drives continuous QI for the entire PACE organization. It is designed and organized to support the mission, values, and goals of CalOptima Health PACE.

The goal of the CalOptima Health PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff. The 2023 PACE QI Workplan Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2024 PACE QI Plan.

SECTION 1: PROGRAM STRUCTURE

The CalOptima Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). It is then reviewed and approved by the CalOptima Health Board of Directors' Quality Assurance Committee (QAC) and then approved by the CalOptima Health Board of Directors annually. The 2023 PACE QI Plan was reviewed and approved by the CalOptima Health Board of Directors on April 11th 2023.

The CalOptima Health PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager ensures timely collection and completeness of data with the support of the PACE QI Program Specialists. Ultimately, oversight of the PACE QI Plan is provided by the CalOptima Health Board of Directors.

The CalOptima Health PACE QI Plan incorporates continuous QI methodology that focuses on the specific needs of CalOptima Health's PACE participants.

- It is organized to identify and analyze significant opportunities for improvement in health care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to ensure that any quality-of-care issues are identified and corrected.

SECTION 2: PACE QAPI PROGRAM

Major Accomplishments

In 2023, CalOptima Health PACE's accomplishments include:

1. Continued response to updates regarding the COVID-19 pandemic, to follow all federal, state, and local guidance.
2. Provided infection control training to all staff in accordance with CDC, California Department of Health Care Services (DHCS) and California Department of Public Health (CDPH) directives.

3. Implemented a plan to assist eligible participants with receiving the latest recommended COVID-19 vaccine, which became available in September 2023.
4. Continued to increase PACE Day center activities and attendance in accordance with infection control guidelines.
5. Distributed 25,532 home delivered meals throughout 2023.
6. 89% of participants received their annual 2023-2024 Influenza vaccine, with continuation of these efforts into Q1 2024.
7. 92.5% of eligible participants completed their recommended Pneumococcal vaccine series.
8. Continued enhanced care coordination program for PACE participants with End Stage Renal Disease on dialysis.
9. 99% of participants had their medications reconciled within 10 days of hospital and/or Skilled Nursing Facility (SNF) discharge.
10. Retrospective reviews of medication utilization were performed daily and monthly. Recommendations were immediately addressed with the PACE provider and/or Interdisciplinary Team.
11. Continued use of telehealth modalities, when appropriate, enabled participants to "visit" their providers from their homes.
12. Quality of Diabetes Care
    a. 89% of participants with diabetes completed an annual eye exam.
    b. 100% of participants with diabetes had nephropathy monitoring in each quarter.
13. Utilization:
    a. Only 0.92% of participants were placed in long-term custodial health care in 2023.
    b. Continued the PACE Emergency Room (ER) Diversion program, with both ER and Hospital utilization goals met for 2023.
    c. Continued to provide in-house specialist health care including podiatry, psychiatry, nephrology and dental services for improved access and coordination of health care.
14. Transportation:
    a. 99.95% of all scheduled trips were completed within 60 minutes or less.
15. Participant Satisfaction
    a. 94% overall satisfaction with care received compared to the national average of 88.6%.
    b. 96% satisfaction with Recreational Therapy compared to national average of 79.2%
    c. 88% satisfaction with Meals compared to national average of 71.5%
16. 100% of staff competency assessments were completed. Year-round staff training was provided covering a broad area of topics including infection control, emergency responses, grievances, appeals, service delivery requests, and participant rights.
17. Bi-Annual testing of the Emergency Response Plan with live-action drill completed in December 2023.
18. Successfully completed an extensive audit of our program by DHCS in July 2023. In this audit, the DHCS team thoroughly examined the PACE quality program, data reporting, contracts, center facilities and the clinic. They reviewed PACE policies, procedures, and desktop references. They examined medical record documentation including progress notes, ER/Hospital visits and provider orders. DHCS nurses observed clinical treatments including

wound care and point of service testing. Ultimately, DHCS had minimal audit findings and all corrective actions were completed and closed without further action needed.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

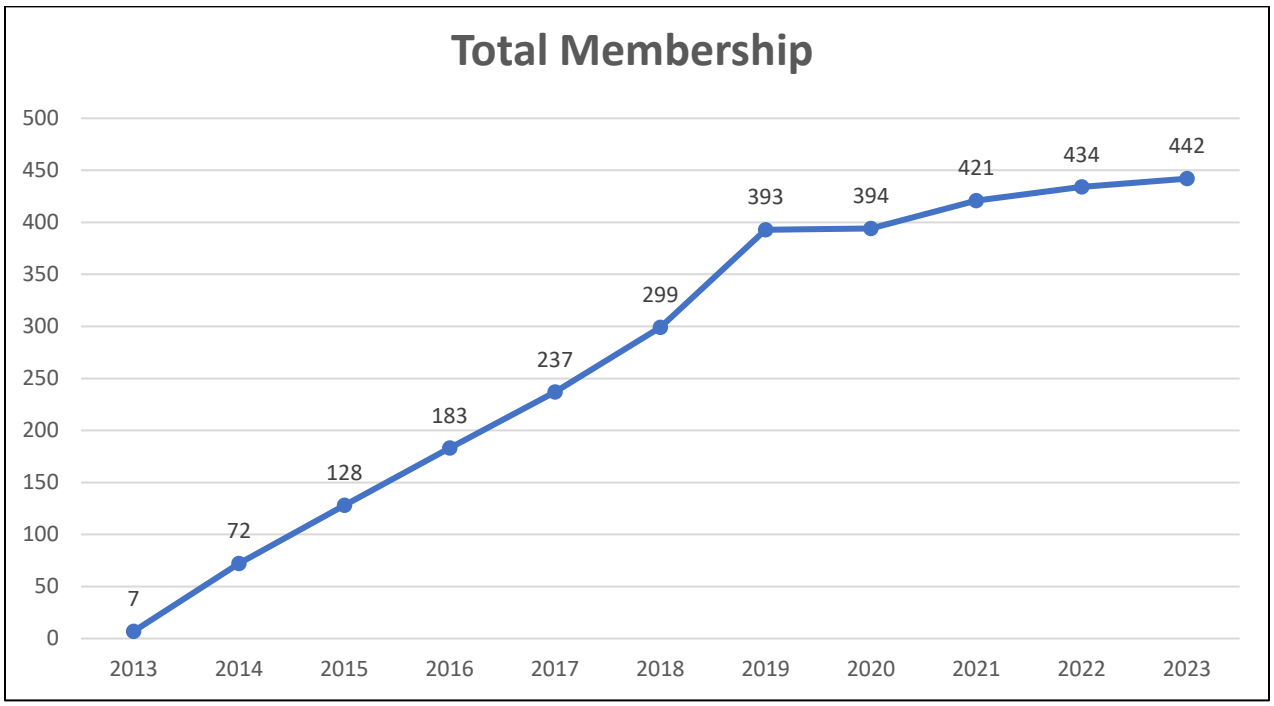
1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, health care, and utilization. Accomplished and evidenced by:
    a. The ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
    b. The ongoing PACE QI activities and initiatives.
2. The quality of clinical care and services and patient safety provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population. Accomplished and evidenced by:
    a. The monitoring of member grievances and complaints, and regular review of delegated entities.
    b. The monthly meeting with the transportation vendor.
    c. The daily morning inpatient and nursing facility clinical reviews by the medical case manager nurse.
    d. The ongoing infection control activities, specifically tracking, reporting, and treatment of all infectious disease cases.
    e. Collaboration with the CalOptima Health Compliance department for identification of potential quality issues that may involve fraud, waste, abuse, confidentiality, security, etc.
    f. The PACE Clinic Workflows to efficiently address participant health care issues.
3. The continuity and coordination of health care between specialists and primary care practitioners, and between medical and behavioral health practitioners. Accomplished and evidenced by:
    a. The Interdisciplinary Team (IDT) meetings at CalOptima Health PACE.
    b. Continued presence of physicians and nurse practitioners during IDT meetings.
    c. Addition of preferred specialists who regularly provide services within the PACE clinic.
    d. The coordination of health care found in the ER Diversion Program.
4. The accessibility and availability of appropriate clinical care and a network of providers with experience in providing health care to the population. Accomplished and evidenced by:
    a. The number of grievances that have been tracked and trended.
    b. Podiatry, nephrology, dental and psychiatry staff providing on-site health care.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality health care and service. Accomplished and evidenced by:
    a. The credentialing and peer review process.

    b. Annual performance evaluations of all CalOptima Health PACE employees.
6. Member and provider satisfaction, including the timely resolution of complaints and grievances. Accomplished and evidenced by:
    a. The 2023 PACE Participant Satisfaction Survey results showing that PACE member satisfaction is higher than both the national average and the CalPACE average in all domains.
    b. Summary of grievances.
    c. The ongoing input from the PACE Member Advisory Committee meetings.
7. Risk prevention and risk management processes. Accomplished and evidenced by:
    a. The QI activities which occur around all quality incidents and including root cause analyses and recommendation for improvement and follow up.
    b. Physical therapy driven groups designed to prevent future falls.
8. Compliance with regulatory agencies and accreditation standards. Accomplished and evidenced by:
    a. The successful submission of data as required by CMS and DHCS each quarter.
9. Compliance with clinical practice guidelines and evidence-based medicine. Accomplished and evidenced by:
    a. The adoption of the National PACE Association Preventative Guidelines.
    b. The use of clinical practice standards.
    c. On-going PACE staff training.
10. Support the organization's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently. Accomplished and evidenced by:
    a. Tracking, trending, and analyzing utilization management (UM) data monthly.
    b. The coordination of health care found in the ER Diversion Program.
    c. The weekly PACE leadership team meetings.
    d. Participation in the CalOptima Health QI, UM, and Credentialing and Peer Review Committee meetings.
    e. Participation in the CalOptima Health Board of Directors and the Board of Directors' Quality Assurance Committee meetings.

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS, AND ACTIONS

PACE Membership at a Glance

CalOptima Health PACE offers a community-based program that provides all necessary medical health care coordination and social services support in one location to the frail and elderly within our community. The goal of keeping seniors healthy in their homes and maintaining their independence continues to be our mission eight years later. At the end of 2013, we had 7 participants enrolled and now, ten years later, we have 442 active participants.



As illustrated in the membership graph, PACE has seen a steady enrollment trend over the years. Due to the COVID-19 pandemic, there was almost no growth noted in 2020. However, despite the continued Federal Emergency in 2021, 2022, 2023 PACE saw a slow and steady upward trend in enrollment numbers.

In 2024, our goals for program growth remain intact and strategies are in place to expand our ability to serve even more participants in Orange County. We continue our aggressive marketing strategies which include print, radio and television media to reach a wider audience throughout Orange County. A PACE rebranding campaign is scheduled to take place in 2024. The CalOptima Health executive team is working closely with PACE to develop exciting strategies for expansion in 2024.

2023 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QI23.01 PACE QAPI Plan and Work Plan will be evaluated annually

Approved by the CalOptima Health Board of Directors on April 11, 2023.

QI23.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Health Board of Directors on April 11, 2023.

QI23.03 Increase Influenza immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their annual influenza vaccination by December 31, 2023.

Goal: Not Met

Data/Analysis: 89% percent of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

With a year-end vaccination rate of 89%, we fell short in meeting our 2023 goal. Our influenza vaccination efforts for the 2023/2024 flu season will extend through Quarter 1 of 2024 where we will continue to reach out to those unvaccinated participants. Vaccines were pre-ordered in late spring from our distributer, and we began our process when vaccines arrived in September 2023. PACE used strategies to reach all eligible participants, such as an aggressive flu vaccination campaign which included vaccine clinic events at PACE. Monthly reports were generated by our QI department identifying those participants who still required the vaccine, and this was shared with the primary care providers (PCPs) and registered nurses (RNs) who personally reached out to the unvaccinated participants. It is important to note that CalOptima Health PACE reported zero influenza outbreaks among our participants or staff in 2023. We will continue our goal of 94% in 2024.

QI23.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their Pneumococcal vaccination by December 31, 2023.

Goal: Not Met

Data/Analysis: 93.5% of participants received the pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2023, 93.5% of our eligible participants had completed pneumococcal vaccination. Although we very narrowly missed our goal of 94%, we did show a 4.5% improvement in vaccination from our 2022 pneumococcal data. The PACE QI department provided detailed reports to the clinic which specified which participants still needed the vaccination. It was then shared with all providers. As with previous years, one of our challenges is the complex interval periodicity between the Pneumococcal 13 and Pneumococcal 23 vaccines. In 2022, a new vaccine was introduced to PACE- Pneumococcal 20, which is a one dose vaccine that eliminates the timing and dosage challenges of the previously approved pneumococcal series which led to our improvement in percentages from 2022 to 2023. In 2024, we anticipate that the identification of those needing vaccine through review in the California Immunization Registry (CAIR2) in addition to the new one dose vaccine will continue to increase our ability to meet and maintain the 94% goal moving forward.

QI23.05 Increase COVID-19 Booster Dose immunization rates for all eligible PACE participants

Goal: Greater than or equal to 80% of eligible participants will have their COVID-19 Bivalent Booster vaccination by December 31, 2023.

Goal: **Not Met**

Data/Analysis: 62.9% of participant received COVID-19 vaccination by the of Q3 2023.

Summary and Key Findings/Opportunities for Improvement:

In September 2023, the CDC announced that the Bivalent Booster for COVID-19 would be discontinued, effectively ending our ability to continue with this specific vaccination quality measure. In 2024, we plan to continue our efforts to ensure that all PACE participants are fully vaccinated against COVID-19 by changing this quality element goal to "≥ 50% of eligible participants will receive the latest CDC recommended COVID-19 vaccine by December 31st, 2024". The 2023-2024 one-dose COVID-19 vaccine is the latest recommended vaccine by the CDC. Our ability to now provide the COVID-19 vaccine within our own PACE clinic should additionally help us in reaching and surpassing our vaccination goals in 2024.

QI23.06 Increase Physician Orders for Life-Sustaining Treatment (POLST) utilization for PACE participants

Goal: Greater than or equal to 95% of participants who have been enrolled in PACE for 6 months will have a POLST completed by December 31st, 2023.

Goal: Met

Data/Analysis: 96% of participants enrolled in the PACE for 6 months had POLST by the end of 2023.

Quarters 2023	Completion Rate
Q1	94%
Q2	97%
Q3	98%
Q4	98%
EOY	**96%**

Summary and Key Findings/Opportunities for Improvement:

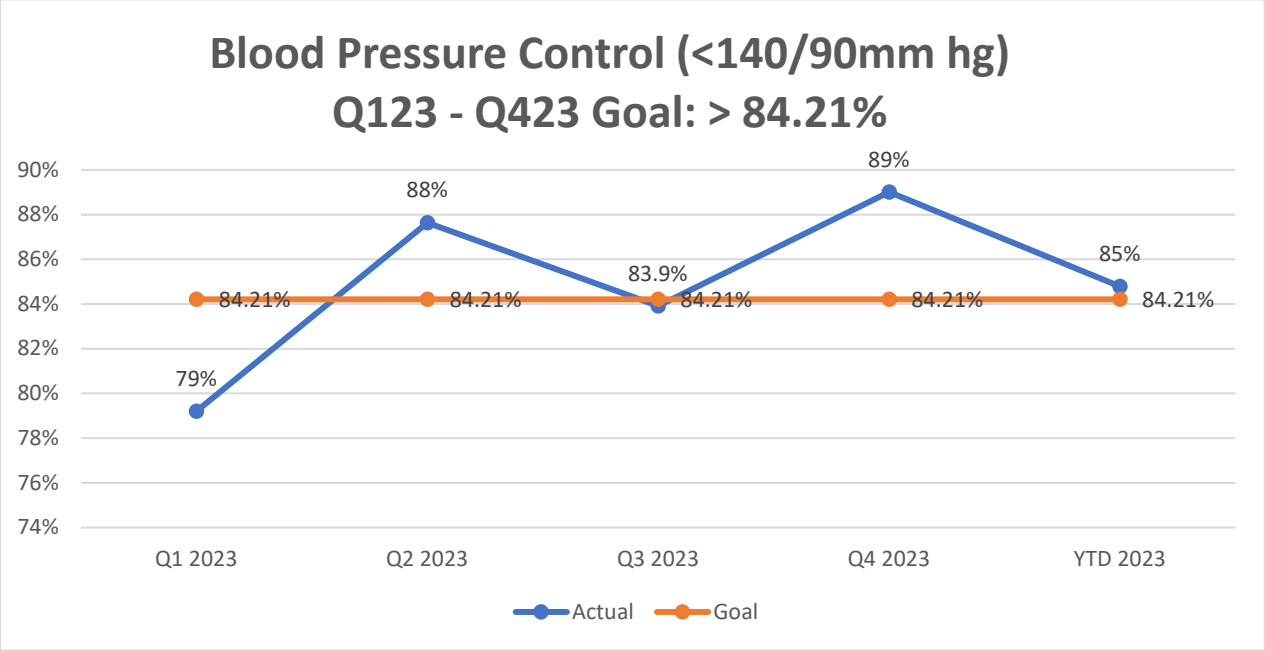
We were able to meet and exceed our POLST goal in 2023. Through the efforts of our PCPs and the PACE Medical Director we were able to improve on our 2022 year end performance of 94%. End-of-life decisions are reviewed with the participant by the Provider to complete this important document that respects the wishes of each participant. End-of-life and palliative health care discussions continue to be integrated into our Interdisciplinary Team meetings (IDT) and are documented in the participant's health care plan. In 2024, we plan to continue our efforts to ensure that our participants have a POLST in place.

QI23.07 Increase the percentage of PACE participants with diabetes who have controlled blood pressured (<140/90 mm hg)

Goal: > 84.21% of Diabetic participants will have a Blood Pressure of <140/90 (Goal in line with Medicare Quality Compass HEDIS 95th percentile).

Goal: Met

Data/Analysis: The 2023 final average was 85%.



Summary and Key Findings/Opportunities for Improvement:

By the end of 2023, we were able to meet our diabetic blood pressure monitoring goal. For 2024 we plan to expand our participant blood monitoring element to also include participant who have a diagnosis of hypertension whether they are diabetic or not. Blood pressure control is measured as regular readings of <140/90 mm HG.

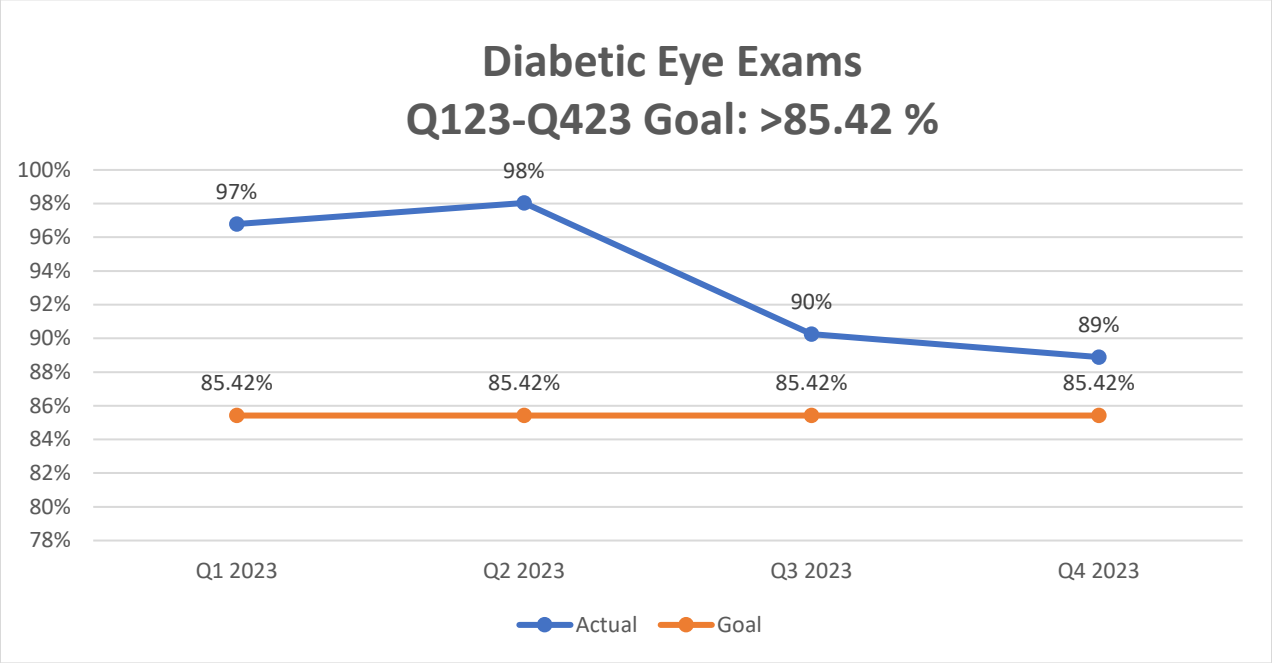
The 2024 goal will be that >82.98% of participants with Hypertension *and/or* Diabetes sill have blood pressure controlled (Comparable to the MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in 2024 QI Work Plan).

QI23.08 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: Greater than 85.42% of Diabetic participants will have an Annual Eye Exam (Goal in line with Medicare Quality Compass HEDIS 95th percentile).

Goal: Met

Data/Analysis: The 2023 final rate was 89%.



Summary and Key Findings/Opportunities for Improvement:

We exceeded our target goal, with 89% of diabetic participants having received an annual eye exam in 2023. With the assistance of monthly reports generated by the PACE QI team, providers were alerted to those diabetic participants who required eye exams. Those participants were then scheduled for an appointment with their PCP on an annual and semi-annual basis. Contracted ophthalmologists and optometrists are very diligent in their follow-up and provide our medical team with timely specialty reports. These results are well above the 2021 Medicare HEDIS Quality Compass 95% percentile. In 2024, the goal will be changed to >87.29% of Diabetics will have an Annual Eye Exam (Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2024 QI Work Plan). We anticipate no difficulty in once again meeting or exceeding this goal in 2024.

QI23.09 Increase the percentage of PACE participants with diabetes who receive nephropathy monitoring

Goal: Greater than 98.78% of Diabetics will have Nephropathy Monitoring (Goal in line with Medicare Quality Compass HEDIS 95th percentile).

Goal: Met

Data/Analysis: The 2023 final rate was 100%.

Summary Key Findings/Opportunities for Improvement: In 2023, 100% of our diabetic participants received nephropathy monitoring. The PACE QI department worked closely with the medical team in providing data generated reports identifying which participants required nephropathy screening/monitoring. These results were comparable to a 2020 Medicare HEDIS Quality Compass 95th percentile. As we have measured 100% in 2023, 2022, and 2021, we feel that we have implemented very effective processes for nephropathy monitoring and no longer need to use this as a quality workplan measure. This element will not be included in the 2024 workplan, however, we will still ensure that our successful methods of monitoring continue.

QI23.10 Ensure participants who fall are evaluated for osteoporosis

Goal: 100% of participants who have a fall will have a bone density scan to assess for osteoporosis

Goal: Not Met

Data/Analysis: The 2023 final rate was 78%.

Quarter 2023	Rate
Q1	70%
Q2	77%
Q3	84%
Q4	82%
EOY	**78%**

Summary Key Findings/Opportunities for Improvement: In 2023, we focused on ensuring that all participants who sustain a fall will have been identified for Osteoporosis and bone fracture risks using Dual-energy X-ray absorptiometry (DEXA) scans. This was a new quality element for PACE, and while we did not meet our goal of 100%, we made great strides in the number of at-risk participants who were scanned for Osteoporosis in 2023. For 2024 we will adapt this element to examine not just participants who have a fall, but all participants who meet certain criteria for assessment. Our goal will be at least 75% of eligible participants will have a DEXA scan on file to identify and treat osteoporosis and reduce the risk of fractures.

QI23.11 Reduce percentage of falls reported by PACE enrollees

Goal: <72 Falls reported per quarter in 2023.

Goal: Not Met

Data/Analysis:

The 2023 rate was an average of 75 fall per quarter:

Quarter 2023	# Falls Per Quarter
Q1	78
Q2	59
Q3	78
Q4	85
EOY	**75**

Summary Key Findings/Opportunities for Improvement:

Although we did meet our goal in Q2 2023, we were unable to meet the goal for the other three quarters of 2023, ultimately falling just short of our overall goal for the year. We have developed multiple strategies for prevention of recurring falls. After each fall, the rehabilitation team of licensed physical and occupational therapists determines if fall is mechanical or related to any medical problems of participant. The PCP and nursing team will check on medical factors and provide referrals and other interventions, as necessary. Pharmacy and provider work together to check medications if need to be adjusted for cases that concern loss of balance, dizziness, or muscle weakness. Rehabilitation, homecare coordinator, and social provide interventions for

mechanical falls such as tripping and or any changes in participant's environment and living situation. All other disciplines provide their input and interventions as the need arises.

In 2024 we will continue our increased surveillance of repeat faller by continuing mandatory home assessments and follow up completed by PACE to reduce total number of falls at home. We will also re-implement the PACE Fall Committee. The Fall Committee meets once every quarter to discuss on-going trends, identify barriers, recommend interventions, and implement strategies to manage fall incidents in CalOptima Health PACE. The Fall Committee is composed of the Medical Director, Center Manager, a Rehab Department Representative, and Clinic representative. Additional attendees may be asked to join as deemed necessary.

QI23.12 Reduce potentially harmful drug/disease interactions in the elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <24.64% of elderly PACE participants with Dementia will be prescribed a tricyclic antidepressant or anticholinergic agent. (Goal in line with Medicare Quality Compass HEDIS 95th percentile).

Goal: Met

Data/Analysis: The 2023 rate was 18%

Quarter 2023	%Per Quarter
Q1	17%
Q2	19%
Q3	19%
Q4	18%
EOY	**18%**

Summary and Key Findings/Opportunities for Improvement:

In 2023, only 18% of our participants who were diagnosed with dementia were prescribed a tricyclic antidepressant or anticholinergic agent, a decrease of 1% from 2022. The PACE QI department worked closely with the medical team and generated reports of participants with dementia who were also prescribed cautionary medications. On a monthly basis our medical providers, clinical pharmacists and data specialists, review in detail all the medications that are considered "red flags" per CMS and Beer's criteria. This is shared with other clinical medical providers and alternative medication options are discussed during provider meetings. Our clinical pharmacist is instrumental in reviewing medications ordered by providers, confirming that there are no contraindications to the drugs and then recommending alternative medication options, thereby preventing adverse outcomes. In 2024 we will be changing our goal from <24.64% to <25% (Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2024 QI Work Plan) and feel confident that we will once again exceed this goal.

QI23.13 Reduce potentially harmful drug/disease interactions in the elderly (DDE): Chronic renal failure + nonaspirin NSAIDS or Cox2 selective NSAIDs

Goal: <2.62% of PACE participants with Chronic Renal Failure will be prescribed a Nonaspirin NSAID or Cox2 Selective NSAID (Goal in line with Medicare Quality Compass HEDIS 95th percentile).

Goal: Met

Data/Analysis: The 2023 rate was 1.0%.

Quarter 2023	%Per Quarter
Q1	1.3%
Q2	1.3%
Q3	0%
Q4	1.2%
EOY	**1.0%**

Summary and Key Findings/Opportunities for Improvement:

Careful review of participants with chronic kidney disease who are prescribed NSAIDS is an important factor in limiting the progression of kidney disease. Our PACE clinical pharmacists are a vital asset in monitoring potential drug/disease interactions and presenting therapeutic alternatives to the medical provider. The continued coordinated efforts of the PACE medical providers and the PACE clinical pharmacists will ensure optimal scrutiny in the use of NSAIDs among our participants with chronic kidney disease. Due to our continued success in surpassing our goal for this element each year for several years, we will be removing this element from our quality work plan in 2024.

QI23.14 Monitor participants who are receiving prescription opioids for 15 days or more days at an average milligram morphine equivalent (MME) dose of 90mg

Goal: 100% of participants receiving high dose opioids for 15 or more days at an average MME 90mg will be reevaluated monthly by their treating provider.

Goal: Met

Data/Analysis: The 2023 rate was 100%

Quarters 2023	# Participants on high dose opioids with PCP follow up
Q1	2 out of 2 participant reevaluated (100%)
Q2	1 out of 1 participant reevaluated (100%)
Q3	1 out of 1 participant reevaluated (100%)
Q4	1 out of 1 participant reevaluated (100%)

Summary and Key Findings/Opportunities for Improvement:

In the 2023 we were able to fully meet our goal of 100% provider opioid evaluation in each quarter. It should be noted that we have very few participants who exceed the established recommendations of daily morphine MME dosing. The PACE QI department works in concert with the pharmacy team to identify any participants who may be taking high dosage opioids. These specific participants are then added onto the provider's monthly schedule so that appropriate

participant/PCP follow-up can occur. We will continue to track and monitor this element and anticipate that we will again achieve 100% in 2024.

QI23.15 Increase the percentage of participants for whom medications were reconciled within 10 days of hospital and/or skilled nursing discharge

Goal: ≥ 90% of participants will have their medications reconciled within 10 days of hospital discharge or skilled nursing facility (SNF) in 2023

Goal: Met

Data/Analysis: 99% of participants had medications reconciled within 10 days post discharge in 2023.

Quarters 2023	# Participants with Medication Reconciliation within 10 days of discharge
Q1	98%
Q2	100%
Q3	100%
Q4	100%
EOY	99%

Summary and Key Findings/Opportunities for Improvement:

Reconciliation of medications post hospital and/or skilled nursing facility discharge remains one of our top priorities. Our clinic staff maintain a close relationship with our participants across all levels of health care to improve the continuity of care. This partnership allows for prompt medication reconciliation after hospital discharge or skilled nursing stay. Our clinical pharmacists play a vital part in the reconciliation process as well as dedicated additional clinical staff members assigned to handle reconciliation for hospital and SNF discharges. In 2023, we changed the goal of Post-Discharge Medication Reconciliation from the previous year. Our 2022 goal was to have ≥ 90% of participants with medication reconciled *within 15* days after discharge but in 2023 we improved upon that goal by changing it to *within 10* days after discharge. This goal was shifted to better ensure that our participants post-discharge needs are met in a timely manner to help prevent recurrent hospital admissions. We met and exceeded that goal in 2023 and in 2024 we will challenge ourselves once again with a new goal that ≥93% of participants will have their medications reconciled *within 7 calendar days* of hospital and/or skilled nursing facility discharge.

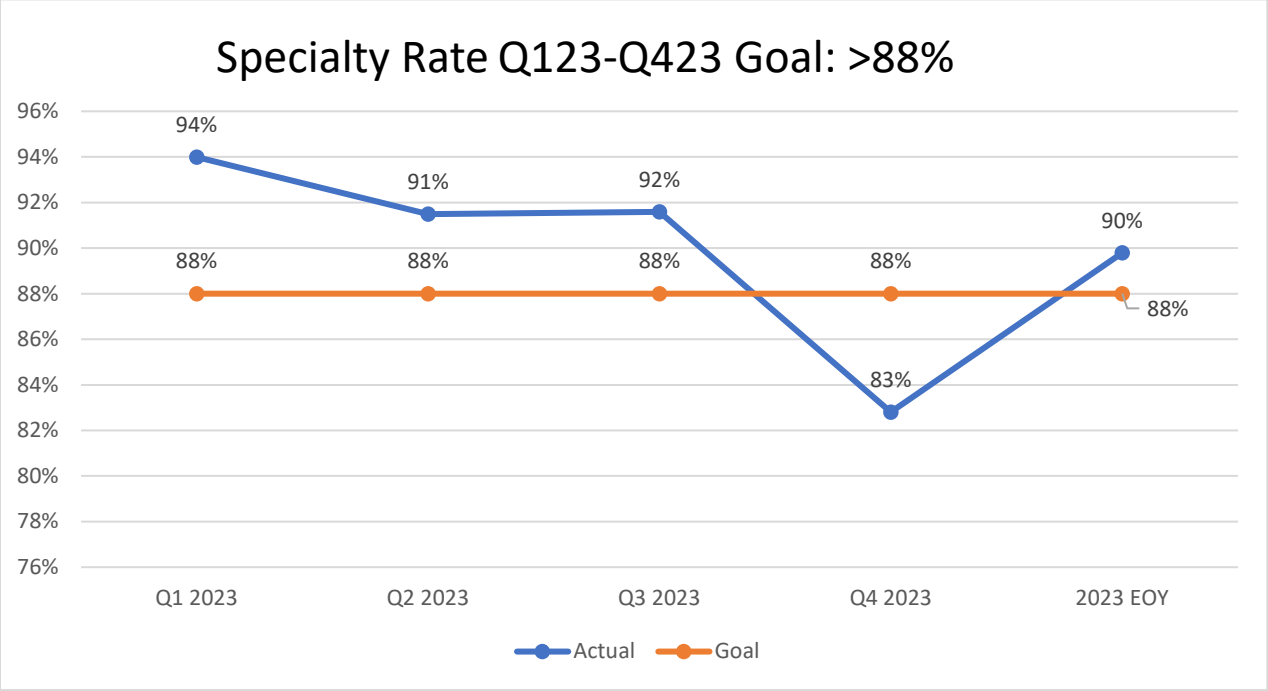
Access and Availability

QI23.16 Improve access to specialty health care providers

Goal: ≥ 88% of specialty health care authorizations will be scheduled within 14 business days in 2023

Goal: Met

Data/Analysis: The 2023 end of year rate was 90%.



Summary and Key Findings/Opportunities for Improvement:

Our PACE scheduling department continues to utilize strategies put in place to improve access to specialty health care. In the past, we expanded the number of staff dedicated to scheduling specialty appointments. Specialty scheduling is complex in that the staff member not only schedules the appointment for the participant, but also handles appointment confirmation, coordinating transportation needs, and submitting relevant medical records to the specialist.

Throughout 2023, we have been able to increase some of our in-house specialty health care activities, such as dentistry and podiatry care. As part of our operational Work Plan for 2024, we will continue to identify additional core specialists who understand the PACE model of care and are willing to work closely with the program. This will improve scheduling access as well as health care coordination through prompt consultation notes and real-time dialogue between the specialist and PACE PCP. Despite a slight decrease in Q4 2023, we ultimately met our quality goal for 2023. In 2024 we plan to improve upon our goal for this element by raising the percentage from ≥ 85% of specialty health care authorizations that will be scheduled within 14 business days to ≥ 90%.

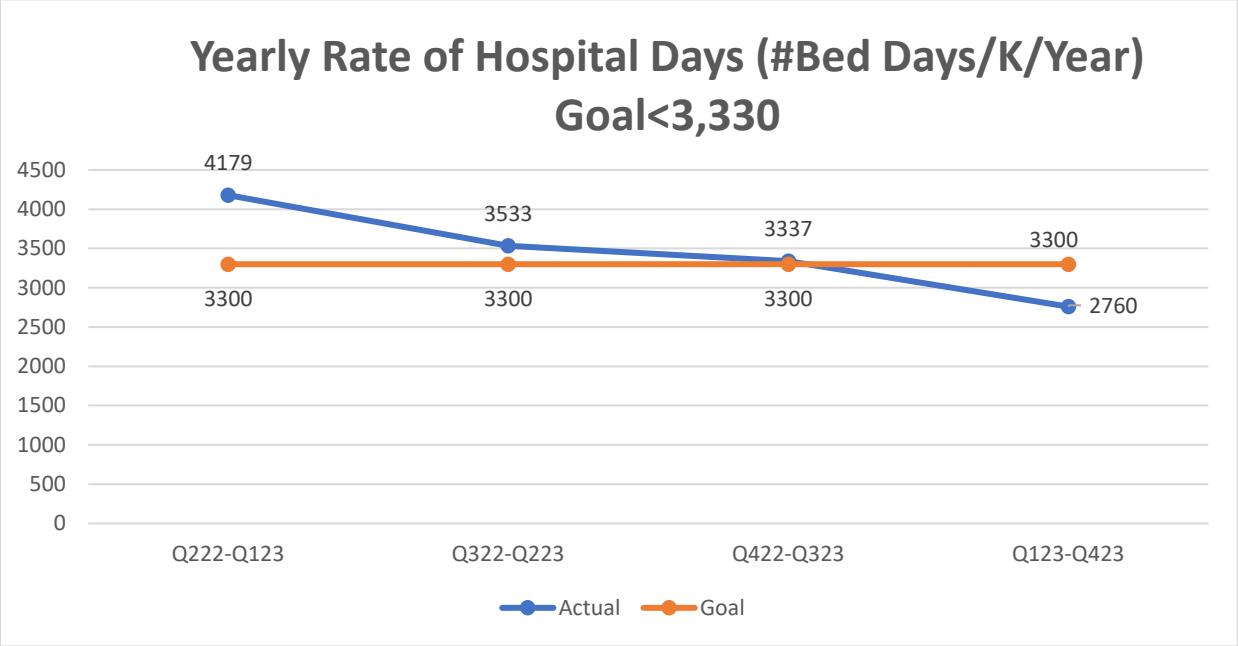
Utilization Management

QI23.17 Reduce the rate of acute hospital days by PACE participants

Goal: < 3,330 hospital days per 1000 per year in 2023.

Goal: Met

Data/Analysis: The 2023 ending rate was 2760 bed days per 1000 per year.



Summary/Key Findings/Opportunities for Improvement

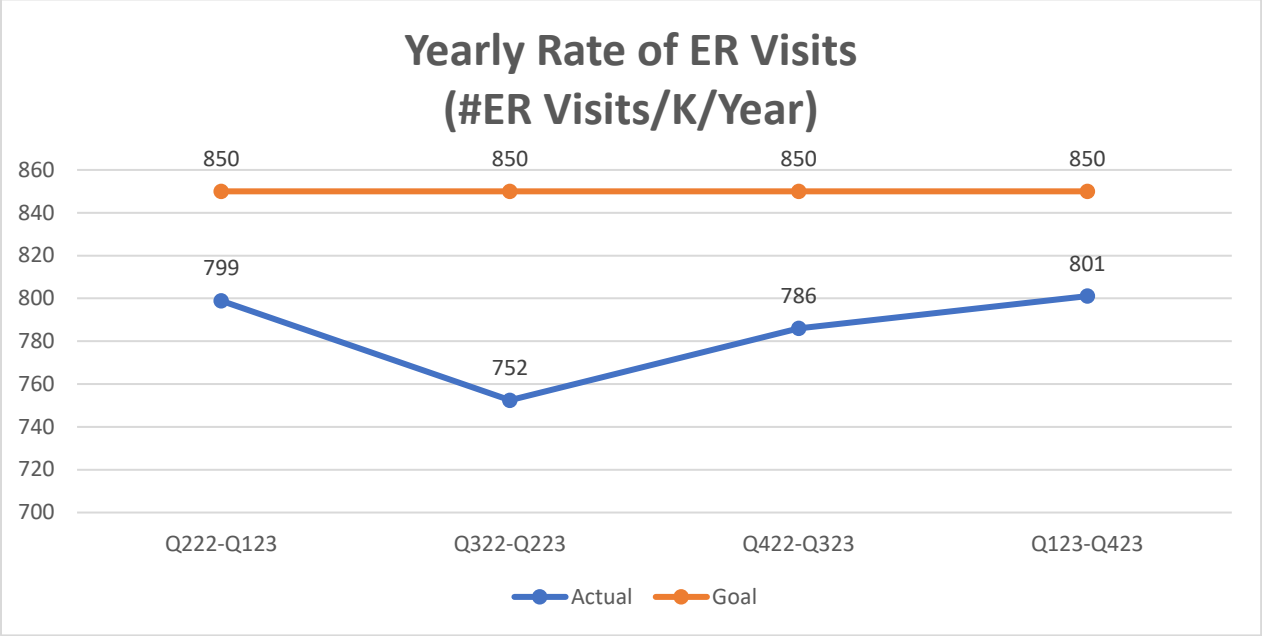
CalOptima Health PACE met our goal of <3,300 hospital days per 1000 per year by the end of 2023. Despite the high number of medically complex patients that are part of our program, we were able to reduce the overall number of hospital bed days and meet our end of year goal in 2023. PACE participants hospital days are monitored and analyzed by the PACE QI department who work with the PACE Medical Director and clinical teams to develop strategies to lower that rate through preventative health care and education. We will maintain this goal as part of the 2024 Work Plan.

QI23.18 Reduce the rate of ER utilization by PACE participants

Goal: < 850 emergency room visits per 1000 per year in 2023

Goal: Met

Data/Analysis: The 2023 rate was 801 emergency room visits per 1000 per year.



Summary and Key Findings/Opportunities for Improvement:

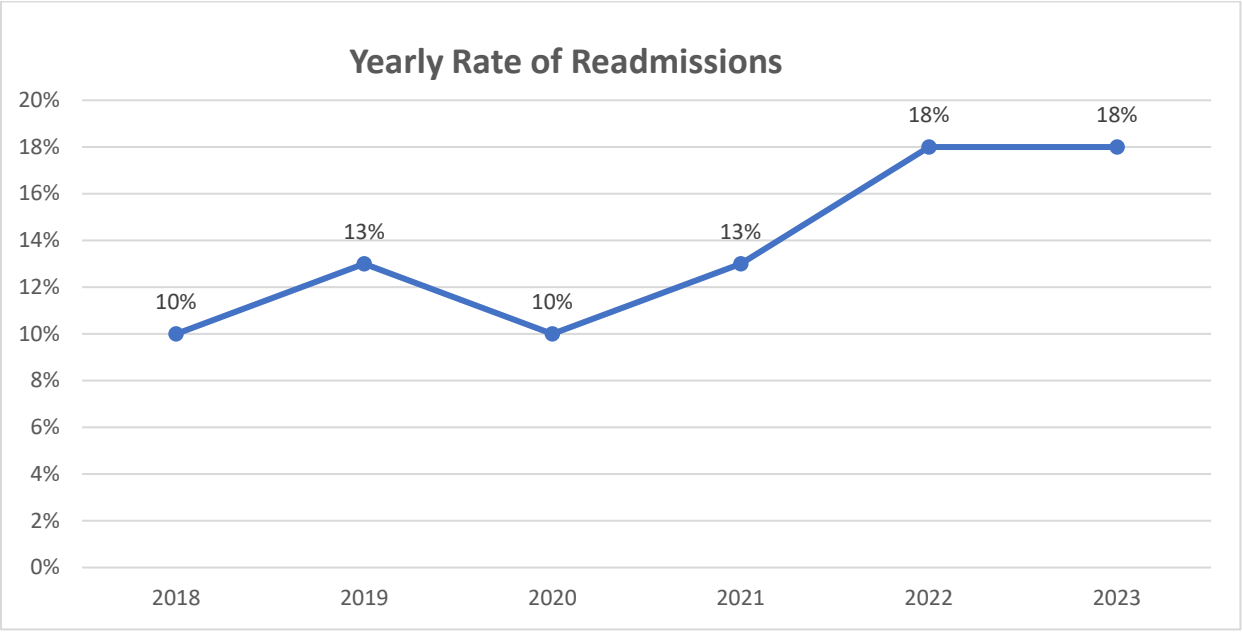
PACE noted a remarkable decline in ER visits per thousand per year in 2023. ER utilization by PACE participants is monitored and analyzed by the PACE QI department who work with the PACE Medical Director and clinical teams to develop strategies to lower ER utilization rates. Additionally, using our 24-hour on-call provider service, we provide round-the-clock assessment of participants and provide ER diversion as warranted. In 2024 we plan to improve upon this utilization element by changing the benchmark from < 850 emergency room visits per 1000 per year to < 825 emergency room visits per 1000 per year.

QI23.19 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 14% 30-day all cause readmissions in 2023.

Goal: Not Met

Data/Analysis: The 2023 end of year rate was 18%.



Summary and Key Findings/Opportunities for Improvement:

PACE readmission rates tend to have variance due to a small group of participants with high level medical needs. We ended 2023 with an 18% 30-day readmission rate which indicates the same performance as in 2022. Our major challenges in readmissions are the medical complexity of our participants, non-compliance on the part of the participant and lack of family support. Our readmission numbers were also affected by planned readmissions related to cancer treatment. In 2023, we continued to incorporate the morning clinical huddles into the interdisciplinary team meetings (IDT) and discuss participant's post-discharge planning. PCPs also followed up with participants soon after their hospital discharge in order reassess the participants immediate health needs following hospitalization as well as any long-term need for changes in health care plan to prevent additional hospitalizations. For 2024, we continue to strive to reach lower readmission rates and will maintain our goal of a <14% 30 day all cause readmission.

QI23.20 Decrease the percentage of participants who are placed in a long-term custodial health care facility

Goal: < 4% of participants will reside in long-term health care (LTC) in 2023.

Goal: Met

Data/Analysis: 2023 rate was 0.92% of the PACE enrollment resided in long-term care.

Summary and Key Findings/Opportunities for Improvement:

One of the most important tenets of the PACE program is to help our participants continue to live safely within their own homes for as long as possible. We ended 2023 with only 0.92% of our participants residing in LTC, both meeting our goal and far surpassing our 2022 end of year percentage of 3.4%. On occasion, PACE participants need temporary placement in LTC as a custodial health care measure. These are participants with complex medical conditions that require complicated workups, specialty health care, or who have difficulty with maintaining their health care plan on their own at home. These participants benefit from placement in LTC facilities until their health is stabilized and they can be reassessed and reeducated regarding their health plan. In

2023 we worked closely with CalOptima Health's Long Term Support Services (LTSS) department to identify and assist individuals who are no longer were able to reside safely in their homes and therefore benefit as participants in PACE. These participants had their health care safely transferred to provide the best possible outcome to the participants and families utilizing LTSS. In 2024, we plan to maintain our benchmark and continue to investigate solutions to address the individualized health care needs of our unique population.

Enrollment/Disenrollment

QI23.21 Increase the qualified lead to enrollment conversion rate

Goal: Increase the qualified lead to enrollment conversion rate to 65% in 2023.

Goal: Met

Data/Analysis: Final rate was 75%.

Quarter 2023	Rate
Q1	71%
Q2	78.3%
Q3	74%
Q4	71%
EOY	**74%**

Summary and Key Findings/Opportunities for Improvement:

In 2023, we again exceeded our goal in the percentage of qualified leads to enrollment. This afforded the frail and elderly in our community greater access to health care in an environment which also supports their physical, rehabilitative, and psychosocial needs.

Several strategies led to successful enrollment:

1. Our screening, intake, and assessment tools to screen-out enrollees including those who were too high-functioning and would not be eligible per state certification, although they initiated an inquiry.
2. Utilization of data indicating origins of referrals to PACE.
3. Various marketing collateral which educated the community in the benefits of enrolling in PACE.

In 2024 we will continue to review and analyze the Qualified Lead to Enrollment conversion rate and develop additional strategies to improve our conversion rates. In 2024 we will increase our conversion rate benchmark from 65% to 70%.

QI23.22 Decrease the number of controllable disenrollment within 90-days of enrollment

Goal: The percentage of participants who disenroll for controllable reasons from the program within the first 90 days of enrollment will be less than 6.5%

Goal: Met

Data/Analysis: Final rate was 2.75%.

Quarter 2023	Rate
Q1	6%
Q2	0%
Q3	4%
Q4	0%
EOY	**2.75%**

Summary and Key Findings/Opportunities for Improvement:

In 2023, we exceeded our goal to reduce the number of participants who disenroll for controllable reasons within their first 90 days with the PACE program. This is accomplished by ensuring that new enrollees fully understand the PACE model and program benefits during the enrollment process. New enrollees are provided with a thorough orientation to CalOptima Health PACE. PACE initial assessments and health care plans are completed in a timely manner. Participants are introduced to their care team and encouraged to ask questions regarding their health care needs, day center services, and transportation. In 2024, we will challenge ourselves by changing our goal from <6.5% to <6%.

QI23.23 Decrease the PACE attrition rate

Goal: Maintain a PACE participant attrition rate of ≤10 %

Goal: Met

Data/Analysis: Final rate was 6.31%.

Quarter 2023	Rate
Q1	7.82%
Q2	7.14%
Q3	5.81%
Q4	4.53%
EOY	**6.31%**

Summary and Key Findings/Opportunities for Improvement:

PACE met our end of year goal in reducing the attrition rate. This was a new element created in 2023 to improve our member retention by thoroughly investigating each PACE disenrollment. This goal was accomplished through examination into each potential disenrollment by PACE Center Manager and the SW team to discover the member's reasons for potential disenrollment and implement interventions to prevent disenrollment whenever possible. Disenrollment interventions include one-on-on meeting with participants and their family members, complaint investigation, and case management to ensure that participant's medical, physical, emotional, social needs are being met by our program.

Transportation

QI23.24 and QI23.25: Improve contracted transportation performance

Goal QI23.24: 100% of transportation trips will be less than 60 minutes in 2023

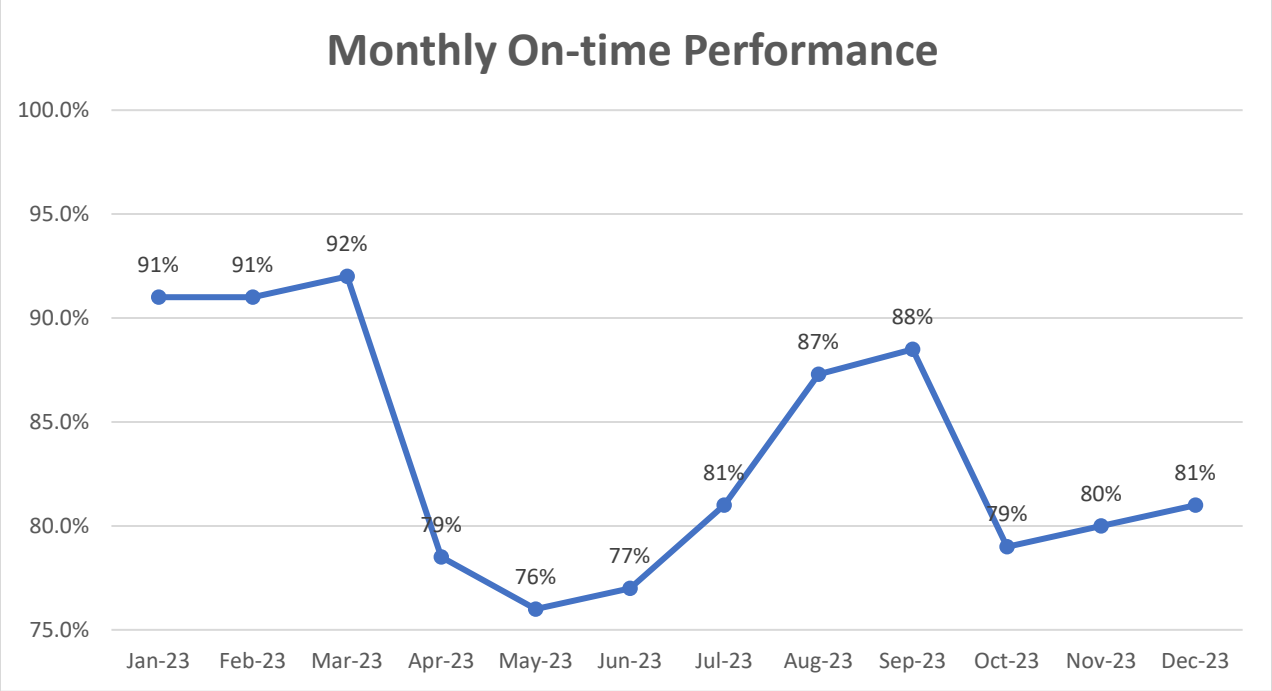
Goal: Not Met

Quarter 2023	Rate
Q1	100%
Q2	100%
Q3	100%
Q4	99.83%
EOY	**99.95%**

Goal QI32.25: ≥92% of all transportation rides will be on-time in 2023

Goal: Not Met

Quarter 2023	Rate
Q1	91%
Q2	77%
Q3	86%
Q4	80%
EOY	**84%**



Summary and Key Findings/Opportunities for Improvement:

Regarding the first transportation performance goal that all one-way trips be 60 minutes or less, PACE fell just shy of the 100% goal, with an EOY rate of 99.95%. As the COVID-19 Public Health Emergency ended in Q2 2023, for the first time in several years PACE was able to fully re-

open day center services. Despite these increased demands, the contracted transportation company was still able to generally maintain an excellent record with very few overall one-hour trip violations in relation to the volume of trips.

For 2023, the contracted transportation vendor ended the year with an on-time performance rate of 84%, falling short of the goal that ≥92% of all transportation rides would be on-time in 2023. On time performance is an extremely important area as it affects transportation related grievances, overall satisfaction with services, and PACE member retention. In October 2023, the PACE leadership team launched a weeklong investigation into transportation on-time performance by having the management team do ride-alongs with contracted drivers noting any errors and areas for improvement. This information was compiled and shared with the contracted transportation vendors executive team. PACE leadership continues to work very closely with the contracted transportation team though daily operational discussion, monthly performance review meetings, grievance review, and participant satisfaction surveys.

QI23.26: Transportation satisfaction

Goal: ≥93.6% on the Overall Satisfaction with Transportation Services summary score on the 2023 PACE Satisfaction Survey

Goal: Met

Data/Analysis: 2023 rate was 95% Overall Satisfaction with Transportation.

Summary and Key Findings/Opportunities for Improvement:

In Summer/Fall 2023, CalOptima Health PACE once again contracted with Vital Research to conduct the annual Participant Satisfaction Survey. Vital Research interviewed 114 of our participants via telephone, to gauge the participants' satisfaction with CalOptima Health PACE services. This is a standardized survey completed by PACE organizations throughout California and the United States.

Despite not meeting our transportation performance goals in 2023, we were able to meet and exceed our transportation satisfaction goals in 2023, with a weighted summary score above the national average. 95% of participants surveyed stated that PACE van service was *Good* to *Excellent*. We take participant satisfaction with services very seriously and always strive to maintain the highest level of satisfaction, addressing any concerns immediately. In 2023 we will maintain our goal at ≥93.6% to compare with 2023 national averages. Our 2024 Quality Workplan also includes a Quality Initiative to address participant concerns with transportation to raise satisfaction and reduce grievances.

Meals

QI23.27: Meal satisfaction

Goal: ≥ 71.1% on Satisfaction with Meals summary score on the 2023 PACE Satisfaction Survey

Goal: Met

Data/Analysis: 88% overall weighted participant satisfaction summary score on the 2023 Participant Survey Satisfaction with Meals Domains.

Domain	2022	2023	2023 National Average
Do the meals look good?	82%	**85%**	70.5%
Do the meals taste good?	76%	**84%**	62.4%
Do you get a variety of foods?	89%	**96%**	82.2%

Summary and Key Findings/Opportunities for Improvement:

In 2023, we met our benchmark with 88% of PACE participants indicating satisfaction with their meals, far exceeding the PACE national average. Survey responses indicated that most participants are satisfied with the look, taste and variety of meals provided by PACE. In 2023 we made an active effort to present a variety of meals which were not only nutritious, but also consistent with the cultural background of our participants. We will continue to monitor this domain in 2024.

Participant Satisfaction

QI23.28 Improve the *overall* satisfaction of participants and their families with the CalOptima Health PACE program

Goal: Greater than or equal to 88.6% Overall Satisfaction Weighted Average on the 2023 PACE Satisfaction Survey.

Goal: Met

Data/Analysis: 94% overall weighted participant satisfaction summary score.

2023 Participant Survey Domains

Domain	CalOptima Health PACE 2022	CalOptima Health PACE 2023	2023 National Averages
Transportation	89%	**95%**	93.6%
Center Aids	96%	**98%**	92.0%
Home Care	85%	**89%**	85.6%
Medical Care	87%	**92%**	89.1%
Health Care Specialist	85%	**92%**	88.4%
Social Worker	95%	**99%**	94.5%
Meals	82%	**88%**	71.5%
Rehabilitation Therapy and Exercise	93%	**98%**	92.9%
Recreational Therapy	84%	**96%**	79.2%
General Service Delivery	92%	**94%**	86.7%
Weighted Summary Score	89%	**94%**	88.6%

Summary and Key Findings/Opportunities for Improvement:

The *overall* satisfaction score was 94% which was both a significant increase from 2022 as well as several percentage points above the 2023 PACE national average.

We saw an increase in satisfaction scores from 2022 across all PACE domains and exceeded the national averages in each area. In 2024 we hope to continue excellence in participant satisfaction by having our all Alternative Care Setting sites up and running, reducing transportation related grievances and maintaining the highest possible level of service satisfaction in every field. We will continue to improve meal satisfaction through frequent internal surveying of participants, encouraging them to make suggestions their regarding food preferences.

SECTION 5: 2023 HEALTH PLAN MANAGEMENT

2023 HPMS: Quality information is reported to CMS on a quarterly basis via the Health Plan Management System (HPMS) and to DHCS via email. The following elements are reported:

1. Grievances
2. Appeals
3. Quality Incidents which require Root Cause Analysis
4. Medication Errors
5. Immunizations (evaluated in the Quality-of-Care section of this report)
6. Falls without Injury
7. ER Visits (evaluated in the Utilization Management section of this report)
8. Denials of Prospective Enrollees

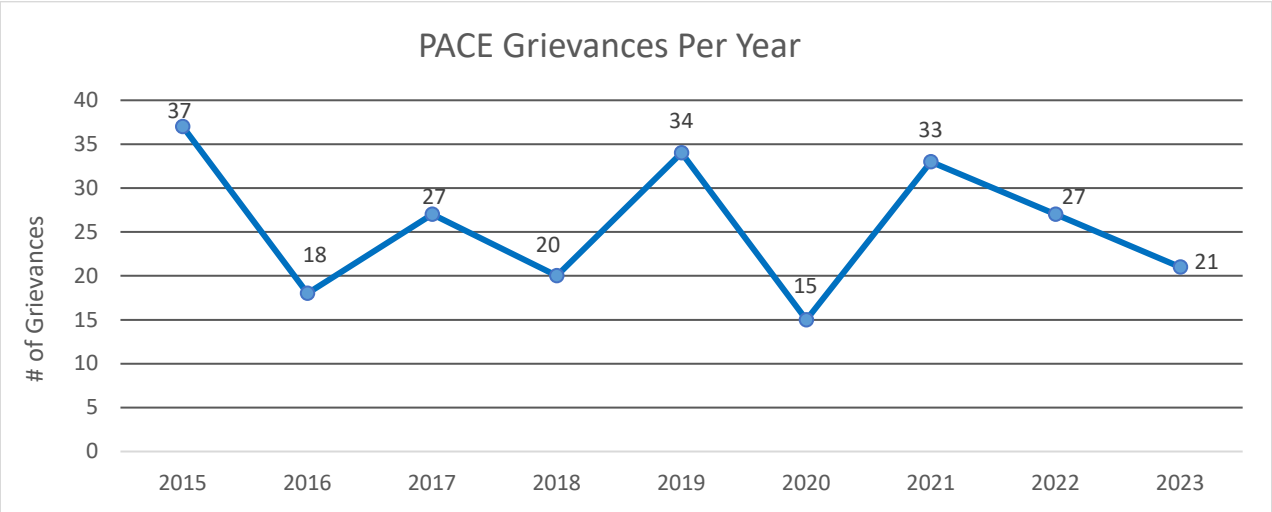
Grievances

Data Analysis:

Quarterly Grievances Q1 2023–Q4 2023

		Grievance Categories			
	# Grievances	Transportation	Contracted Specialist	Medical Care	Communication
Q1 2023	5	4	0	1	0
Q2 2023	11	6	2	1	2
Q3 2023	3	2	1	0	0
Q4 2023	2	2	0	0	0
Total	**21**	**14**	**3**	**2**	**2**

PACE Grievances Per Year 2015–2023



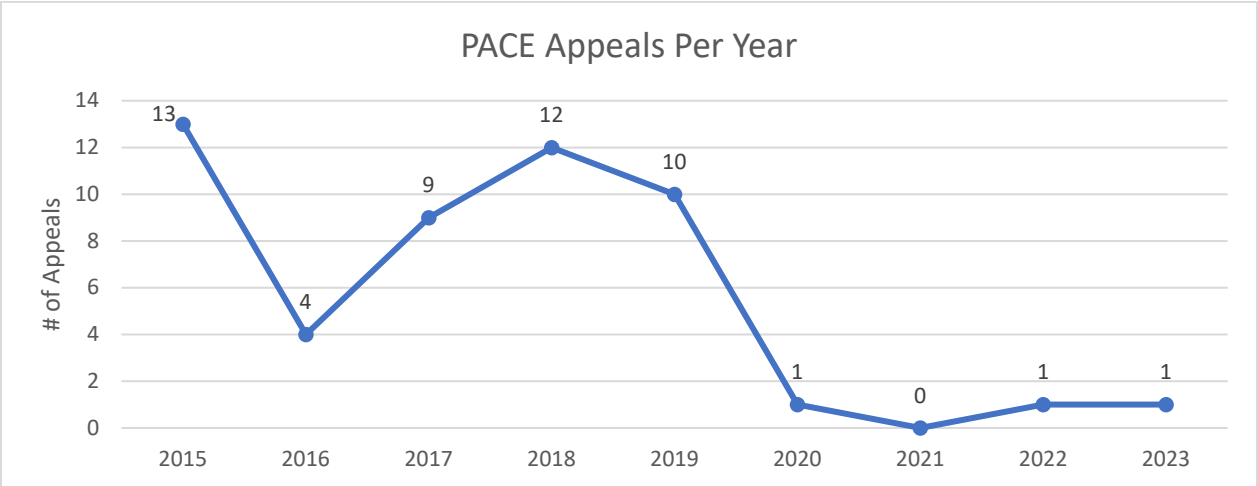
In 2023, we saw a decrease in the number of grievances filed by participants. Many of the grievances that were filed were transportation related issues such as being picked up late. All grievances are investigated by our QI department and a resolution to the grievance is provided to the participant within a 30-day period. To fully resolve all transportation related grievances, we share the grievances directly with our contracted transportation provider, Secure Transportation, and their Quality Assurance department. The Secure QA department thoroughly researches each grievance and provides us with their investigation and resolution notes. Additionally, grievance issues are discussed during our monthly scheduled Secure Transportation meeting with the transportation leadership team. Corrective action plans are used as needed.

Most participants filing grievances are satisfied with the resolutions reached by the PACE QI department. As with previous years, we will continue to monitor and observe trends with grievances filed.

Appeals

Data Analysis:

PACE Appeals Per Year 2015–2023

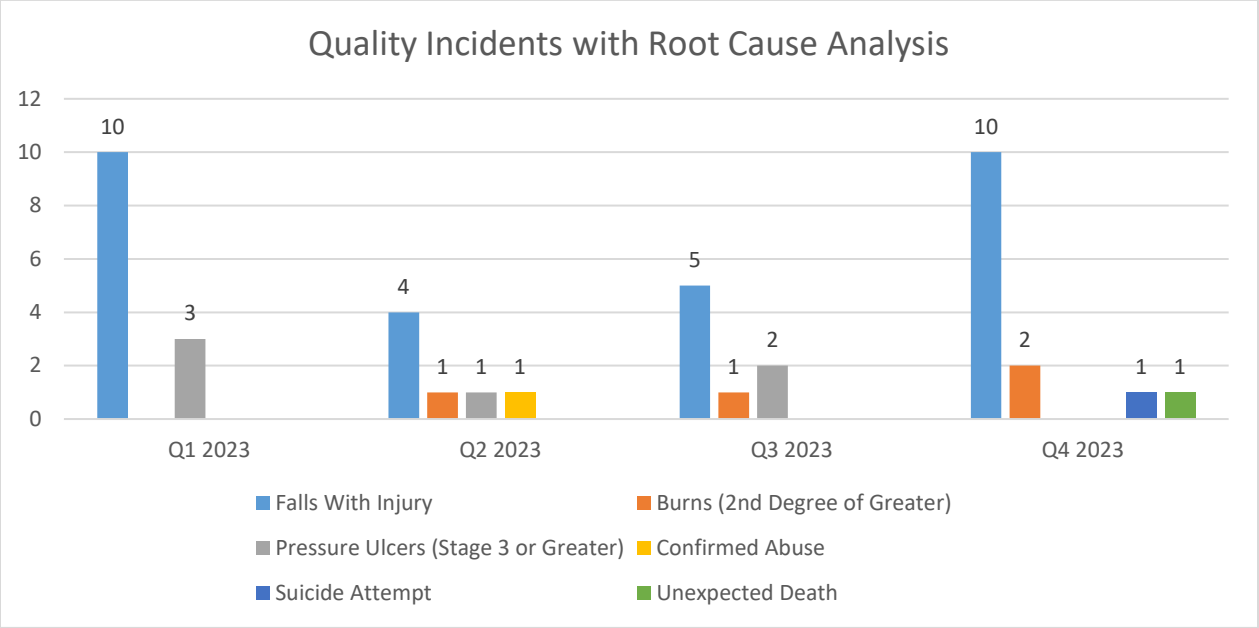


Appeals by participants continued to be minimal in 2023. Only 1 appeal was finalized in 2023, which was an appeal to reverse a denial of enrollment into CalOptima Health PACE. A prospective PACE enrollee was denial enrollment with CalOptima Health PACE due to health and safety concerns. A family member of that prospective enrollee appealed the denial by requesting a State Hearing through the California Department of Social Services (CDSS). During that process, information was presented to an assigned Administrative Law Judge. This judge rendered the decision to uphold the original PACE denial on 1/17/23.

Quality Incidents

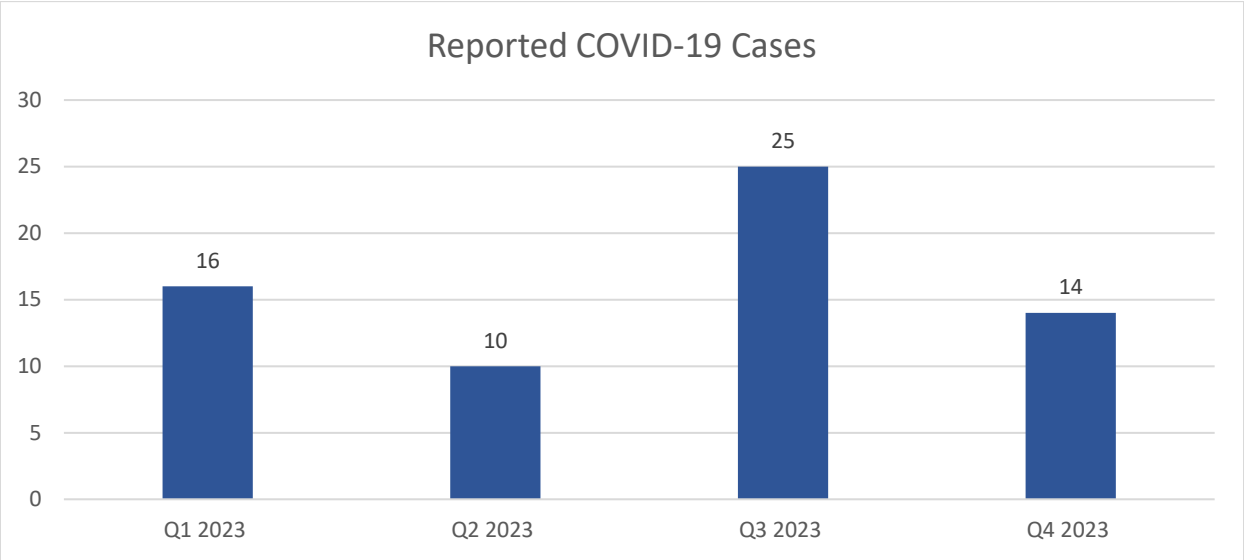
Description of Reportable Incidents: All quality incidents are monitored by the PACE QI team. Quality incidents including falls with injury, elopements, burns, pressure ulcers (stage III–IV, unstageable), motor vehicle accidents and infectious disease outbreaks and are reported to CMS and DHCS. Essentially, the objective is to monitor the health and safety of PACE participants as well as the effectiveness of our risk management and QI program. All quality incidents are reported to the QI team with an ensuing root cause analysis (RCA) completed for each incident as required. The RCA begins with the QI team investigating the incident (what, where and when) then followed by a meeting of appropriate disciplines such as nursing, social worker, and rehabilitation services. Potential causes of the incident are discussed and interventions to prevent further occurrences are implemented.

Data Analysis:



Falls with injury are generally one of the most prevalent quality events at PACE. As in previous years, most falls in 2023 were either a result of non-use of durable medical equipment or lack of family supervision of participants who are at risk for falls at home. In addition to the above, PACE continues to monitor for infectious disease outbreaks related to COVID-19 cases. In quarter 3 of 2023, we experienced a small surge in community based COVID-19 cases. All participants with a reported case of COVID-19 infection had follow up from the PACE clinic nurse and primary health care provider to assess needs. The anti-viral medication Paxlovid was provided in all appropriate cases, as well as any medication needed for symptom relief. Additionally, all cases

were reviewed by QI in compliance with the established PACE Infection Control manual. There were no PACE deaths from COVID-19 reported in 2023.

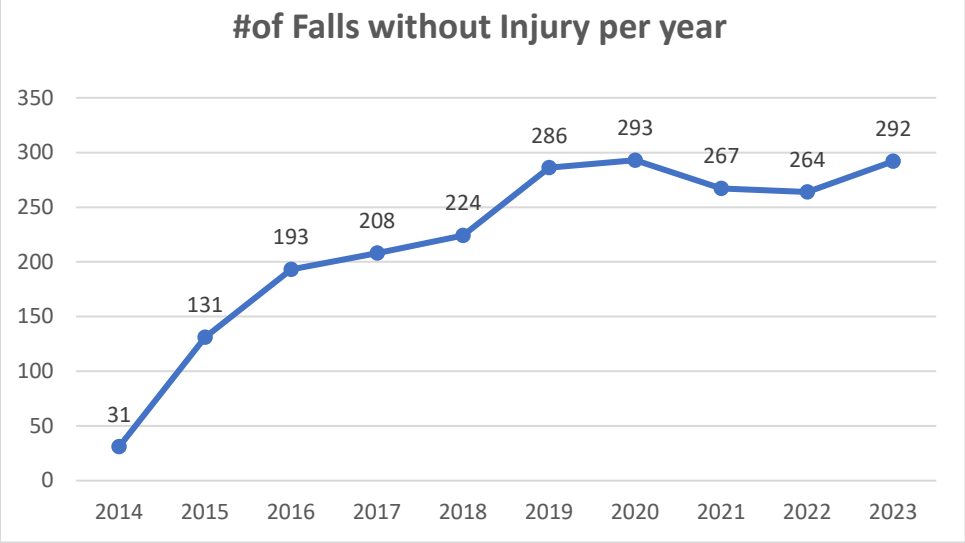


Medication Errors

A total of 4 medication errors were reported in 2023. In Q1 there was an error in which the contracted pharmacy mistranslated/mislabeled a participant's medication. The correct dosage was listed in Spanish on the medication, but a different dosage was also listed in English. The pharmacy did a review and reeducation with their technicians to double check both languages when verifying prescription doses. The participant did not take the incorrect dose, and no adverse outcomes applied. There were two errors in Q2. In the first case, a participant's medication was discontinued by their provider and the provider faxed the information to the pharmacy to stop providing this medication. Per contracted pharmacy, they did not receive the discontinuation order and so continued providing this medication to the participant until the error was caught by PACE team. No adverse outcomes occurred from the temporary continuation of this medication. The other error that occurred in Q2 was a case in which a participant missed a weekly injection (to be provided in the clinic) due to clinic nurse error in transcribing the medication onto the clinic calendar. Similarly, the last error, which occurred in Q4, was also related to transcription. A weekly treatment to be provided in the PACE clinic was ordered for a participant but not added to the clinic calendar. In both cases the clinic RNs and LVNs were retrained on the process for ensuring that medication to be given within the PACE center clinic are provided correctly. None of these medication errors resulted in any injury to participants.

Falls Without Injury

Data Analysis**:**



In 2023, we saw an increase in falls without injury from the 2022 figures. Most falls continue to occur in the community, specifically in the participant's home environment. CalOptima Health PACE has spearheaded fall prevention groups among the high fall risk participants, with the goal of continued decreasing fall trends.

Disciplines, including physicians, nurses, social workers, physical and occupational therapy, and clinical pharmacy, continue to collaborate to develop participant-specific strategies for fall prevention. PACE is using an individualized approach to falls. Once any of the disciplines get information from participants and/or families via wellness calls related to a fall, they will send a Clinic Service Request to clinic and rehab for quick intervention. Rehab then reaches out to participant/family to provide immediate education and follow-up. If further evaluation and skilled rehab is warranted, PACE will ask the participant to do an in-person visit at PACE center. In this way, PACE maintains a direct response to each and every fall reported in a timely manner.

Denials of Prospective Enrollees

In 2023, 4 total prospective enrollees were denied enrollment to CalOptima Health PACE. In 2 of the cases the denial was initiated by the DHCS due to the participant not meeting the Level-Of-Care needs required to enrollee in PACE. In the other 2 cases, the denial was initiated by the PACE enrollment team and approved by DHCS, because the prospective enrollee's health and safety would be jeopardized by living in a community setting.

SECTION 6: QUALITY INITIATIVES

In 2023, we focused on our Quality Initiatives to improve the participant experience and assure optimal clinical outcomes. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's three quality initiatives for 2023 were:

- Advance Health Care Directive
    - This initiative focused on increasing the number of PACE participants who have a completed Advance Health Directive (AHCD) scanned into their medical record. The PACE leadership team created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 50% of participants having a completed AHCD in 2023. We ended 2023 with 36% of participants having a scanned AHCD in their medical record. In order to improve the process for completing AHCDs, PACE had two staff members trained and certified to become Notary Publics. Based on these new resources, in 2024 we will not only keep this quality intuitive but have also raised our goal from ≥ 50% to ≥ 70% by the end of 2024.
- Dental Satisfaction Quality Initiative
    - This initiative focused on increasing participant satisfaction with contracted dental services. PACE wants to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. PACE Enrollment Coordinators highlighted what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry) during the enrollment process for new participants. Clinic administrative staff followed up each month with at least 5 randomly chosen participants who received dental services, to find any areas of dissatisfaction that could be addressed in a timely manner. The goal was ≤ 1 dental related grievance per quarter in 2023. This goal was met each quarter, with only 2 dental related grievance reported throughout 2023. Based on this success, we will continue this initiative into 2024.
- Transportation Satisfaction Quality Initiative
    - This initiative focused on increasing participant satisfaction with contracted transportation services, by providing participants with timely resolutions to transportation related issues as noted within a transportation complaint log. The PACE Center Manager in conjunction with Secure Transportation Manager and PACE Clinic Manager reviewed and resolved all complaints received by PACE participants regarding PACE transportation in a timely manner. The goal was ≤ 3 **valid** transportation related grievance per quarter in 2023. The validity of each grievance is determined by the Secure Transportation Quality Assurance department based on thorough investigation of each complaint. Despite receiving transportation related grievances in each quarter of 2023, we met our goal regarding **valid** grievances each quarter. Based on this success, we will continue this initiative into 2024.

SECTION 7: OPPORTUNITIES FOR IMPROVEMENT IN 2024

1. **Improve the Quality of Care (QOC) for Participants**
    a. Updating all pneumococcal and influenza vaccine processes to always follow CDC guidelines.
    b. Updating the COVID-19 quality element to ensure as many eligible participants are vaccinated against COVID-19 with the latest CDC recommended vaccines.
    c. Adding new cancer screening elements for breast and colorectal cancer.
    d. Adding new element to ensure that diabetic blood sugars are closely controlled.
    e. Adjusting the blood pressure monitoring element to be more inclusive by adding participants with hypertension to monitoring, regardless of diabetic status.
    f. Ensuring that additional participant receive preventative health care and diagnostic monitoring such as DEXA scans to look at bone mineral density, regardless of fall

status.

2. **Ensure the Safety of Participants and Clinical Care**
    a. Continuing efforts to reduce falls at home including home assessment review for repeat fallers and the reintroduction of the quarterly PACE fall committee in 2024.
    b. Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.
    c. Raising the goal in reducing potential harmful drug/disease interactions in the elderly to match the highest level of health care guidelines (annual HEDIS 95th percentiles).
3. **Ensure the Appropriate Use of Resources**
    a. Inpatient/ER Utilization
        i. Further expansion of our complex case management program with individualized interventions with a focus on high-risk participants.
        ii. Continuing to refine the ER diversion process to treat participants with minor ailments in their homes using the PACE clinic team as well as after hours on-call physicians services.
    b. Specialty Care
        i. Increasing the number of core PACE specialists who are willing to work closely with our PACE organization and receive training in the PACE Model of Care.
        ii. Continuing to leverage CalOptima Health's Provider Relations department to ensure that the specialist network meets the needs of PACE.
4. **Improve Participant Experience**
    a. Grievances and potential quality issues monitoring and thorough analysis. Use of transportation logs to resolve participant minor transportation issues immediately as they are reported.
    b. Exploring the potential use of more frequent in-house meal satisfaction surveys and make refinements to our meal program based on that feedback.
5. **Ensure Appropriate Access and Availability**
    a. Reopening of access to all ACS sites and improved utilization of these sites will be completed in 2024.

SUMMARY

CalOptima Health PACE developed and implemented systems using evidence-based guidelines that incorporate data and best practices tailored to the frail and elderly participants within our community. Our focus is to prevent institutionalization of these participants and enable them to live safely at home with the support of PACE services. To accomplish our goals, we target many aspects of the health care continuum, such as preventive care, case management and disease management, closing any potential gaps. Through our ongoing data analysis, we are positioned to identify opportunities for improvement resulting in optimal clinical outcomes and participant satisfaction. Although individual measures may vary in their level of accomplishment, our overall effort as a program has been a considerable success over the past 10 years. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to have a positive impact on our participants.

APPENDIX: 2023 PACE QI EVALUATION

2023 CalOptima Health PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI23.01	Improve the Quality of Care for Participants	2022 PACE QAPI Plan and Work Plan Annual Evaluation	2022 PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 2023	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/8/2023	PACE Medical Director	N/A	N/A	Completed	Met	N/A	N/A	N/A	N/A	Met	Met
QI23.02	Improve the Quality of Care for Participants	2023 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by CalOptima Health Quality Assurance Committee March 2023	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/8/2023	PACE Medical Director	N/A	N/A	Completed	Met	N/A	N/A	N/A	N/A	Met	Met
QI23.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2023	Improve compliance with influenza immunization recommendations	Q1, Q3 and Q4 2023	12/31/2023	PACE Medical Director	93.5%	Not Met	NA	NA	46%	Not Met	89%	Not Met	89%	Not Met
QI23.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have completed their pneumococcal vaccination by December 31st, 2023	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2023)	Quarterly	12/31/2023	PACE Medical Director	90.5%	Not Met	90%	Not Met	91%	Not Met	92.5%	Not Met	92.5%	Not Met
QI23.05	Improve Quality of Care for Participants	COVID-19 Booster Immunization Rates	≥ 80% of eligible participants will have had their COVID-19 Bivalent Booster Vaccine by December 31st, 2023	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2023)	Quarterly	12/31/2023	PACE Medical Director	65%	Not Met	63.1%	Not Met	62.9%	Not Met	N/A	N/A	Not Met	Not Met
QI23.06	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st,2023	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2023	PACE Clinical Operations Manager and PACE Medical Director	94%	Not Met	97%	Met	98%	Met	98%	Met	96%	Met
QI23.07	Improve the Quality of Care for Participants	Diabetes Care	>84.21% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement in maintaining healthy blood pressure.	Quarterly	12/31/2023	PACE Medical Director	79%	Not Met	88%	Met	84%	Not Met	89%	Met	85%	Met
QI23.08	Improve the Quality of Care for Participants	Diabetes Care	> 85.42% of Diabetics will have an Annual Eye Exam (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement in maintaining healthy vision.	Quarterly	12/31/2023	PACE Medical Director	97%	Met	98%	Met	90%	Met	89%	Met	89%	Met
QI23.09	Improve the Quality of Care for Participants	Diabetes Care	> 98.78% of Diabetics will have Nephropathy Monitoring (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement in maintaining kidney function.	Quarterly	12/31/2023	PACE Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI23.10	Improve the Quality of Care for Participants	Osteoporosis	100% of participants who have a fall will have a bone density scan to assess for osteoporosis	Medical records of participants who have a fall will be reviewed to see if they have had a bone density scan within the past 2 years. If not, a scan will be completed on that participant within 6 months of reported fall.	Quarterly	12/31/2023	PACE Medical Director	70%	Not Met	77%	Not Met	84%	Not Met	82%	Not Met	78%	Not Met
QI23.11	Ensure the Safety of Participants	Reduce Percentage of Falls Reported by PACE Enrollees	<72 falls reported per quarter in 2023	The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total number of falls.	Quarterly	12/31/2023	PACE Center Manager	78	Not Met	59	Met	78	Not Met	85	Not Met	75	Not Met
QI23.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<24.64% (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2023	PACE Medical Director	17%	Met	19%	Met	19%	Met	18%	Met	18%	Met
QI23.13	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	<2.62% (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2023	PACE Medical Director	1.3%	Met	1.3%	Met	0.0%	Met	1.2%	Met	1.0%	Met
QI23.14	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2023.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day. (Exclusion: Participants who have a diagnosis of Palliative Care)	Quarterly	12/31/2023	PACE Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI23.15	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconciled within 10 days of hospital and/or skilled nursing facility discharge in 2023	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2023	PACE Pharmacist	98%	Met	100%	Met	100%	Met	100%	Met	99%	Met
QI23.16	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥ 88 % of specialty care authorizations will be scheduled within 14 business days in 2023	Appointments for specialty care will be scheduled within 14 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2023	PACE Clinical Operations Manager	94%	Met	91%	Met	92%	Met	83%	Not Met	90%	Met

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI23.17	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<3,330 hospital days per 1000 per year	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education. (Exclusion: Participants who have Long Term Acute Care Hospitalizations of >90days).	Quarterly	12/31/2023	PACE Medical Director	4179	Not Met	3541	Not Met	3337	Not Met	2760	Met	2760	Met
QI23.18	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<850 emergency room visits per 1000 per year	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2023	PACE Medical Director	799	Met	752	Met	786	Met	801	Met	801	Met
QI23.19	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<14% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2023	PACE Medical Director	16%	Not Met	21%	Not Met	27%	Not Met	7%	Met	18%	Not Met
QI23.20	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2023	PACE Center Manager	3.18%	Met	0.46%	Met	0.08%	Met	0%	Met	0.92%	Met
QI23.21	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 65% in 2023	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2023	PACE Marketing and Enrollment Manager	71%	Met	78%	Met	74%	Met	71%	Met	74%	Met
QI23.22	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths, to develop strategies for improvement	Quarterly	12/31/2023	PACE Marketing and Enrollment Manager	6%	Met	0%	Met	4%	Met	0%	Met	2.75%	Met
QI23.23	Improve Participant Experience	Disenrollment	Maintain a PACE participant attrition rate of ≤10 %	PACE will create focus groups to identify areas that need operational improvement to strategically support growth and increase census to 450 participants.	Quarterly	12/31/2023	PACE Center Manager and PACE Director	7.82%	Met	7.14%	Met	5.81%	Met	4.53%	Met	6.31%	Met
QI23.24	Improve Participant Experience	Transportation Performance	l00% of transportation trips will be less than 60 minutes in 2023	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2023	PACE Center Manager	100%	Met	100%	Met	100.0%	Met	99.83%	Not Met	99.95%	Not Met
QI23.25	Improve Participant Experience	Transportation Performance	≥92% of all transportation rides will be on-time in 2023	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2023	PACE Center Manager	91%	Not Met	77%	Not Met	86%	Not Met	80%	Not Met	84%	Not Met
QI23.26	Improve Participant Experience	Transportation Satisfaction	≥93.6% Satisfaction with Transportation Services (2022 PACE National Average) on the 2023 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with the PACE Transportation program	Annually	12/31/2023	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	95%	Met
QI23.27	Improve Participant Experience	Participant Satisfaction with Meals	≥71.1% Satisfaction with Meals (2022 PACE National Average) on the 2023 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant satisfaction with the meals within the PACE program.	Annually	12/31/2023	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	88%	Met
QI23.28	Improve Participant Experience	Overall Participant Satisfaction	≥88.6% on the Overall Satisfaction-Weighted Average (2022 PACE National Average) on the 2023 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant satisfaction with the PACE program	Annually	12/31/2023	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	94%	Met

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2023 Program of All-Inclusive Care for the Elderly (PACE) Quality Work Plan Evaluation

Quality Assurance Committee Meeting

March 13, 2024

Donna Frisch, M.D., PACE Medical Director

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.

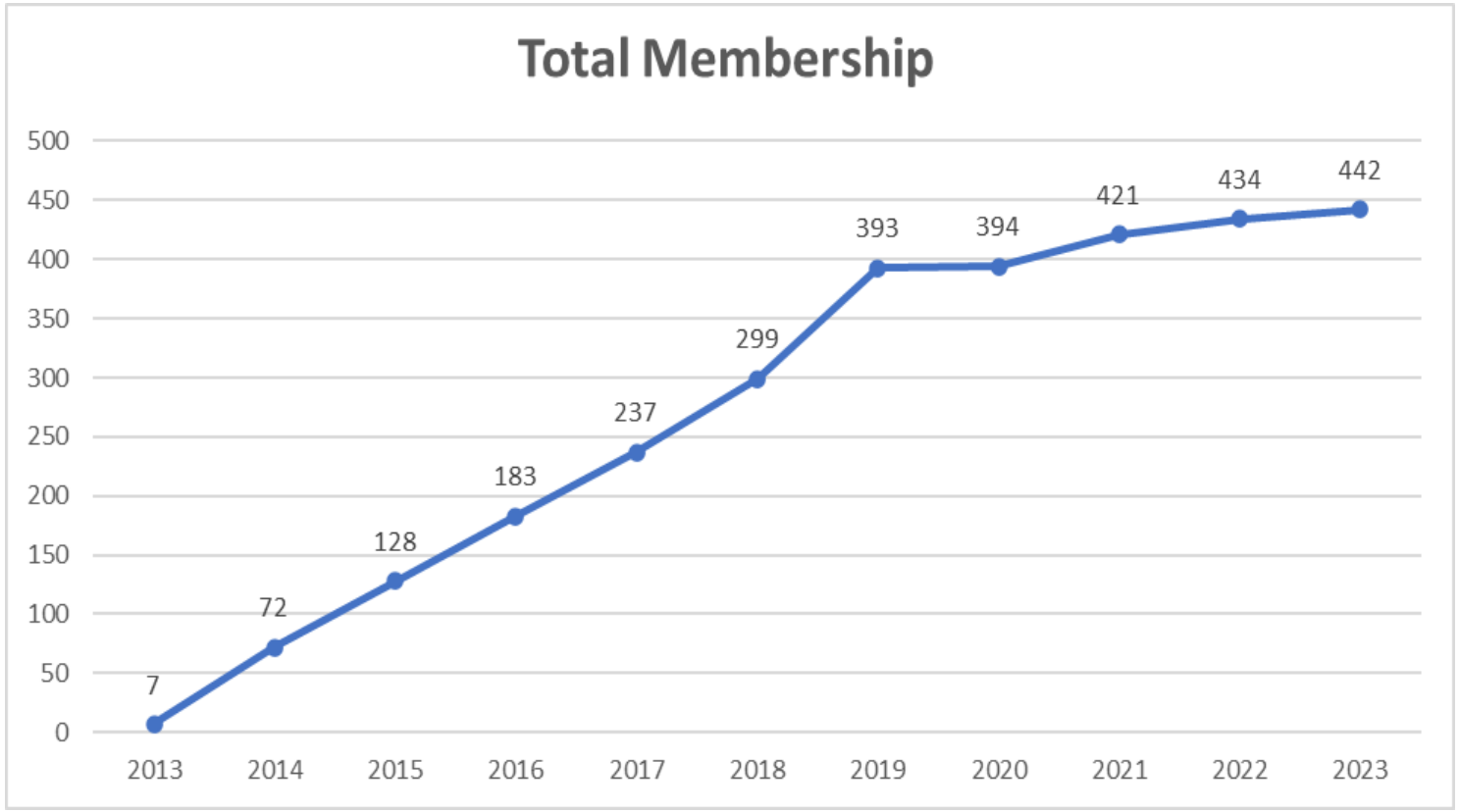
2023 PACE Accomplishments

- PACE continued to maintain all guidance through the end of the Federal COVID -19 Public Health Emergency on May 11, 2023
- PACE collaborated with CalOptima Health Long Term Support Services (LTSS) to significantly reduce the number of PACE participants residing in long-term care
- 89% Influenza immunization rate by Q4 2023
- 93.5% Pneumococcal immunization rate by Q4 2023
- Quality of Diabetes Care
  - 89% annual eye exams completed
  - 100% nephropathy monitoring of diabetic members

2023 PACE Accomplishments, Cont.

- 100% medication reconciliation within 10 days following a hospital or skilled nursing discharge
- 96% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed
- Reduction in the number of participant grievances filed in 2023
- Overall participant satisfaction score of 94% compared to the national average of 88.6% and the CalPACE score of 89%

CalOptima Health PACE Membership Growth 2013-2023



2023 saw PACE's highest number of active enrollees since opening in 2013

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PACE CalOptima Health

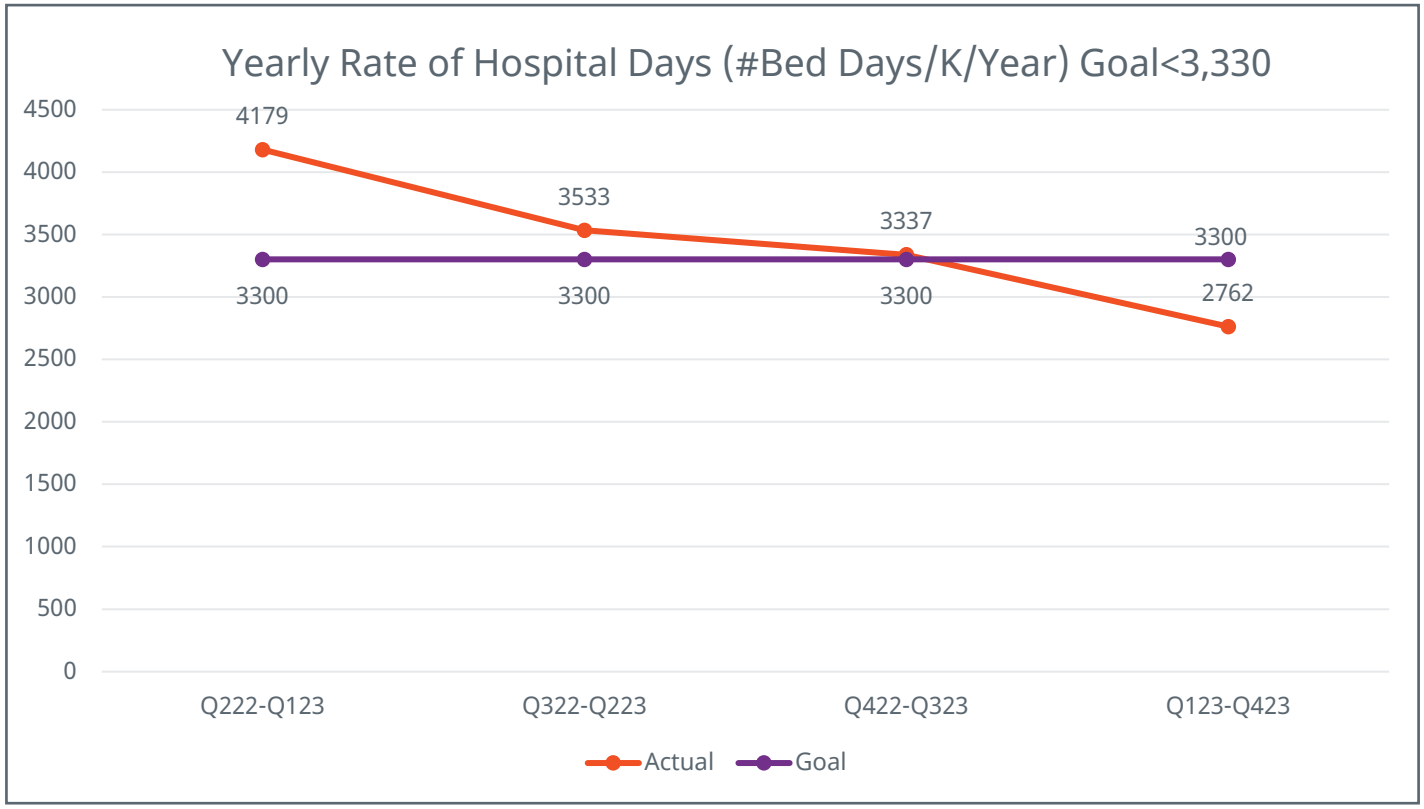
Workplan Elements 8 & 9: Comprehensive Diabetes Care

Higher Is Better		Medicare Quality Compass 2022 HEDIS Percentiles			
Domain	**2023 PACE Rate**	50th Percentile	75th Percentile	90th Percentile	**95th Percentile (PACE Goal)**
Annual Diabetic Eye Exams	**89%**	72.34%	79.31%	83.33%	**85.42%**
Nephropathy Monitoring	**100%**	95.17%	96.88%	98.05%	**98.78%**

Workplan Elements 12 & 13: Potential Harmful Drug/Disease Interactions in the Elderly

Lower Is Better		Medicare Quality Compass 2022 HEDIS Percentiles			
Domain	**2023 PACE Rate**	50th Percentile	75th Percentile	90th Percentile	**95th Percentile (PACE Goal)**
Dementia + Tricyclic Antidepressants or anticholinergic Agents	**18%**	37.09%	32.76%	28.89%	**24.64%**
Chronic Renal Failure + NSAID use	**1.0%**	8.97%	6.15%	3.8%	**2.62%**

Element 18: Hospital Bed Days



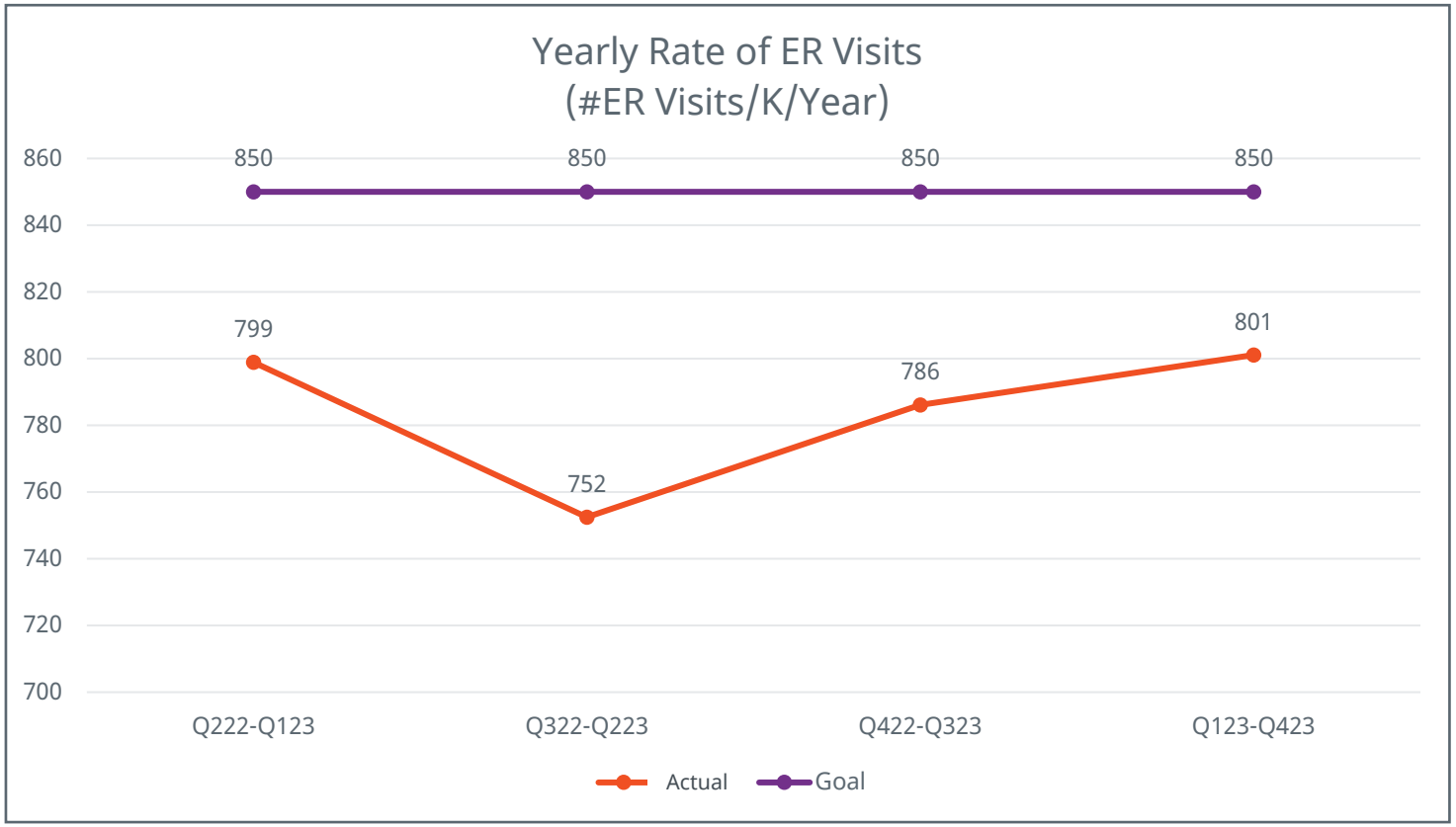
Steady Reduction of Hospital Bed Days to meet utilization goals in 2023

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Element 19: ER Utilization



Goal of reducing ER visits was met in 2023

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Element 28: Annual Participant Satisfaction Survey Results (Goal: ≥ % on Overall Weighted Score)

Domain	2022 CalOptima PACE	2023 CalOptima PACE	2023 National PACE Average
Transportation	89%	**95%**	93.6%
Center Aids	96%	**98%**	92.0%
Home Care	85%	**89%**	85.6%
Medical Care	87%	**92%**	89.1%
Health Care Specialist	85%	**92%**	88.4%
Social Worker	95%	**99%**	94.5%
Meals	82%	**88%**	71.5%
Rehabilitation Therapy and Exercise	93%	**98%**	92.9%
Recreational Therapy	84%	**96%**	79.2%
General Service Delivery	92%	**94%**	86.7%
Overall Weighted Score	89%	**94%**	88.6%

Opportunities for Improvement in 2024

- Improve the Quality of Care for Participants
  - Updating all pneumococcal and influenza vaccine processes to follow CDC guidelines at all times.
  - Updating the COVID-19 quality element to ensure as many eligible participants are vaccinated against COVID-19 with the latest CDC recommended vaccines.
  - Adding new cancer screening elements for breast and colorectal cancer.
  - Adding new element to ensure that diabetic blood sugars are closely controlled.
  - Adjusting the blood pressure monitoring element to be more inclusive by adding participants with hypertension to monitoring, regardless of diabetic status.
  - Ensuring that additional participant receive preventative health care and diagnostic monitoring such as DEXA scans to look at bone mineral density, regardless of fall status.

Opportunities for Improvement in 2024 (Cont.)

- Ensure the Safety of Participants and Clinical Care
  - Continuing efforts to reduce falls at home including home assessment review for repeat fallers and the reintroduction of the quarterly PACE fall committee in 2024.
  - Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.
  - Raising the goal in reducing potential harmful drug/disease interactions in the elderly to match the highest level of health care guidelines (annual HEDIS 95th percentiles).

Opportunities for Improvement in 2024

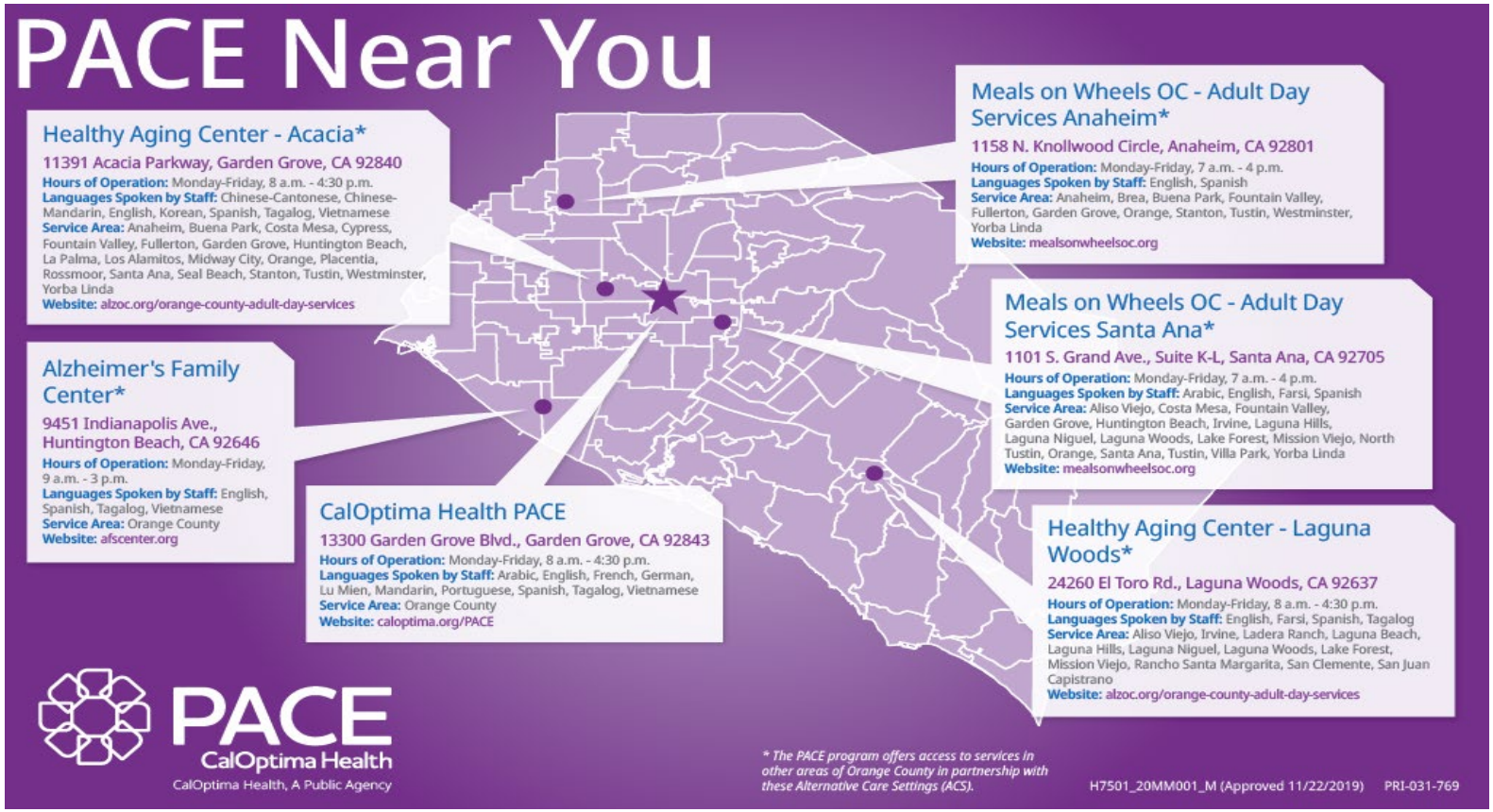
- Ensure the Appropriate Use of Resources
  - Inpatient/ER Utilization
    - Further expansion of our complex case management program with individualized interventions with a focus on high-risk participants.
    - Continuing to refine the ER diversion process to treat participants with minor ailments in their homes using the PACE clinic team as well as after hours on-call physicians services.
  - Specialty Care
    - Increasing the number of core PACE specialists who are willing to work closely with our PACE organization and receive training in the PACE Model of Care.
    - Continuing to leverage CalOptima Health's Provider Relations department to ensure that the specialist network meets the needs of PACE.

Opportunities for Improvement in 2024

- Improve Participant Experience
  - Grievances and potential quality issues monitoring and thorough analysis. Use of transportation logs to resolve participant minor transportation issues immediately as they are reported.
  - Exploring the potential use of more frequent in-house meal satisfaction surveys and make refinements to our meal program based on that feedback.

Opportunities for Improvement in 2024

- Ensure Appropriate Access and Availability
  - Reopening of access to all ACS sites and improved utilization of these sites will in 2024.



Questions?

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CALOPTIMA HEALTH PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) QUALITY IMPROVEMENT PLAN DESCRIPTION

2024~~3~~

PACE Quality Improvement Subcommittee Chairperson:

Donna Frisch, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. **Date**

Board of Directors ~~Acting~~ Chairperson:

Clayton Corwin **Date**

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima Health PACE. It is designed and organized to support the mission, values, and goals of PACE.

Overview

- The goal of the CalOptima Health PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.
- The CalOptima Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima Health's governing body, the Board of Directors has the final authority to review and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The CalOptima Health ~~PACE QI Committee (~~PQIC~~)~~ ~~will~~ completes an annual evaluation of the data collected~~e approved~~ throughout the year~~QI Plan~~. This evaluation and analysis ~~will help~~help to find opportunities for quality improvement and ~~will~~ drives appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
  - Ensure all QI activities fit into a well-integrated system that oversees quality of health care and coordination of all services.
  - Ensure the QI program involves all providers of care within ~~the~~ PACE ~~program~~.
  - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
  - Identify and address areas for improvement that arise from unusual incidents. ~~, and sentinel events.~~
  - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) to identify areas needing quality improvement.
  - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the CalOptima Health Board of Directors.
  - Share results of QI identified benchmarks with staff and contracted providers at least annually.
  - Involve the physicians and other health care providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of health care. Professional standards of CalOptima Health PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g.

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California Board of Nursing, etc.).
    - Ensure that all levels of care are consistent with professionally recognized standards of practice.
    - Assure compliance with the regulatory requirements of all responsible agencies.
- **Improve the participant experience.**
    - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
    - Provide education to staff on the multiple dimensions of the PACE participant ~~tient~~ experience.
    - Identify and implement ways to better engage participants in the PACE experience (e.g., menu selection and PMAC).
    - Evaluate customer service, access, and timeliness of health care provided by contracted licensed providers.
    - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration.
    - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advance ~~d~~ Health Care Directives which honors participants'~~members'~~ wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
    - Review and analyze utilization data regularly, including hospital admissions, Emergency Room (ER) visits, and hospital 30-day all-cause readmissions, to identify high-risk participants ~~members~~ and opportunities for improvement in complex case management~~t~~.
    - Review documentation and coordination of health care for participants receiving services ~~care~~ in institutional settings and investigate any potential infractions in the quality of care provided in these settings.
    - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
    - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
    - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care.**
    - Reduce potential risks to the health and safety ~~and health~~ of PACE participants through ongoing risk management.
    - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
    - Monitor, report and perform a Root Cause Analysis on all participant-involved events resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.
    - Monitor and track falls occurring in the PACE Day Center, in the home and within the community.
    - Monitor and track the use of prescription opioids at high dosages.
    - Meet or exceed community standards for credentialing of licensed providers.
    - Monitor staff and contractors to ensure that appropriate standards of health care are met.
- **Ensure appropriate access and availability.**

- Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
- Monitor and analyze access to specialty health care.
- Continue to develop the network of Alternative Care Setting (ACS) sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining ~~the~~ PACE ~~program~~.

Organizational and Committee Structure

CalOptima Health Board of Directors provides oversight and direction to CalOptima Health PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima Health — including the CalOptima Health PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima Health's Quality Improvement Committee (QIC) described in CalOptima Health's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed in~~during~~ the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods to address quality problems in any clinical or administrative process that have been identified as critical to participants, families, or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report its ~~activities up~~activities to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, ~~PACE Program Manager,~~ PACE QI Program Specialist(s), ~~Coordinator,~~ PACE Program Manager of Community-Based Programs~~,~~ and the PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues that rise to the level of warranting further study and action. Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, ~~PACE Program Manager,~~ PACE QI -Program Specialist(s)~~Coordinator~~, PACE Intake/Enrollment Manager, PACE Program Manager of Community-Based Programs and/or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Center Manager or PACE QI Manager. The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC.

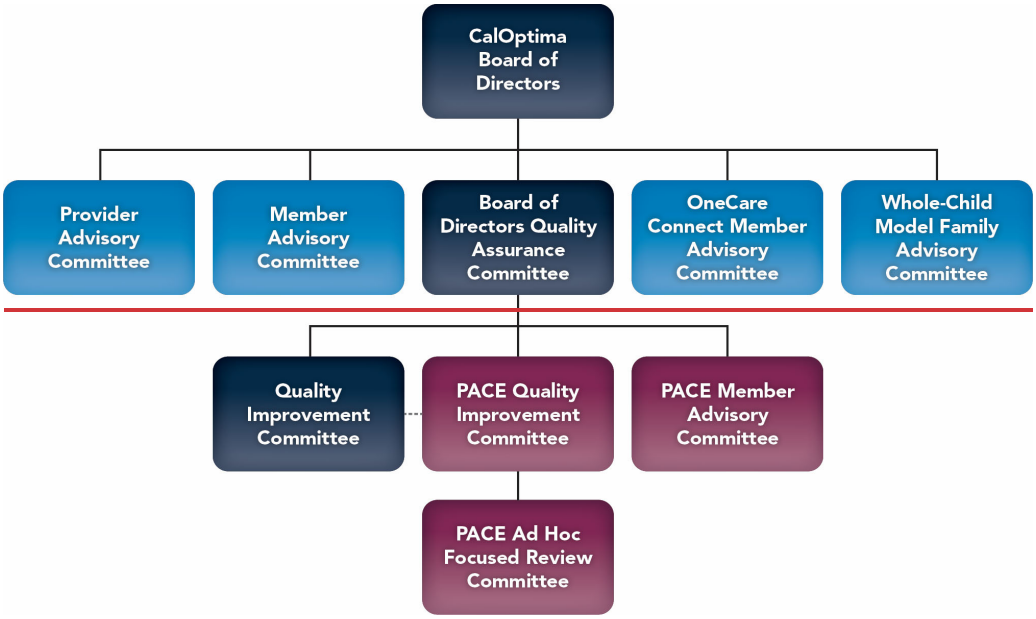
PACE Member Advisory Committee

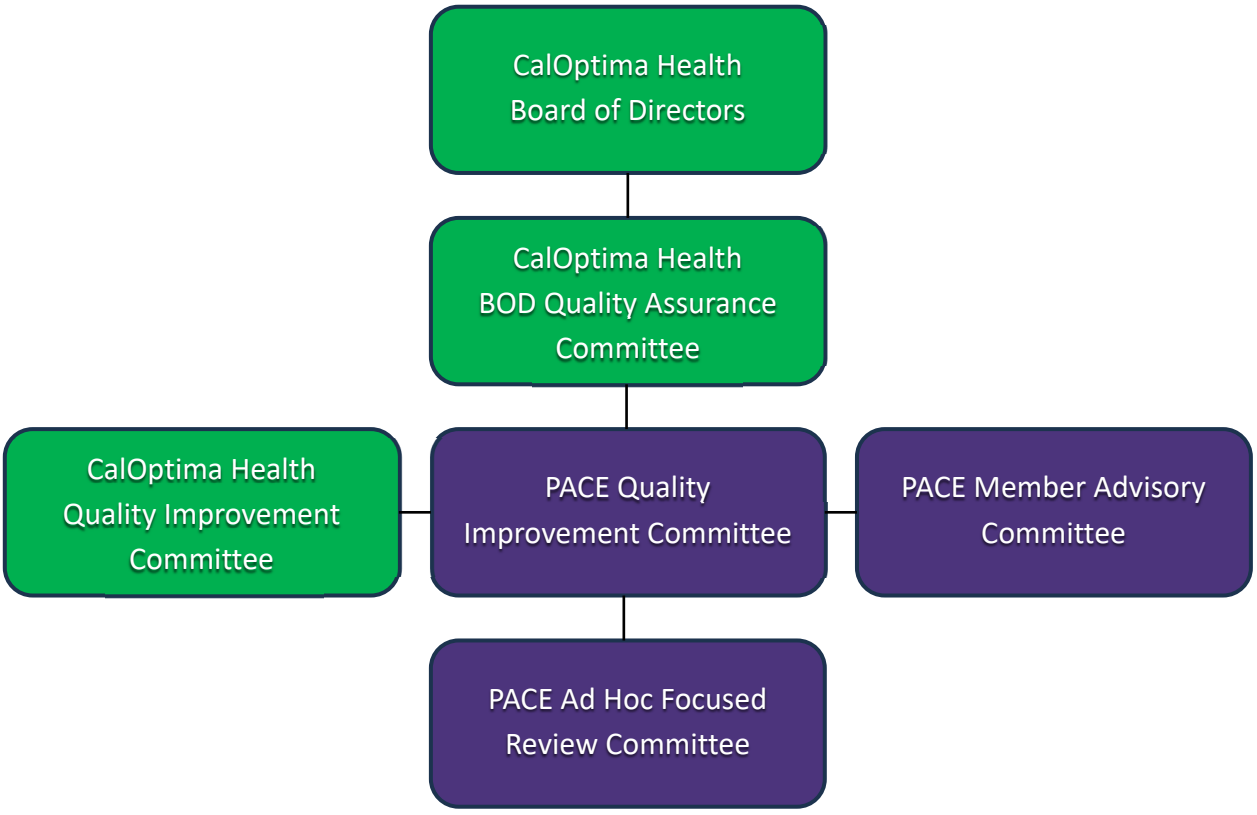
Purpose
The PACE Member Advisory Committee (PMAC) provides recommendations to the Board on issues related to participant health care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to QAC, which then will be reported to the Board. The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

Membership
The PMAC is comprised ~~comprises representatives of participants~~of participants and/or their representatives~~, participants' families,~~ and community representatives~~ies~~ from which participants are referred. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and email/telephonic correspondence and all interested participants are invited to join. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing chair and will ~~facilitate for~~facilitate the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

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20243 Committee Organization Structure — Diagram





OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, analyze, and report any utilization data it deems necessary to evaluate both quality of health care and fiscal well-being of the organization including:
    - Hospital Bed Days
        - Exclusion criteria:
            - Participants who are hospitalized in long term acute care hospitals for >90 days.
            -
    - ER Visits
    - 30-Day All-Cause Readmissions
        - Exclusion criteria:
            - Participants who are re-hospitalized within 30 days of discharge for scheduled visits such as cancer treatment.
    - Participants residing in LTC ~~ong-Term Care~~
- Data analysis will allow for ~~analyzing~~investigation into ~~-~~both overutilization and ~~underutilization~~underutilization of resources to provide ~~for areas of~~ quality improvement and ensure the appropriate use of resources. ~~-~~

Participant and Caregiver Satisfaction

- PACE will ~~shall~~ survey the participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback to improve quality of services throughout the year. ~~-~~
- Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
- The PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.
- ~~PACE will monitor the percentage of participants who disenroll from the PACE program within 90 days *for controllable reasons*.~~
- ~~The qualified lead to enrollment conversion rate will be monitored to ensure the program continues to have a smooth enrollment process.~~PACE will monitor the percentage of participants who disenroll from ~~the~~ PACE ~~program~~ within 90 days *for controllable reasons*.
-
- PACE will monitor attrition rate to identify any need for operational improvement to strategically support continued growth in 2024.

Clinically Relevant Data- Quality Workplan Elements

- ~~Unusual Incidents/Reportable Quality Incidents~~
- ~~Medication Errors~~
- ~~Falls without Injury~~

- Clinical measures from the 2024 QI Work Plan elements which include:
  - Influenza Immunizations Rates
    - Exclusion criteria:
      - Participants who have dx of Palliative Care Approach, ICD-10 Z515
      - Participants with diagnosis of Guillain Barre, -ICD-10: G61.0
      - Participants who are allergic to Influenza vaccine
  - Pneumococcal Immunizations Rates
    - Exclusion criteria:
      - Participants who enroll in the program in December 2024~~3~~
      - Participants who have dx of Palliative Care Approach, ICD-10 Z515
      - Participants who are allergic to Pneumococcal vaccine
  - COVID-19 ~~Bivalent Booster~~ Immunization Rates
    - Exclusion criteria:
      - Participants who enroll in the program in December 2024~~3~~
  - Colon Cancer Screening
    - Inclusion criteria:
      - Participants enrolled for at least six months during measurement year (For Q1 2024, look at October 1, 2023, or earlier)
    - Exclusion criteria
      - Participants who are 76 years and older as of December 31, 2024
      - Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
      - Participants who have a dx of Frailty (ICD-10: R54)
  - Breast Cancer Screening
    - Inclusion criteria:
      - Women enrolled for at least six months during measurement year (For Q1 2024, look at October 1, 2023, or earlier)
    - Exclusion criteria
      - Participants who are 76 years and older as of December 31, 2024
      - Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
      - Participants who have a dx of Frailty (ICD-10: R54)
      - Participants with Hx of Breast Cancer dx who have had a double mastectomy
      - ~~Participants who have not already received their initial doses of COVID-19 vaccine~~
      - ~~Participants who have recently tested positive for COVID-19, or at provider's discretion based on health history.~~
  - Advance~~d~~ Health Care Planning: POLST Completion
    - Exclusion criteria:
      - Participants who have been enrolled <6 months.
  - Controlling High Blood Pressure
    - Inclusion criteria:
      - Participants with a dx of Hypertension (ICD-10: I.10) and/or Diabetes (multiple ICD.10 codes used).
      - Enrolled for at least six months during measurement year (For Q1 2024, look at October 1 2023 or earlier)

- Exclusion criteria:
  - Participants who are 76 years and older as of December 31, 2024
  - Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
  - Participants who have a dx of Frailty (ICD-10: R54)
  - Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.

~~- Diabetes Care: Blood Pressure Control~~
  ~~- The following inclusion and exclusion criteria will be in place for this measure:~~
    ~~- Inclusion criteria:~~
      ~~- Enrolled for at least six months during measurement year~~
        ~~- For Q1 2023, look at October 1 2022 or earlier~~
    ~~- Exclusion criteria:~~
      ~~- Participants who have dx of Palliative Care Approach, ICD-10 Z515~~
      ~~- Participants who have a dx of Frailty, ICD-10 R54~~
      ~~- Participants who are 76 years and older as of December 31, 2023~~
      ~~- Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.~~

- Diabetes Care: Annual Eye Exams
  ~~- The following inclusion and exclusion criteria will be in place for this measure:~~
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus
    - ~~-~~Enrolled for at least six months during measurement year (
    - For Q1 2024~~3~~, look at October 1 2023~~2~~ or earlier)
  - Exclusion criteria:
    - Participants who have dx of Palliative Care Approach, ICD-10 Z515
    - ~~-~~Participants who are 76 years and older as of December 31, 2024~~3~~
    -
    - ~~-~~Participants who are legally blind in both eyes.~~-~~
    -

- Diabetes Care: HbA1c Control for Diabetics
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus
    - Enrolled for at least six months during measurement year (For Q1 2024, look at October 1, 2023, or earlier)
  - Exclusion criteria:
    - Participants who are 76 years and older as of December 31, 2024
    - Participants who have dx of Palliative Care Approach (ICD-10 Z515)
    - Participants who have a dx of Frailty (ICD-10 code R54)

~~- Diabetes Care: Nephropathy Monitoring~~
  ~~- The following inclusion and exclusion criteria will be in place for this measure:~~
    ~~- Inclusion criteria:~~

- ~~Diagnosis of Diabetes Mellitus~~
- ~~Enrolled for at least six months during measurement year~~
  - ~~For Q1 2023, look at October 1 2022 or earlier~~
- ~~Exclusion criteria:~~
  - ~~Participants who have dx of Palliative Care Approach, ICD-10 Z515~~
  - ~~Participants who are 76 years and older as of December 31, 2023~~
  - ~~Participants with End Stage Renal Disease~~

- Monitoring Participants for Osteoporosis
  - Inclusion criteria
    - All Diabetic participants, as well as Non-diabetic Women aged 55-85, and Non-diabetic Men aged 70-85.
    - Enrolled for at least six months during measurement year (For Q1 2024, look at October 1, 2023, or earlier)
  - Exclusion criteria:
    - Participants who have dx of Palliative Care Approach, ICD-10: Z515
    - Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.
  - ~~The following inclusion and exclusion criteria will be in place for this measure:~~
    - ~~Inclusion criteria~~
      - ~~Any participant who has a fall in 2023~~
- Reduce Number of Falls Reported at PACE ~~tion of repeat falls through home visits and follow up by Rehabilitation team with repeat fallers.~~
  - Exclusion criteria:
    - Participants who have a fall in a hospital or skilled nursing facility (SNF).
- Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
  - ~~The following inclusion and exclusion criteria will be in place for this measure:~~
  - Inclusion criteria:
    - Diagnosis of Dementia
    - Continuous enrollment throughout year (enrolled for at least a year) (
    - For Q1 2024~~3~~, Look at enrollment from 3/1/2~~3~~2 and before)
    - ~~For Q2 2023, Look at enrollment from 6/1/22 and before~~
    - ~~For Q3 2023, Look at enrollment from 9/1/22and before~~
    - ~~For Q4 2023, Look at enrollment from 12/1/22 and before~~
    - Participants who are 66 years and older as of December 31, 2023
  - Exclusion criteria:
    - Participants who have dx of Palliative Care Approach, ICD-10 Z515
    - Participants with Schizophrenia or ~~Bipolar Disorder~~bipolar disorder
    -
    - Monitoring of Risks from High Dosage Opioid Use ~~Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Nonaspirin NSAIDS or Cox2 Selective NSAIDs~~
  - ~~The following inclusion and exclusion criteria will be in place for this~~

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~~measure:~~

- ~~Inclusion criteria:~~
  - ~~Participants with diagnosis of CKD 3,4, or 5/End Stage Renal Disease.~~
  - ~~Continuous enrollment throughout year~~
    - ~~For Q1 2023, Look at enrollment from 3/1/22 and before~~
    - ~~For Q2 2023, Look at enrollment from 6/1/22 and before~~
    - ~~For Q3 2023, Look at enrollment from 9/1/22and before~~
    - ~~For Q4 2023, Look at enrollment from 12/1/22 and before~~
  - ~~Participants who are 66 years and older as of December 31, 2023~~
- ~~Exclusion criteria:~~
  - ~~Participants who have dx of Palliative Care Approach, ICD-10 Z515~~
  - ~~TOPICAL NSAIDS such as Voltaren (Diclofenac) gel may be excluded from this list since they have minimal systemic absorption.~~

- ~~Opioids at High Dosage Monitoring by PCPs.~~
  - Inclusion criteria:
    - Receiving prescription opioids milligram morphine dose MME >90 MME/day for ≥15 days.
  - Exclusion criteria:
    - Participants on Hospice Care
    - ~~o~~ Participants with short term (<15 days) high dosage opioids.
- Medication Reconciliation Post Discharge from h~~H~~ospital or SNF ~~Skilled Nursing Facility~~.
- Access to Specialty Care services.

Effectiveness and Safety of Staff-Provided and Contract-Provided Services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, care plan update, and review of medical record documentation. ~~s, and success of infection control efforts.~~
- All clinical and certain non-clinical positions have competency profiles specific to their positions.
- Annual competency evaluations of PACE staff.
- PACE will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima Health guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight of all services and activities~~activities~~ offered by PACE.
- Member grievances will be forwarded to the PACE QI Department for investigation, tracking, trending, and data gathering. These results will be shared with the PACE Director and leadership for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
- Member appeals for denied or partially denied service determination requests will be forwarded to the PACE QI Department for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third-party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by The PACE QI manager as well as either the PACE Director or the PACE Medical Director and will be immediately shared with via telephone and/or written letter with information about additional rights to appeal, should the decision not be in the participant's favor. ~~.~~
- Continued integration of telehealth to expand access to care. ~~through the continued COVID-19 pandemic and beyond.~~
- Increased utilization of Alternative Care Settings in 2024, including a goal that 15% of all eligible PACE Enrollees will utilize day center services at one of the PACE ACS sites by the end of 2024.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. Complaints will be tracked and addressed via the Transportation Log. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE Center Manager and other leadership staff will monitor transportation services with periodic ride-~~alongs~~along. The times gathered during the ride-~~alongs~~along will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through participant satisfaction surveys, as well as comments solicited by the PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual mock code and ~~mock~~ disaster drills, as well as regulatory agency inspections.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.

- Potential impact on participant safety.
- Participant, caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and DHCS to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported through the PACE monitoring module of Health Plan Management System (HPMS). The following data is reported to both CMS via ~~the~~ HPMS and Department of Health Care Services (DHCS) via email, ~~-~~on a quarterly basis or more often as needed:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents and Participant Monitoring

- When unusual incidents meet specified thresholds, PACE must notify CMS ~~on a quarterly basis~~ through HPMS and DHCS via email.~~.~~ PACE must complete a Root Cause Analysis with the appropriate PACE IDT members and share the results with CMS and DHCS~~and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS) as well as internally at PQIC~~. The goal of this analysis is to identify any systems failures and improvement opportunities. CMS and DHCS may ask for further exposition and follow up for each individual quality incident case during the quarterly conference call with CalOptima Health PACE. Examples of Unusual Quality Incidents include:
    - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
    - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
    - Infectious disease outbreaks that meet the threshold of three or more cases linked to the same infectious agent within the same time frame, including COVID-19 infections.
    - Pressure injuries Stage 3, Stage 4, or Unstageable acquired while enrolled in PACE.
    - ~~Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.~~
    - Elopement by cognitively impaired participants.
    - Adverse drug reactions.
    - Foodborne disease outbreak.

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    - Burns 2nd degree or higher.
- Health Outcomes Survey-Modified (HOS-M)
    - PACE will participate in the annual Medicare HOS-M to assess the frailty of the population in our center.
- Other external reporting requirements
    - Suspected elder abuse shall be reported to appropriate state agency.
    - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
    - ~~o~~ Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.
    -

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager and/or~~or~~ QI Medical Case Manager ~~QI Coordinator~~ will consult with relevant PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately.

Re-Evaluation and Follow-Up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

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Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of each PACE Quality Initiative~~s are~~is presented to the PQIC on a quarterly basis. The program's quality initiatives for~~in~~ 2024~~3~~ are:
    - Advance Health Care Directive (AHCD)
        - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Care 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, with a goal of ≥ 7~~5~~0% of participants having a completed AHCD by the end of~~in~~ 2024~~3~~.
    - Dental Satisfaction
        - This initiative will focus on increasing participant satisfaction with contracted dental services, to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. The PACE Enrollment Coordinators will highlight for new enrollees what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry). Clinic administrative staff will follow up each month with 5 randomly chosen participants who received dental services from a dental specialist ~~*outside of PACE,*~~ to find any areas of dissatisfaction that can be addressed in a timely manner. The goal will be for PACE to ~~have <~~have ≤ 1 dental related grievance per quarter in 2024~~3~~.
        -
    - Transportation Satisfaction
        - This initiative will focus on reducing the number of PACE participants who have been dissatisfied with contracted transportation services, as identified by transportation grievances. The PACE leadership team has created a plan to be implemented by the PACE Center manager to utilize the transportation logs and to follow up with participants to assess their satisfaction and to identify any areas of concern or miscommunication regarding provision of services. The goal will be for PACE to have ≤ 3 transportation related grievance per quarter in 2024.~~.~~

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX ~~A~~ A (SEE ATTACHMENT)

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CALOPTIMA HEALTH PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) QUALITY IMPROVEMENT PLAN DESCRIPTION

2024

PACE Quality Improvement Subcommittee Chairperson:

Donna Frisch, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. **Date**

Board of Directors Chairperson:

Clayton Corwin **Date**

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima Health PACE. It is designed and organized to support the mission, values, and goals of PACE.

Overview

- The goal of the CalOptima Health PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.
- The CalOptima Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima Health's governing body, the Board of Directors has the final authority to review and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The CalOptima Health PQIC completes an annual evaluation of the data collected throughout the year. This evaluation and analysis help to find opportunities for quality improvement and drives appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of health care and coordination of all services.
    - Ensure the QI program involves all providers of care within PACE.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents.
    - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) to identify areas needing quality improvement.
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the CalOptima Health Board of Directors.
    - Share results of QI identified benchmarks with staff and contracted providers at least annually.
    - Involve the physicians and other health care providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of health care. Professional standards of CalOptima Health PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).

    - Ensure that all levels of care are consistent with professionally recognized standards of practice.
    - Assure compliance with the regulatory requirements of all responsible agencies.
- **Improve the participant experience.**
    - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
    - Provide education to staff on the multiple dimensions of the PACE participant experience.
    - Identify and implement ways to better engage participants in the PACE experience (e.g., menu selection and PMAC).
    - Evaluate customer service, access, and timeliness of health care provided by contracted licensed providers.
    - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration.
    - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advance Health Care Directives which honors participants' wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
    - Review and analyze utilization data regularly, including hospital admissions, Emergency Room (ER) visits, and hospital 30-day all-cause readmissions, to identify high-risk participants and opportunities for improvement in complex case management.
    - Review documentation and coordination of health care for participants receiving services in institutional settings and investigate any potential infractions in the quality of care provided in these settings.
    - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
    - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
    - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care.**
    - Reduce potential risks to the health and safety of PACE participants through ongoing risk management.
    - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
    - Monitor, report and perform a Root Cause Analysis on all participant-involved events resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.
    - Monitor and track falls occurring in the PACE Day Center, in the home and within the community.
    - Monitor and track the use of prescription opioids at high dosages.
    - Meet or exceed community standards for credentialing of licensed providers.
    - Monitor staff and contractors to ensure that appropriate standards of health care are met.
- **Ensure appropriate access and availability.**
    - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.

- Monitor and analyze access to specialty health care.
- Continue to develop the network of Alternative Care Setting (ACS) sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining PACE.

Organizational and Committee Structure

CalOptima Health Board of Directors provides oversight and direction to CalOptima Health PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima Health — including the CalOptima Health PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima Health's Quality Improvement Committee (QIC) described in CalOptima Health's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed in the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods to address quality problems in any clinical or administrative process that have been identified as critical to participants, families, or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report its activities to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE QI Program Specialist(s), PACE Program Manager of Community-Based Programs and the PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues that rise to the level of warranting further study and action. Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

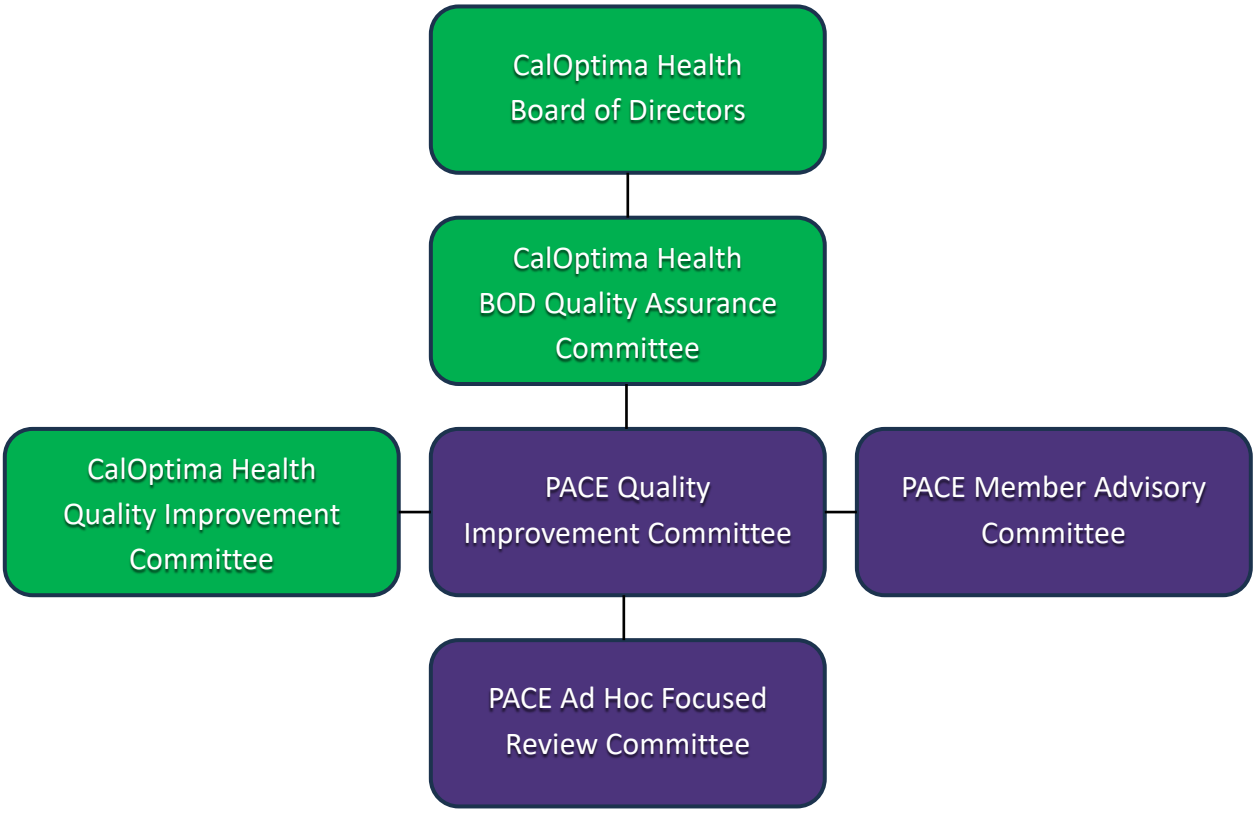
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Program Specialist(s), PACE Intake/Enrollment Manager, PACE Program Manager of Community-Based Programs and/or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Center Manager or PACE QI Manager. The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC.

PACE Member Advisory Committee

Purpose
The PACE Member Advisory Committee (PMAC) provides recommendations to the Board on issues related to participant health care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to QAC, which then will be reported to the Board. The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

Membership
The PMAC is comprised of participants and/or their representatives and community representatives from which participants are referred. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and email/telephonic correspondence and all interested participants are invited to join. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing chair and will facilitate the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

2024 Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, analyze, and report any utilization data it deems necessary to evaluate both quality of health care and fiscal well-being of the organization including:
    - Hospital Bed Days
        - Exclusion criteria:
            - Participants who are hospitalized in long term acute care hospitals for >90 days.
    - ER Visits
    - 30-Day All-Cause Readmissions
        - Exclusion criteria:
            - Participants who are re-hospitalized within 30 days of discharge for scheduled visits such as cancer treatment.

    - Participants residing in LTC
- Data analysis will allow for investigation into both overutilization and underutilization of resources to provide quality improvement and ensure the appropriate use of resources.

Participant and Caregiver Satisfaction

- PACE will survey the participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback to improve quality of services throughout the year.
- Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
- The PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.
- PACE will monitor the percentage of participants who disenroll from PACE within 90 days *for controllable reasons*.
- PACE will monitor attrition rate to identify any need for operational improvement to strategically support continued growth in 2024.

Clinically Relevant Data- Quality Workplan Elements

- Clinical measures from the 2024 QI Work Plan elements which include:
    - Influenza Immunizations Rates
        - Exclusion criteria:
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants with diagnosis of Guillain Barre, ICD-10: G61.0
            - Participants who are allergic to Influenza vaccine
    - Pneumococcal Immunizations Rates
        - Exclusion criteria:
            - Participants who enroll in the program in December 2024
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants who are allergic to Pneumococcal vaccine
    - COVID-19 Immunization Rates
        - Exclusion criteria:
            - Participants who enroll in the program in December 2024
    - Colon Cancer Screening
        - Inclusion criteria:
            - Participants enrolled for at least six months during measurement year (For Q1 2024, look at October 1, 2023, or earlier)
        - Exclusion criteria
            - Participants who are 76 years and older as of December 31, 2024
            - Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
            - Participants who have a dx of Frailty (ICD-10: R54)
    - Breast Cancer Screening
        - Inclusion criteria:
            - Women enrolled for at least six months during measurement year (For Q1 2024, look at October 1, 2023, or earlier)
        - Exclusion criteria

- Participants who are 76 years and older as of December 31, 2024
- Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
- Participants who have a dx of Frailty (ICD-10: R54)
- Participants with Hx of Breast Cancer dx who have had a double mastectomy

- Advance Health Care Planning: POLST Completion
  - Exclusion criteria:
    - Participants who have been enrolled <6 months.
- Controlling High Blood Pressure
  - Inclusion criteria:
    - Participants with a dx of Hypertension (ICD-10: I.10) and/or Diabetes (multiple ICD.10 codes used).
    - Enrolled for at least six months during measurement year (For Q1 2024, look at October 1 2023 or earlier)
  - Exclusion criteria:
    - Participants who are 76 years and older as of December 31, 2024
    - Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
    - Participants who have a dx of Frailty (ICD-10: R54)
    - Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.
- Diabetes Care: Annual Eye Exams
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus
    - Enrolled for at least six months during measurement year (For Q1 2024, look at October 1 2023 or earlier)
  - Exclusion criteria:
    - Participants who have dx of Palliative Care Approach, ICD-10 Z515
    - Participants who are 76 years and older as of December 31, 2024
    - Participants who are legally blind in both eyes.
- Diabetes Care: HbA1c Control for Diabetics
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus
    - Enrolled for at least six months during measurement year (For Q1 2024, look at October 1, 2023, or earlier)
  - Exclusion criteria:
    - Participants who are 76 years and older as of December 31, 2024
    - Participants who have dx of Palliative Care Approach (ICD-10 Z515)
    - Participants who have a dx of Frailty (ICD-10 code R54)
- Monitoring Participants for Osteoporosis
  - Inclusion criteria
    - All Diabetic participants, as well as Non-diabetic Women aged 55-85, and Non-diabetic Men aged 70-85.
    - Enrolled for at least six months during measurement year (For Q1 2024, look at October 1, 2023, or earlier)
  - Exclusion criteria:

        - Participants who have dx of Palliative Care Approach, ICD-10: Z515
        - Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.
    - Reduce Number of Falls Reported at PACE
        - Exclusion criteria:
            - Participants who have a fall in a hospital or skilled nursing facility (SNF).
    - Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
        - Inclusion criteria:
            - Diagnosis of Dementia
            - Continuous enrollment throughout year (enrolled for at least a year) (For Q1 2024, Look at enrollment from 3/1/23 and before)
            - Participants who are 66 years and older as of December 31, 2023
        - Exclusion criteria:
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants with Schizophrenia or bipolar disorder
    - Monitoring of Risks from High Dosage Opioid Use
        - Inclusion criteria:
            - Receiving prescription opioids milligram morphine dose MME >90 MME/day for ≥15 days.
        - Exclusion criteria:
            - Participants on Hospice Care
            - Participants with short term (<15 days) high dosage opioids.
    - Medication Reconciliation Post Discharge from hospital or SNF.
    - Access to Specialty Care services.

Effectiveness and Safety of Staff-Provided and Contract-Provided Services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, care plan update, and review of medical record documentation.
- All clinical and certain non-clinical positions have competency profiles specific to their positions.
- Annual competency evaluations of PACE staff.
- PACE will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima Health guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight of all services and activities offered by PACE.
- Member grievances will be forwarded to the PACE QI Department for investigation, tracking, trending, and data gathering. These results will be shared with the PACE Director and leadership for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
- Member appeals for denied or partially denied service determination requests will be forwarded to the PACE QI Department for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third-party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by The PACE QI manager as well as either the PACE Director or the PACE Medical Director and will be immediately shared with via telephone and/or written letter with information about additional rights to appeal, should the decision not be in the participant's favor.
- Continued integration of telehealth to expand access to care.
- Increased utilization of Alternative Care Settings in 2024, including a goal that 15% of all eligible PACE Enrollees will utilize day center services at one of the PACE ACS sites by the end of 2024.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. Complaints will be tracked and addressed via the Transportation Log. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE Center Manager and other leadership staff will monitor transportation services with periodic ride-along. The times gathered during the ride-along will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through participant satisfaction surveys, as well as comments solicited by the PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual mock code and disaster drills, as well as regulatory agency inspections.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Participant, caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and DHCS to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported through the PACE monitoring module of Health Plan Management System (HPMS). The following data is reported to both CMS via HPMS and Department of Health Care Services (DHCS) via email, on a quarterly basis or more often as needed:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents and Participant Monitoring

- When unusual incidents meet specified thresholds, PACE must notify CMS through HPMS and DHCS via email. PACE must complete a Root Cause Analysis with the appropriate PACE IDT members and share the results with CMS and DHCS. The goal of this analysis is to identify any systems failures and improvement opportunities. CMS and DHCS may ask for further exposition and follow up for each individual quality incident case during the quarterly conference call with CalOptima Health PACE. Examples of Unusual Quality Incidents include:
    - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
    - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
    - Infectious disease outbreaks that meet the threshold of three or more cases linked to the same infectious agent within the same time frame, including COVID-19 infections.
    - Pressure injuries Stage 3, Stage 4, or Unstageable acquired while enrolled in PACE.
    - Elopement by cognitively impaired participants.
    - Adverse drug reactions.
    - Foodborne disease outbreak.
    - Burns 2nd degree or higher.
- Health Outcomes Survey-Modified (HOS-M)
    - PACE will participate in the annual Medicare HOS-M to assess the frailty of the population in our center.
- Other external reporting requirements
    - Suspected elder abuse shall be reported to appropriate state agency.
    - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
    - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager and/or QI Medical Case Manager will consult with relevant PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately.

Re-Evaluation and Follow-Up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of each PACE Quality Initiative is presented to the PQIC on a quarterly basis. The program's quality initiatives for 2024 are:
    - Advance Health Care Directive (AHCD)
        - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Care 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, with a goal of ≥

70% of participants having a completed AHCD by the end of 2024.

- Dental Satisfaction
  - This initiative will focus on increasing participant satisfaction with contracted dental services, to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. The PACE Enrollment Coordinators will highlight for new enrollees what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry). Clinic administrative staff will follow up each month with 5 randomly chosen participants who received dental services from a dental specialist to find any areas of dissatisfaction that can be addressed in a timely manner. The goal will be for PACE to have ≤ 1 dental related grievance per quarter in 2024.
- Transportation Satisfaction
  - This initiative will focus on reducing the number of PACE participants who have been dissatisfied with contracted transportation services, as identified by transportation grievances. The PACE leadership team has created a plan to be implemented by the PACE Center manager to utilize the transportation logs and to follow up with participants to assess their satisfaction and to identify any areas of concern or miscommunication regarding provision of services. The goal will be for PACE to have ≤ 3 transportation related grievance per quarter in 2024.

Annual review of PACE QI Plan

- The PACE QI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

Appendix A (see attachment)

2024 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI24.01	Improve the Quality of Care for Participants	2023 PACE QAPI Plan and Work Plan Annual Evaluation	2023 PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 2024	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/13/2024	PACE Medical Director
QI24.02	Improve the Quality of Care for Participants	2024 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by CalOptima Health Quality Assurance Committee in March 2024	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/13/2024	PACE Medical Director
QI24.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2024	Improve compliance with influenza immunization recommendations (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Q1, Q3 and Q4 2024	12/31/2024	PACE Medical Director
QI24.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have completed their pneumococcal vaccination by December 31st, 2024	Improve compliance with pneumococcal immunization recommendations (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥ 50% of eligible participants will receive the latest CDC recommended COVID-19 vaccine by December 31st, 2024	Improve compliance with current COVID-19 immunization recommendations (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.06	Improve Quality of Care for Participants	Colorectal Cancer Screening	>65% of eligible participants will have had a screening for colorectal cancer by December 31st, 2024 (Comparable to the 2022 MEDICARE Quality Compass HEDIS 37.84th percentile)	Improve compliance with colorectal cancer screening recommendations for older adults by tracking the percentage of colonoscopies and/or FIT tests completed for our participants (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.07	Improve Quality of Care for Participants	Breast Cancer Screening	>82.56% of eligible participants will have a screening for breast cancer by December 31st, 2024 (Comparable to the 2022 MEDICARE Quality Compass HEDIS 90th percentile)	Improve compliance with breast cancer screening recommendations for older adults by tracking the percentage of mammograms completed for our participants (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.08	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed	Ensure all PACE members are offered the opportunity to complete a POLST upon enrollment and every six months until they have one completed, in order to improve POLST utilization (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Clinical Operations Manager and PACE Medical Director
QI24.09	Improve the Quality of Care for Participants	Controlling High Blood Pressure	> 82.98% of participants with Hypertension *and/or* Diabetes will have their blood pressure controlled (Comparable to the 2022 MEDICARE Quality Compass HEDIS 90th percentile)	PACE participants with hypertension and/or diabetes will have their blood pressure regularly monitored and adequately controlled, as defined by readings of <140/90 mmHG. (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI24.10	**Improve the Quality of Care for Participants**	**Diabetic Eye Care**	> 87.29% of Diabetic participants will have an Annual Eye Exam (Comparable to the 2022 MEDICARE Quality Compass HEDIS 95th percentile)	PACE participants with diabetes will be monitored by their Primary Care Providers to ensure they maintain healthy vision through annual examination by eye doctor (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.11	**Improve the Quality of Care for Participants**	**Diabetic Blood Sugar Control**	<11.78% of Diabetic participants will have an HbA1c measurement of >9% (Comparable to the 2022 MEDICARE Quality Compass HEDIS 90th percentile)	PACE participants with diabetes will be monitored by their Primary Care Providers to ensure they maintain blood sugar control as measured by HbA1c lab work (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.12	**Improve the Quality of Care for Participants**	**Osteoporosis**	75% of eligible participants will have a bone density scan to assess for Osteoporosis	Medical records of all eligible participants will be reviewed to see if they have had a bone density scan within the past 5 years. If not, a scan will be completed on that participant (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.13	**Ensure the Safety of Participants**	**Reduce Percentage of Falls Reported by PACE Enrollees**	<72 falls reported per quarter in 2023	The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total number of falls. (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Center Manager
QI24.14	**Improve the Quality of Care for Participants**	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents**	<25% (Comparable to the 2022 MEDICARE Quality Compass HEDIS 95th percentile)	PACE participants with a diagnosis of Dementia will be monitored by their Primary Care Providers and Clinic Pharmacists to ensure they are not prescribed medications that may cause harm (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.15	**Ensure the Safety of Clinical Care**	**Monitoring of Risks from High Dosage Opioid Use**	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2024.	The PACE Primary Care Providers will provide monthly monitoring any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.16	**Improve the Quality of Care for Participants**	**Medication Reconciliation Post Discharge (MRP)**	≥93% of participants will have their medications reconciled within 7 calendar days of hospital and/or skilled nursing facility discharge in 2024	The PACE QI Department will work with the PACE Clinic, Pharmacist and Providers to ensure that participant medications are reviewed in a timely matter after discharge.	Quarterly	12/31/2024	PACE Pharmacist

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI24.17	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥90% of specialty care authorizations will be scheduled within 14 calendar days in 2023	Appointments for specialty care will be scheduled within 14 calendar days to improve access to specialty care	Quarterly	12/31/2024	PACE Clinical Operations Manager
QI24.18	Ensure Appropriate Access and Availability	Improve Utilization of PACE Alternative Care Settings (ACS)	≥15% of all eligible PACE Enrollees will utilize day center services at one of the PACE Alternative Care Settings by end of 2024.	Eligible participants will be scheduled for day center services to be provided by one of our contracted ACS (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Center Manager and PACE Program Manager for Community Based Services
QI24.19	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<3,330 hospital days per 1000 per year	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.20	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<825 emergency room visits per 1000 per year	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2024	PACE Medical Director
QI24.21	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<14% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director
QI24.22	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	PACE participants placed in long term custodial care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2024	PACE Center Manager
QI24.23	Improve Participant Experience	Enrollment/Disenrollment	The Qualified Lead-to-Enrollment conversion rate will be 70% in 2024	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement	Quarterly	12/31/2024	PACE Marketing and Enrollment Manager
QI24.24	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment (for controllable reasons) to develop strategies for improvement	Quarterly	12/31/2024	PACE Marketing and Enrollment Manager
QI24.25	Improve Participant Experience	Enrollment/Disenrollment	Maintain a PACE participant attrition rate of ≤8 %	PACE will create focus groups to identify areas that need operational improvement to strategically support growth in 2024.	Quarterly	12/31/2024	PACE Center Manager and PACE Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI24.26	Improve Participant Experience	Transportation Performance	I00% of transportation trips will be less than 60 minutes in 2024	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2024	PACE Center Manager
QI24.27	Improve Participant Experience	Transportation Performance	≥92% of all transportation rides will be on-time in 2024	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2024	PACE Center Manager
QI24.28	Improve Participant Experience	Transportation Satisfaction	≥93.6% Satisfaction with Transportation Services (2023 PACE National Average) on the 2024 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with the PACE Transportation program	Annually	12/31/2024	PACE Center Manager
QI24.29	Improve Participant Experience	Participant Satisfaction with Meals	≥71.5% Satisfaction with Meals (2023 PACE National Average) on the 2024 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant satisfaction with the meals within the PACE program.	Annually	12/31/2024	PACE Center Manager
QI24.30	Improve Participant Experience	Overall Participant Satisfaction	≥88.6% on the Overall Satisfaction-Weighted Average (2023 PACE National Average) on the 2024 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve overall participant satisfaction with the PACE program	Annually	12/31/2024	PACE Director

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2024 Proposed Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Work Plan Description

Quality Assurance Committee Meeting

March 13, 2024

Donna Frisch, M.D., PACE Medical Director

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.

2024 PACE Quality Improvement (QI) Program Description

- Encompasses all clinical care, clinical services and organizational services provided to our participants
- Aligns with the PACE vision and mission
- Focuses on optimal health outcomes for our participants
- Uses evidence-based guidelines, data and best practices tailored to our populations
- Updated to address new COVID-19 vaccination recommendations
- Updated to address the cancer health screening needs of the PACE population

2024 PACE (QI) Work Plan Goals

- Improve the Quality of Care for Participants
- Ensure the Safety of Clinical Care
- Ensure Appropriate Access and Availability
- Ensure Appropriate Use of Resources
- Improve Participant Experience

2024 PACE (QI) Work Plan Elements Changes

- In 2024, some of the PACE Quality Workplan Elements have had minor changes to their timeframes for data collection, goals, or exclusions. Information regarding these changes is available for review in the 2023 PACE Quality Workplan Review and the 2024 PACE Quality Improvement Plan Description
- The following slides reflect the *major* changes that were made to the PACE Quality Workplan for 2024 including any quality elements that were:
  - Removed
  - Modified
  - Added

2024 PACE (QI) Work Plan Elements Removed, Modified, and Added

- **Removed Elements**
  - *Nephropathy Monitoring of Diabetic Participants*
    - This goal was continuously met at 100%
    - PACE PCPs, in addition to in-house nephrology specialist, ensure close monitoring for nephropathy in our diabetic participants
  - *Drug/Disease Interaction Monitoring of Participants with Chronic Renal Failure with prescription Nonaspirin NSAIDS or Cox2 Selective NSAIDs*
    - This goal was consistently met
    - PACE PCPs, in addition to clinic pharmacists, ensure that participants with renal failure are not prescribed *non-topical* NSAIDs

2024 PACE (QI) Work Plan Elements Removed, Modified, and Added

- **Modified Elements**
  - *COVID-19 Vaccine*
    - This element has been modified to align with the most recent recommendations by the CDC. Bivalent boosters are no longer available. PACE participants are now receiving the 2023-2024 one-dose updated COVID-19 vaccine
  - *Blood Pressure Monitoring of Diabetic Participants*
    - This element has been modified to not only monitor diabetic participant's blood pressure but to include monitoring for non-diabetic participants with hypertension as well

2024 PACE (QI) Work Plan Elements Removed, Modified, and Added

- **Added Elements**
  - *Colorectal Cancer Screening*
    - This element has been added for 2024 to improve compliance with recommendations for colorectal screening of older adults
  - *Breast Cancer Screening*
    - This element has been added for 2024 to improve compliance with recommendations for breast cancer screening of older adults
  - *Diabetic Blood Sugar Monitoring*
    - This element has been added for 2024 to improve compliance with recommendation for monitoring of HbA1c in our participant population
  - *Improve Utilization of Alternative Care Sites (ACS)*

    This element has been added for 2024 to ensure we are properly utilizing the ACS that we currently have available to us

2024 PACE Quality Initiatives

- **Advance Health Care Directive**
  - The goal for 2024 is ≥ 70% of participants will have a completed AHCD in 2024
  - In 2023, 2 PACE staff members were certified as notaries to assist with this initiative
- **Dental Services Satisfaction**
  - The goal for 2024 is ≤ 1 dental related grievance per quarter in 2024
  - Participants are surveyed after their dental visits.
- **Transportation Services Satisfaction**
  - The goal for 2024 is ≤ 3 valid transportation related grievance per quarter in 2024
  - A transportation log is in place to immediately address transportation issues

Recommended Action

- Recommend approval of the 2024 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Description

Questions?

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PACE CalOptima Health

PACE

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 13, 2024
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

6. Recommend that the Board of Directors Approve Recommendation for Vice Chair Appointment to the Whole-Child Model Family Advisory Committee

Contacts

Ladan Khamseh, Executive Director, Operations, (714) 246-8866
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. The Whole-Child Model Family Advisory Committee (WCM FAC) recommends that the Board of Directors approve the appointment of Erika Jewell as the Vice-Chair to fulfill a remaining term through June 30, 2025.

Background

The CalOptima Health Board of Directors established the WCM FAC by Resolution No. 17-1102-01 on November 2, 2017, to serve solely in an advisory capacity, providing input and recommendations concerning the Whole-Child Model program. The WCM FAC is comprised of 11 voting members, seven of whom are designated as family representatives and four of whom are designated as community seats representing the interests of children receiving California Children's Services.

Pursuant to Resolution No. 20-0806, the CalOptima Health Board of Directors is responsible for the appointment of the WCM FAC Chair and Vice Chair biennially from among appointed members. The Chair and Vice Chair may serve a two-year term. On October 6, 2022, the Board approved a request for all members of the committee to be eligible to serve as the chair or vice chair.

Discussion

The WCM FAC has been without a Vice-Chair since August 2023. Members were asked to submit a letter of interest in the open Vice-Chair position. WCM FAC Consumer Advocate member Erika Jewell submitted a letter of interest to fulfill a remaining term through June 30, 2025. At the December 19, 2023, WCM FAC meeting, the committee voted to recommend that the Board of Directors approve Ms. Jewell as the committee Vice-Chair.

WCM FAC Vice Chair Candidate

Erika Jewell

Ms. Jewell currently holds a consumer advocate seat on the WCM FAC and has been on the committee since 2022. She is the Manager for Case Management at Children's Hospital Orange County and has a good working knowledge of the needs of the Whole-Child Model Family Advisory Committee.

Fiscal Impact

There is no fiscal impact.

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Rationale for Recommendation

Open nominations were held at the December 19, 2023, WCM FAC meeting based on the letter of interest received. There were no additional nominations from the floor. The WCM FAC forwards the recommended Vice Chair candidate to the Board of Directors' Quality Assurance Committee for consideration and appointment.

Concurrence

Whole-Child Model Family Advisory Committee
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *03/08/2024*
Authorized Signature **Date**

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Board of Directors'
Quality Assurance Committee Meeting
March 13, 2024

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

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

December 13, 2023: PMAC Meeting Summary

Updates from the Director
Director Monica Macias thanked PMAC members for joining the meeting in person. Members were updated on the status of the program, open positions, respiratory illnesses updates, and transportation. The Director welcomed new members who were joining PMAC for the first time. The Director provided staffing updates and was happy to share that most of the PACE positions are currently filled. Two positions are pending, one for a social worker and one for a scheduler. The Director shared that PACE staff continue to monitor any trends in cases and adjust operations if deemed necessary around respiratory illnesses. CalOptima Health's PACE clinic staff continue to support PACE members' medical needs and test as deemed necessary. Lastly, PACE leadership continues to work with its transportation vendor to improve member experience.

COVID-19 Updates
Jennifer Robinson, Quality Improvement Manager, provided updates related to respiratory illnesses. Ms. Robinson reminded everyone that this is the season for respiratory illness season (September to March). She noted that there has been an increase in Flu and COVID-19 cases in Orange County. Members were reminded of the respiratory illnesses symptoms and encouraged to stay home when not feeling well. In addition, members were reminded that the PACE clinic provides vaccinations for both Flu and COVID-19. Members were also educated on the new COVID-19 vaccine and this dose is not dependent on individuals receiving previous vaccines.

PMAC Member Forum
- Participants mentioned that transportation appears to improve at times, and then they continue to have challenges from time to time.
- Participants made a recommendation to add fresh fruit to their lunches.
- Participants expressed gratitude for the 10-year celebration and mentioned feeling special.

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Board of Directors'
Quality Assurance Committee Meeting
March 13, 2024

Regular Meeting of the
Whole-Child Model Family Advisory Committee
Report to the Quality Assurance Committee

On December 19, 2023, the Whole-Child Model Member Family Advisory Committee (WCM FAC) conducted its quarterly meeting in-person and telephonically using Zoom Webinar technology.

The committee received presentations from the children's hospitals in the Los Angeles and Orange County areas. Children's Health Orange County (CHOC), Miller's Children's Hospital, Long Beach and Children's Hospital Los Angeles presented an overview of the services available for children in the Whole-Child Model (WCM) Program. Michael Weiss, M.D., Vice President, Population Health, presented on behalf of CHOC, Dr. Graham Tse, Chief Medical Officer, along with Christina Bell, Executive Director, Outpatient Specialty Clinics, and Donna Rosenlund, Director, Social Work Services, presented on behalf of Miller's Children Hospital, Long Beach. Mona Patel, M.D., presented on behalf of Children's Hospital, Los Angeles.

Kinisha Mills Campbell, Executive Director, Medi-Cal Care Coordination, from Kaiser Permanente presented an update on the transition of former CalOptima Health Medi-Cal members now being served directly through Kaiser. Ms. Mills Campbell responded to questions from committee members regarding the transition.

Yunkyung Kim, Chief Operating Officer, thanked the members on the committee for their service and the candid feedback on the WCM program. She also noted that the feedback received on the Workforce Development plan had allowed for the first round of funding which would be focused on education opportunities with four additional pillars to be funded.

The members on the committee held nominations for a committee Vice-Chair and members recommended appointing Erika Jewell as the Vice-Chair of WCM FAC.

The WCM FAC appreciates and thanks the CalOptima Board Directors' Quality Assurance Committee for the opportunity to present input and updates on the its current activities.

Applied Behavior Analysis (ABA) and Behavioral Health (BH) Pay-for- Value (P4V) Programs

March 13, 2024

Carmen Katsarov, LPCC, CCM, Executive Director
Behavioral Health Integration

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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Background:
Previous ABA Pay-for-Value Program

ABA P4V Program Timeframe
January 2, 2021 - December 31, 2022

P4V Program Evaluation
ABA consultant met with the ABA Providers between December 2022 – March 2023

Need a clearer understanding of the data used

More frequent payout

Increase the collaboration

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CalOptima Health

New ABA P4V and BH P4V Programs



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CalOptima Health

Applied Behavior Analysis Pay-for-Value (ABAP4V) Program

Medi-Cal

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ABA P4V Program Elements

	Category	Program Element	Target*	Data Source	Weight
1	Quality Process	Clients actively receive H2019 or H2014 services.	>=**80%**	Claims Data (i.e., H2019, H2014)	1.5%
2	Quality Process	Clients received 10% or more supervision (combined BCBA & mid-tier)	>=**70%**	Claims Data (i.e., H0032)	1.5%
3	Assessment	Documented analysis and reasoning for variations in meeting utilization targets.	**100%**	Provider Attestation Form with Data	1.5%
4	Quality Process	Clients received 6 in-person field visits of BCBA oversight	>=**70%**	Claims Data (i.e., H0032-HO) In person mod/claims data	1.5%
5	Care Effectiveness	Assessment goals marked as “in progress” (at least 5 data points) or “mastered”	>=**70%**	Provider Attestation Form with Data	1%
6	Care Access	Clients met the 60-day goal from inquiry to treatment	>=**70%**	Claims Data (i.e., H2019, or H0032)	1%
7	Care Experience	Parents reported progress based on social validity instrument	>=**70%**	Digital Survey	1%
8	Care Experience	Clients received 6 Parent Training visits	>=**70%**	Claims Data (i.e., S5110; S5108)	1%
					10%

Each measure that meets or exceeds the target earns 100% of the incentive allocation for that measure.

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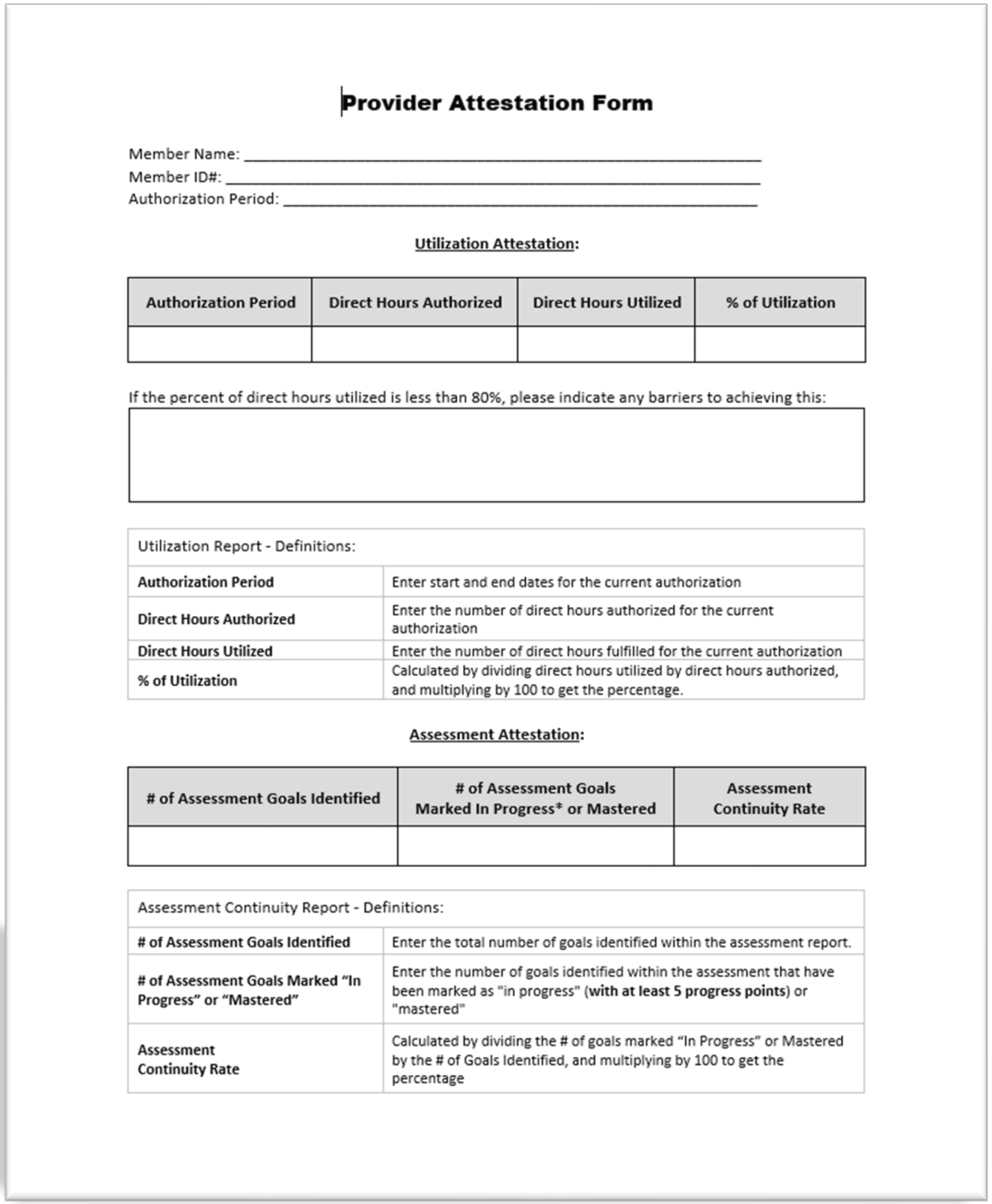
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ABA P4V Program Methodology

- Data Collection
  - 8 Program Elements (slide 5)
    - 5 of the 8 captured through claim and encounter data
    - 2 of the 8 captured by the Provider Attestation Form
    - 1 of the 8 captured by the digital parent survey data
- Measurement & Scoring Methodology
  - 6-month measure period for program elements captured by claims and encounter data
  - Annual measurement period
    - Random sample of the provider attestation forms
    - Digital parent survey results

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Provider Attestation Form



Provider Attestation Form

Member Name: _____
Member ID#: _____
Authorization Period: _____

Utilization Attestation:

Authorization Period	Direct Hours Authorized	Direct Hours Utilized	% of Utilization

If the percent of direct hours utilized is less than 80%, please indicate any barriers to achieving this:

Utilization Report - Definitions:	
Authorization Period	Enter start and end dates for the current authorization
Direct Hours Authorized	Enter the number of direct hours authorized for the current authorization
Direct Hours Utilized	Enter the number of direct hours fulfilled for the current authorization
% of Utilization	Calculated by dividing direct hours utilized by direct hours authorized, and multiplying by 100 to get the percentage.

Assessment Attestation:

# of Assessment Goals Identified	# of Assessment Goals Marked In Progress* or Mastered	Assessment Continuity Rate

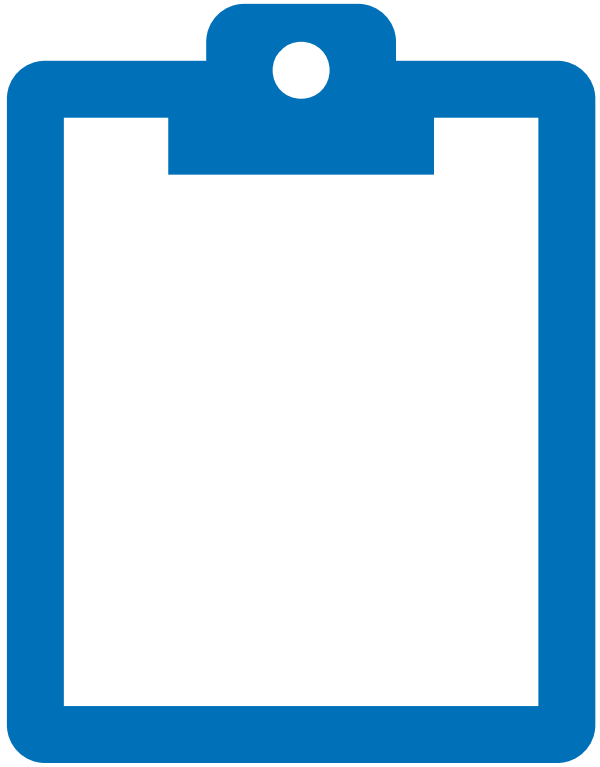
Assessment Continuity Report - Definitions:	
# of Assessment Goals Identified	Enter the total number of goals identified within the assessment report.
# of Assessment Goals Marked "In Progress" or "Mastered"	Enter the number of goals identified within the assessment that have been marked as "in progress" (**with at least 5 progress points**) or "mastered"
Assessment Continuity Rate	Calculated by dividing the # of goals marked "In Progress" or Mastered by the # of Goals Identified, and multiplying by 100 to get the percentage

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Care Experience Digital Parent Survey*

1) My child's program addresses the goals that are most important to my family
2) I have the appropriate support and resources to use the intervention strategies
3) I use the intervention strategies outside of the session.
4) My child is maintaining the skills previously taught during session.
5) The intervention strategies have produced meaningful results over the past month.



The survey will be available in multiple CalOptima Health member threshold languages.

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ABA P4V Measurement Period and Payout

- Providers will be able to earn up to 10% of the paid claims during each measurement period by achieving any or all the program elements

	Measurement Period	Incentive Payment Timeframe*
Baseline	January – December 2023	NA
Measurement Period 1	July – December 2024	Quarter 2 - 2025
Measurement Period 2	January – June 2025	Quarter 4 - 2025
Measurement Period 3	July – December 2025	Quarter 2 - 2026
Measurement Period 4	January – June 2026	Quarter 4 - 2026

*Incentive Payout timeframe will be affected by claims lag time

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CalOptima Health

Behavioral Health Pay-for-Value (BHP4V) Program

OneCare and Medi-Cal

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CalOptima Health

BH P4V Program Elements

#	Quality Measures	Measure Acronym	Measure Steward	Weight %
1	Follow-Up After ED Visit for Mental Illness—30 days	FUM	NCQA	2.0
2	Follow-Up After ED Visit for Substance Use—30 days	FUA	NCQA	2.0
3	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	NCQA	.5
4	Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	.5
5	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	NCQA	.75
6	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-E C&M	NCQA	.75
7	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-E-INIT	NCQA	.75
8	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM-E	NCQA	.75
9	Antidepressant Medication Management: Acute Phase Treatment	AMM-ACUTE	NCQA	.5
10	Antidepressant Medication Management: Continuation Phase Treatment	AMM-CONT	NCQA	.5
11	Percentage of appointments that occurred within 10 business days from the referral		CalOptima Health	1.0
	Total			**10**

National Committee for Quality Assurance (NCQA)

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BH P4V Program Methodology

- Measurement Set
  - Use industry standard measures aligned with product regulatory requirements i.e. Department of Health Care Services (DHCS), Managed Care Accountability Set (MCAS) and Centers for Medicare and Medicaid Services(CMS) Star measurement sets
  - Aligning with Department of Managed Health Care (DMHC) timely access standard
- Benchmarks
  - Align with DHCS Minimum Performance Levels (MPL) at 50th percentile
  - Use National Committee for Quality Assurance (NCQA) Medicare National Percentile Benchmarks
  - Assess performance on BH provider achieving benchmarks

Metrics	Performance Benchmark	Incentive Percentage
Quality Measure	50th percentile	50%
	75th percentile	75%
	90th percentile	100%

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CalOptima Health

Measurement Period and Payout

- Provider will be able to earn up to 10% of the paid claims during each measurement period by achieving any or all the program elements

	Measurement Period	Incentive Payment Timeframe*
Baseline	January – December 2024	NA
Year 1	January – December 2025	Quarter 4 2026
Year 2	January – December 2026	Quarter 4 2027

*Incentive Payment Timeframe will be affected by HEDIS reporting timeframes and claims lag

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CalOptima Health Board of Directors
Quality Assurance Committee Meeting
March 13, 2024

Quality Improvement Health Equity Committee (QIHEC)
Fourth Quarter 2023 Report

QIHEC Summary		
QIHEC Chair(s)	Quality Medical Director Chief Health Equity Officer	
Reporting Period	Quarter 4, 2023	
QIHEC Meeting Dates	October 10, 2023; November 11, 2023; and December 12, 2023	
Topics Presented and Discussed in QIHEC during the reporting period	• Access and Availability • Adult Wellness and Prevention • Behavioral Health Integration (BHI) • Blood Lead Screening • Care Management and Care Coordination • Chronic Conditions Management • Credentialing and Recredentialing • Cultural and Linguistic • Customer Service • Delegation Oversight • Emergency Department Diversion Program • Facility Site Review (FSR)/Medical Record Review (MRR)/Physical Accessibility Review Survey (PARS)	• Grievance & Appeals Resolution Services • Health Education • Health Equity • Initial Health Appointment • Long Term Support Services • Member Experience • NCQA Accreditation • OneCare Model of Care • Pediatric Wellness and Prevention • Population Health Management • Potential Quality Issues (PQIs) • Maternal Care • Redetermination • Social Determinants of Health • Transitional Care Services • Utilization Management Program and Activities

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QIHEC Actions in Quarter 4, 2023
QIHEC Approved the Following Items: • September 12, 2023, QIHEC Meeting Minutes • October 10, 2023, QIHEC Meeting Minutes • November 11, 2023, QIHEC Meeting Minutes • 2023 Cultural and Linguistic Evaluation • 2024 Cultural and Linguistic Program and Work Plan • Changes to the Initial Health Appointment Key Performance Indicators (KPIs) for delegated networks, where goal increased from 17% to 50% • Population Health Management Strategy Updates • 2023 QI Work Plan 3rd Quarter **Policies:** • GG.1110 Primary Care Practitioner Definition, Role, and Responsibilities • GG.1617 Infection Control Plan • GG.1621 CBAS Quality Assurance and Site Visits • GG.1633 Board Certification Requirements for Physicians • GG.1602 Non-Physician Medical Practitioner (NMP) Scope of Practice • GG.1628 Confidentiality of Quality Improvement Activities • GG.1639 Post Hospital Discharge Medication Supply • GG.1643 Minimum Physician Credentialing Standards • GG.1655 Reporting Provider Preventable Conditions • GG.1656 Quality Improvement and Utilization Management Conflicts of Interest • GG.1657 State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting • GG.1713 Certified Nurse Midwife Practice Guidelines • GG.1652 DHCS Notification of Change in the Availability or Location of Covered Services • GG.1615 Corrective Action Plan for Practitioners and Organizational Providers
Accepted and filed the following items: • Utilization Management Committee Meeting Minutes: August 24, 2023 • Member Experience Committee Meeting Minutes: August 22, 2023 • Delegation Oversight Committee Meeting Minutes: June/July 2023 • Whole Child Model Clinical Advisory Committee Meeting Minutes: August 15, 2023 • Grievance and Resolutions Services Committee Meeting Minutes: August 15, 2023
Committee Membership Updates: • New Health Equity Officer for CalOptima Health • New CalAIM Medical Director for CalOptima Health • New member representing Latino Health Access • New member representing the County of Orange Social Services Agency

QIHEC Quarter 4 2023 Highlights

- QIHEC was made aware of an increase in turnaround time for Community Based Adult Services (CBAS) authorizations. A follow-up report in Q3 2023 indicated that the CBAS team implemented interventions that reduced the authorization turnaround times for CBAS from 5.77 to 1.57 days in mid-October.
- QIHEC was made aware of an increase in non-medical transportation services in Q3 2023 due to the vendor's change in system platforms. A follow-up report in Q3 2023 indicated that staff conducted remediation efforts which include daily collaboration meetings to discuss progress and vendor staff education and saw a reduction of grievances by 60%. In addition, CalOptima Health will be transitioning to a new vendor in April 2024.
- QIHEC was made aware of an issue with authorization in the Provider Portal where files were not loaded for referrals when the system migrated to the cloud. The provider portal team and UM staff resolved all impacted authorizations by end of day 11/15/2023.
- CalOptima staff continues to monitor the OneCare CMS star rating that was below 3.0 for Part C. The star rating has improved for the reporting year 2024 and, due to its improvement, staff expect that CMS will close the current Corrective Action Plan for low performance. A new Stars Steering Committee will commence on January 2024 to track and implement performance improvement activities for Part C and D Star measures.
- CalOptima Health conducted five annual audits of the delegates in Q3 2023. Delegation Oversight found trends in utilization management related to HN's decision and notification timeliness, translation of member notifications, missing or not current member attachments, and missing forms in NEMT reviews. CAPs are issued for areas of noncompliance.
- CalOptima Health continues to plan for the transition to a new clinical management system, Jiva, and system readiness will go-live on 1/15/24 and operations will go-live on 2/1/24.
- Due to a change in the credentialing turnaround times from 180-days to 60-days for mental health and substance use disorder providers, 98 providers are past the 60-day credentialing period, where 70 of the providers are Applied Behavioral Analysis (ABA) provider who are currently working under the supervision of a credentialed provider. To remediate, temporary staff has been hired, internal staff has been trained to assist in credentialing, and staff is seeking services from a Credentialing Verification Organization (CVO).
- COVID-19 Vaccination and Communication Strategy met the 70% goal with a vaccination rate of 70.28%. Program will end on 12/31/2023.
- CalOptima Health continues to not meet Initial Health Appointment (IHA) goals of members obtaining an IHA within 120-days of member enrollment. IHAs were being completed by specialists instead of a Primary Care Physician (PCP). Interventions to include an updated IHA report, provider education, and a pilot chart review.
- CalAIM is on track to meeting the six goals for the program. CalAIM activities include launching the Enhanced Care Management (ECM) Academy Pilot to bring on new ECM provider beyond the HNs, Street Medicine and Shelter Clinic Partnership Program (HCAP), increase utilization and establish an oversight strategy.

QIHEC Subcommittee Report Summary in Quarter 4, 2023	
Credentialing and Peer Review Committee (CPRC)	• CPRC met on 10/18/2023, 11/16/2023, and 12/14/2023. • Reviewed PQI and credentialing cases. • Three new medical directors joined CPRC. • Approved two new certifications for credentialing of providers. • Reviewed PQI cases and trend report. • Four physicians were recommended for de-credentialing.
Grievance & Appeals Resolution Services Committee (GARS)	• GARS Committee met on 11/14/2023. • Reviewed Q3 trends by line of business. • Increase in Medi-Cal grievances related to NMT as the vendor transitioned to a new system platform. Vendor remediation efforts are ongoing. Effective April 2024, a new vendor will provide NMT services. • OneCare grievances decreased due to a decrease in complaints regarding member billing and member access.
Member Experience Committee (MemX)	• MemX met on 11/28/2023. • Reviewed the 2022 Timely Access Survey Results. Corrective action plans were issued to providers for immediate action. • Reviewed the 2023 CAHPS Survey Results. Measure performance was between the 10th and 33rd percentile when compared to the Quality Compass benchmarks. • CalOptima Health submitted the Subcontractor Network Certification Submission to DHCS, where CAPs will be issued to HNs for areas of noncompliance. • CAHPS improvement activities using predictive analytics to be launched in January to March 2024.
Utilization Management Committee (UMC) • Benefits Management Subcommittee (BMSC) • Pharmacy and Therapeutics Committee (P&T)	• UMC met on November 16, 2023 • Reviewed over and under-utilization rates against goals. • The TCS process improvement project was a joint effort with Case Management and Utilization Management staff to create a new discharge script to enhance reporting and gather information regarding contacts. • Staff developed and implemented three workgroups focused on utilization patterns, oversight, and monitoring of bed day and readmission reduction, authorization strategy.
Whole-Child Model Clinical Advisory Committee (WCM CAC)	• WCM CAC met on November 12, 2023.

QIHEC Subcommittee Report Summary in Quarter 4, 2023	
	• WCM CAC charter was updated and approved adding a representative from Regional Center of Orange County (RCOC) and County of Orange Social Services Agency (SSA) to voting membership. • Reviewed WCM utilization and service data. • Customer Service data indicates that Medi-Cal Program, ABA Services and Change of Network were the top three categories for 2022 and 2023.

For more detailed information on the workplan activities, please refer to the Fourth Quarter of the 2023 QI Work Plan.

Attachment

Approved at QIHEC throughout Q4 2023: Fourth Quarter 2023 QI Work Plan 4Q

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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
Program Oversight	2023 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Quality Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIHEC-BOD; QI Work Plan-QIHEC-QAC	Annual Adoption by April 2023	Marsha Choo	Approved: QIHEC 2/14/2023, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2022 Quality Improvement Program Evaluation	Complete Evaluation 2022 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by January 2023	Marsha Choo	Approved: QIHEC 2/15/2022, QAC 3/8/2023, BOD 4/6/2023		
Program Oversight	2023 Utilization Management and Case Management Program	Obtain Board Approval of 2023 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Approved: UMC Committee via eVote on 4/7/2023, QIHEC 4/11/2023, BOD 8/3/2023		
Program Oversight	2022 Utilization Management Program Evaluation	Complete Evaluation of 2022 UM Program	UM Program will be evaluated for effectiveness on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	Approved: UMC Committee via eVote on 4/7/2023, QIHEC 4/11/2023, BOD 8/3/2023		
Program Oversight	Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Cultural and Linguistic Services Program and Cultural and Linguistic Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by April 2023	Carlos Soto	Approved: QIHEC 4/11/2023		
Program Oversight	Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	Hit one major milestone with the first ever submission of our PHM Strategy to DHCS. As part of the PHM Strategy, the PHM team worked with stakeholders from across the organization to identify gaps and opportunities to better serve the CalOptima Health population. Partnered with the Orange County Health Care Agency (OCHCA) to identify mutual priorities within their Community Health Assessment and Community Health Improvement Plan process to develop shared goals and SMART objectives that will be part of our 2024 PHM Strategy. Obtained approval from the Quality Improvement Health Equity Committee (QIHEC) to form a new PHM committee that will report up to the QIHEC and provide oversight and guidance on the PHM Strategy implementation	1) Implementation of PHM Strategy 2) Continue collaboration with the OCHCA to support development of goals and objectives for the CHIP and continue refining SMART objectives for the PHM Strategy 3) Commence the PHM Committee in Q1 2024	
Program Oversight	**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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Laura Guest	I. FSR/MRR/PARS, NF and CBAS II. Credentialing: CCN Initial Credentialing=64; CCN Recredentialing=98; BH Initial Credentialing=26; BH Recredentialing=33 III. A. PQI - In Q4 176 PQIs were opened, which has remained steady from Q2-Q4, and 121 were closed, which is a drop from Q1 and Q2. Six cases were presented at CPRC. 57% of the cases were categorized as Medical Care; 67% of those were Mismanaged care. 11% of the cases were leveled as 1, 2 or 3. 98% (improvement over Q3) of DG were reviewed in 30 days. At the end of Q4, 437 cases were in queue, a sharp rise from 343 at the end of Q1. 37% (drop from Q3) of PQIs were reviewed in 90 days. The number of QOC grievances reviewed in Q4 was 600, which was a 2%-17% increase over previous quarters. We interviewed for 1 new RN and 1 PS. We have been in involved with testing and training for a new system, Jiva for the QOC grievances, which will be implemented in Q1. B. PPCs - There were no PPCs identified through claims review in Q4.	**I. FSR/MRR/PARS, NF and CBAS** **A. FSR:** Initial FSRs=11 Initial MRRs=2 Periodic FSRs=30 Periodic MRRs=35 On-Site Interims=12 Failed FSRs=1 Failed MRRs=9 CAPs**:** CE=27 FSR=33 MRR=38 **B. PARS:** Completed PARS=78 BASIC Access=27 LIMITED Access=51 **C: CBAS:** Critical Incidents=5. All Critical Incidents reported were COVID cases. Non-Critical Incidents=14 Falls=9 Completed Audits=14 CAPs=10 Unannounced Visits=1 **NF**: No Critical Incidents were reported in Q4. Completed Audits=0 Unannounced Visits=0 **II. Credentialing:** Continue to credentialing and recredentialing of CCN and BH providers. Have engaged with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialling and recredentialing files. We have also hired temporary positions to assist in the high volume of initial credentialing providers. Additional training by Symplr (Cactus Provider Mgmt Platform), for the credentialing staff occured in the 4th Qtr of 2023. **III. A. PQI** - Continue to monitor the volume and TAT of PQIs, DC and QOC Grievances. Hire and train new staff. Contine to test and train team on Jiva for QOC grievances and prepare for the implementation of the PQI module. **B. PPCs** - Continue to review claims for PPCs and report them to the DHCS.	
Program Oversight	**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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Tyronda Moses	Meeting occurred on November 14, 2023 - Committee Approved Q2 GARS Committee minutes and reviewed Q3 trends by LOB. Trends and Remediation for Medi-Cal: Medi-Cal Grievances increased from 1.57 (Q2) to 1.77 (Q3) average rate per 1000/member months Atributing Factor: (NMT Transportation Q2 302 to Q3 612, MTM changed the Veyo members to align with the MTM system/platform on August 1, 2023 - significant hold times in the month of August,Calls answered by a national call center vs. a dedicated call center for CalOptima Health - this lead to incorrect benefits being quoted/services denied **Remediation, which continues:** - Benefits training by MTM for their staff on the rich CalOptima Health transportation benefits - Additional staff hired by MTM to answer calls - Frequent meetings as needed but no less than weekly - Effective April 2024, ModivCare will be the new servicing vendor for CalOptima Health transportation Trends and Remediation for OneCare: OneCare Grievances decreased from 19.06 (Q2) to 14.66 (Q3) aveage rate per 1000/member months Atributing Factors: (Decrease in Member Billing complaints Q2 112 to Q3 22, Decrease in Member Access complaints Q2 201 to Q3 65,Trending member dis-satisfaction, NMT Transportation,Provider Attitude) **Remediation, which continues:** - Benefits training on MTM for their staff on the rich CalOptima Health transportation benefits - Frequent meetings as needed but no less than weekly - Effective April 2024, MoivCare will be the new servicing vendor for CalOptima Health transportation - Provider and Health Network education and reminders on access standards - Provider and Health Network notification and/or request for training on any issues identified or perceived by our members	GARS to continue to monitor and report as appropriate. Next GARS Committee meeting scheduled for February 8	

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Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2023 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.	1Q23 update (6/13 QIHEC) 2Q23 update (9/12 QIHEC) 3Q23 update (12/12 QIHEC) 4Q23 update (TBD 2024 QIHEC)	Marsha Choo	In Q4, MemX Committee repurposed the ad-hoc meeting date of 10/30/2023 and met on 11/28/23 following its' quarterly cadence. Agenda items reviewed and discussed at November meeting are as follows: •Predictive Analytics RFP •Fast Facts Scorecard for Customer Service, Claims, GARS •CAHPS -Medi-Cal Plan/HN and MC HN Corrective Action -OneCare HN -Improve CAHPS •Member Experience Improvement Prgram -CY2024 OneCare Stars -Corrective Action Plan update •Increase Primary Care Utilization •Network Adequacy -Regulatory Updates -Reduce gaps in network and OON requests -Data analysis and reporting -Network Adequacy Workgroup •Timely Access -Regulatory updates -Timely Access SUrvey- Data Collection -Timely Access Workgroup	Met goal and continue to meet in 2024	
Program Oversight	**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.	1Q23 update (4/11 QIHEC) 2Q23 update (7/11 QIHEC) 3Q23 update (10/10 QIHEC) 4Q23 update (Jan 2024 QIHEC)	Stacie Oakley	UMC met 11/16/23 and is on track to meet quarterly. Meeting minutes are available for review. Quarterly metrics for UM, pharmacy, BHI, and LTSS are updated and presented. The BMSC meeting minutes from 8/30/23 and 9/20/23 were presented and approved.	An Ad Hoc UMC is scheduled for 1/25/24 and the next regular quarterly meeting is scheduled for 2/22/24	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.		1) Meet quarterly to provide clinical and behavioral service advice regarding Whole Child Model operations **2023 Meeting Schedules** WCM CAC Q1: February 21, 2023 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (4/11 6/13QIHEC) 2Q23 update (7/11 6/13 QIHEC) 3Q23 update (9/12 QIHEC) 4Q23 update (Jan 2024 12/12 QIHEC)	T.T. Nguyen, MD/H.Kim	WCM Met 11/7/2023. They presented and discussed the following: •Update by DCMO on redetermination efforts •Shared flyer with information regarding Medi-Cal Dental covered services •Care Coordination membership data and risk levels. •ECM and respite service for the CalAim program •WCM age-out process improvement efforts on hold and further discussion in Q1 2024 •WCM DHCS Assessment Report - Process improvement in pediatric risk stratification showed an increase in identified Hight Risk members •Transplant Program status update on continued efforts to obtain contracts with more hospitals. •Network Adequacy - All networks met the network adequacy requirement for WCM. •Utilization Management -- Admits and days PTMPY increased slightly, and all TAT goals were met. •Grievance and Appeals Resolution Services data - There were no significant changes for overall grievance and appeals in Q2 over Q1 however Behavioral Health grievances were trending lower. •Whole Child Model Member Inquiries - 7 of the 10 top categories remained the same. General questions received regarding the Medi-Cal Program more for WCM members than non WCM members; Questions regarding change of network were received by more non WCM members than WCM members. Inbound calls increased for behavioral health customer service since the pandemic but no trends have been identified •Pediatric Quality Measures -Well-Child Visits in the First 30 Months of Life: First 15 Months (W30) overall WCM rates are lower than the overall rates by about five points. All the other metrics for WCM surpasses the non WCM population. •Behavioral Health Quality Measures/Utilization - Increase in BHT excluding Kaiser members. Will monitor to see if this is a result of the effects from the pandemic. No significant changes on the number of members receiving ABA services. •Update - Student Behavioral Health Incentive Program, Pediatric California Advancing & Innovating Medi-Cal, and Pharmacy. •DHCS and CalOptima Health Policies affecting Whole Child Model - New release.	WCM CAC members requested consideration to include UM data for entire plan/MCP. CalOptima Health will discuss internally for data retrieval approach. The next meeting is scheduled for 2/20/24.	
Program Oversight	Pediatric Risk Stratification Process (PRSP) monitoring		Discuss annually the Pediatric Risk Stratification algorithm with the CCS program	Aug-23	Hannah Kim	Reviewed with QIHEC and no input/updates provided.	Review annually in 2024.	
Program Oversight	Managed Care Accountability Set (MCAS)	Achieve 50th percentile on all MCAS measures for MY2022	Share results to Quality Improvement Committee annually	end of 3Q 2023	Paul Jiang	Results presented.	Review annually in 2024.	
Program Oversight	Health Network Quality Rating	Achieve 4 or above	Will share HN performance on all P4V HEDIS Measures via prospective rates report each month	end of 4Q 2023	Sandeep Mital	The Pay for Value (P4V) team generates a Prospective Rate (PR) report each month for all participating health networks and CalOptima Health to allow health networks monitor their progress on clinical HEDIS measures in the P4V program. Performance on each measure is compared to the overall CalOptima Health performance, as well as to the National Medicaid HEDIS benchmarks established by NCQA.	The overall health network quality rating (HNQR) is the weighted average of the network's HEDIS and CAHPS measure ratings, as well as accreditation bonus points and is calculated on a scale of 1-5 (5 being the highest). The final HNQR for MY2022 for the Medi-Cal line of business for all participating health networks was presented at the QIHEC Committee meeting on September 12, 2023.	
Program Oversight	CalAIM	Improve Health & Access to care for enrolled members	1) Launch ECM Academy; a pilot program to bring on new ECM providers. 2) Increase CalOptima Health's capacity to provide community supports through continued expansion of provider network. 3) Continue to increase utilization of benefits. 4) Establish oversight strategy for the CalAIM program. 5) Implement Street Medicine Program 6) Select and fund HHIP projects through Notice of Funding Opportunity. 7) Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	1) 1Q 2023 2) 4Q 2023 3) 4Q 2023 4) 3Q 2023 5) 1Q, 2Q 2023 6) 1Q 2023 7) 3Q 2023	Mia Arias	1. ECM Academy has graduated 40 proividers. 2. The CalAIM provider network has grown to 77 providers. 3. The utilization of benefits has continued to grow and is now reaching levels of 44,000 members served. 4. Now that a CalAIM Medical Director has been onboarded; this oversight strategy will be developed. 5. Street Medicine has been operating in Garden Grove since April 2023; it will expand to Costa Mesa and Anaheim in the coming months. 6. HHIP Round 2 proposals were selected and approved in October 2023; $52.3 million was committed to 15 proposals to develop permanent housing. 7. HCAP will be re-launched as of January 1, 2024.	Work on these efforts will continue as described.	

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Program Oversight	Health Equity	Increase member screening and access to resources that support the social determinants of health	1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	1) 4Q 2023 2) 4Q 2023 3) 3Q 2023	Katie Balderas	1) Activities reported in Q3 carried on during Q4. SDOH questions finalized are being programmed into JIVA. Pending DHCS approval on the SDOH screening question added to the Health Information Form/Member Evaluation Tool (HIF-MET). ITS continued development of the SDOH screening in member portal using CMS Accountable Communities for Health questions. 2) Received and review closed-loop referrals RFPs 3) As of the end of this quarter, 159 CalOptima Health Staff from 22 departments enrolled in the Health Literacy for Equity program with 42 successfully completing the certificate program.	1) SDOH screening questions will launch with Jiva implementation in January 2024. Pending DHCS approval of SDOH questions added to the HIF-MET tool. Continue development of the SDOH Screening in the member portal 2) Continue RFP process and bring recommendation to CalOptima Health for approval of a closed-loop referral vendor 3) Continue to encourage staff to complete the Health Literacy for Equity certificate.	
Program Oversight	Improvement Projects Medi-Cal PIP(BH)	Meet and exceed goals set forth on all improvement projects	Non-Clinical PIP - FUM/FUA 1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	Improve the percentage of members enrolled into care management, complex care management (CCM), or enhanced care management (ECM), within 14-days of a Emergency Dept visit where the member was diagnosed with SMH/SUD. 1) Submitted BH Non-Clinical PIP to DHCS 9/29/23, awaiting feedback. 2) Feedback from DHCS recieved-Technical assistance was provided by DHCS. 3) Re-submitted PIP on 11/29/2023. 4) Received final 2023–24 PIP validation findings on 01/04/24 and no further action is required.	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis for CCN and COD members. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. BHI will conduct the outreach and provide information about case managment including ECM and referrals. 3) Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CCN members identified who meet FUM/FUA criteria. 4) Working with internal depts to identify baseline data for CM, CCM, and ECM enrollment.	
Program Oversight	Improvement Projects OneCare 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 for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	end of 2Q2023	Helen Syn	Live Call: CM and Dm Medication Adherence Call Campaign and due for other measures (HBD, EED, SPD, KED) Statin Mailer (SPD) Medication Adherence Text Campaign (SPD) IVR Campaign (HBD/SPD) Baseline Data: PR Report Nov 2023 HbA1C <8 Total (HBD): MC: 40.41% OC: 52.79% HbA1c>9 Total (Poor Control) (HBD): MC: 53.40% OC: 40.56% Eye Exam for Patients with Diabetes (EED): MC: 48.68% OC: 64.84% Kidney Health Evaluation for Patients with Diabetes (KED): MC: 42.38% OC: 53.07% Statin Use in Persons with Diabetes (SUPD) OC only: 82.87% 3)VSP Eye Exam Reminder Letters: MC Total sent in Q4 2023: 4521, OC Total sent in Q4 2023: 1199 5) Member Incentive: A1C Test: Processed 1556 approved 1498 for MC; Processed 337 approved 329 for OC EED: Processed 1341 approved 1243 for MC; Processed 309 and approved 291 for OC	1) Track submitted diabetes member incentive forms 2) Chronic Disease Management Group: Initiate Emerging Risk Diabetes Cohort. 3) Diabetes Live Call Outreach campaign 4) Continue VSP Eye Exam Reminder Letters 5) Continue multimodal member engagement and outreach campaigns.	
Program Oversight	Improvement Projects Medi-Cal PIP	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP - Health Disparity remediation for W30 6+ measure (Jan Pending January Module Training January 2023 projected. Please note that the focus for the Clinical and Non-Clinical PIP topics is related to DHCS' "50 by 2025: Bold Goals Initiatives"- See links for more information on the Bold Goals Initiatives: https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/Equity-and-Practice-Transformation-Grants-May-Revise.pdf or https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf	Quarterly Status update on modules as they are completed.	Helen Syn	1) CalOptima received final validation findings for PIP and was approved by HSAG	Next Steps - Working to identify staffing resources to support PIP intervention. Expecting to launch call campaign in Feb 2024	
Program Oversight	OneCare Performance measures	Achieve 4 or above	1) Implement Star Improvement Program 2) Track measures monthly 3) Implement OC Pay4Value	1. 1Q2023 2. 2Q2023 3. 3Q2023	Linda Lee	2024 Part C improved to 3.0 stars from 2.5 in the prior year. 2024 Part D and overall star rating remained at 3.5 an 3.0 stars, respectively.	Identified Star measures for focused interventions for remainder of CY. Initiatives underway.	
Program Oversight	Plan Performance Monitoring and Evaluation (PPME): HRA and ICP	Retired: 3.2 ICP completion 90 days Benchmark 90% adjusted. 2.1 Initial HRA collected in 90 days from eligibility Benchmark: 95% adjusted. NEW: Successful transition to revised Oversight process.	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring.	1Q23 (5/9 QIHEC) 2Q23 (8/8 QIHEC) 3Q23 (11/14 QIHEC) 4Q23 (February 2024 QIHEC)	S. Hickman/M. Dankmyer/H. Kim	1)Met 2023 Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance: December file used to provide feedback to Health Networks. 2) Met 2023 Develop communication process with Networks for tracking outreach and completion to meet benchmarks: December MOC tracking file analysis with feedback sent to Health Networks. 3) Met 2023Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring: This has been implemented and is ongoing with each Health Network reviewed on quarterly basis. 4) Met 2023 Initial HRA collection in 90 days from eligibility benchmark 95% adjusted for Core 2.1 reporting. Revision were submitted to DHCS for Q1, Q2, and Q3 as follows: Q1: Members unwilling to participate 10% (93) Members unable to be reached 26% (252) Members who completed assessment 64%(605) Members reached, willing and completed assessment 100% Q2: Members unwilling to participate 5% (45) Members unable to be reached 18% (159) Members who completed assessment 77%(675) Members reached, willing and completed assessment 100% Q3: Members unwilling to participate 3% (28) Members unable to be reached 18% (149) Members who completed assessment 78% (637) Members reached, willing and completed assessment 100% 5)Not Met 2023."Benchmark (90%) not met for 3.2 ICP completion 90 days in Q1-3. Root causes relate to mass transition of OCC to OC members 1/1/2023; and, DHCS revision of technical specifications on 11/17/2023 retroactive to 1/1/2023." Initial ICP collection in 90 days from eligibility for Core 3.2 which has been removed from QI Workplan: Reporting revised Q1/2/3 rates with DHCS resubmission: Q1 Members unwilling to participate 10% (99) Members unable to be reached 14% (133) Members who completed assessment 43%(406) Members reached, willing and completed care plan 56% Q2 Members unwilling to participate 9% (82) Members unable to be reached 20% (178) Members who completed assessment 54% (571) Members reached, willing and completed care plan 76%% Q3 Members unwilling to participate 15% (124) Members unable to be reached 23% (185) Members who completed assessment 371 (46%) Members reached, willing and completed care plan 73%	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance: Will require remediation with JIVA. 2) Continue with monthly communication to Networks for tracking ICP outreach and completion to meet benchmarks and establish MOC Tracking file error validation response process. 3) Ongoing quarterly audit of Health Networks using Oversight audit tool. Creation of tracking tool for score summary month by month. 4) Initial HRA collection in 90 days from eligibility benchmark 95% adjusted for Core 2.1 reporting.	

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Program Oversight	NCQA Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and **NCQA Health Equity Accreditation by no later than January 1, 2026.**	1) Continue to Work with Business owners to collect all required documents for upcoming HP re-accreditation.(Must collect all Year one required documents by 2Q2023. 2) Comple Gap Analysis for Health Equity Accreditation.	1) end of 1Q2023 2) end of 2Q2023	Veronica Gomez	A. Health Plan Accreditation 1. 95% of Year-One documents (4/30/2022-4/30/2023) have been collected. 2. 80% of Year-two documents (4/30/2023- 4/30/2024) have been collected. Staff completing final reviews and revisions to documents before submitting for final review by consultant. B. Health Equity Accreditation 1. Consultant completed a review of all the applicable standards. 2. Developed a work plan. 3. Several working sessions have taken place to meet with owners and identify gaps in meeting specific elements. 4. Consultant does not anticipate any difficulty in meeting the June 2025 target date for completing Health Equity accreditation.	The collection and completion of deliverables for both Health Plan and Health Equity accreditation will continue until the submission date. CalOptima's Health NCQA Consultant has developed a detailed work plan that outlines all the gaps, recommended actions and dates for actions that need to be completed for Health Equity Accreditation. The consultant will set up recurring meetings with CalOptima Health staff to go over the work plan and monitor the completion of tasks. The recurring meetings will also be used to answer questions for staff and go over their documents in a working session.	
Program Oversight	Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	1 Implement SBHIP DHCS targeted interventions 2. bi-quarterly reporting to DHCS	1) 4Q2023 2) 4Q2023	Diane Ramos/ Natalie Zavala/Carmen Katsarov	1) Completed and submitted 4 Biquarterly Reports, sent to RAC 12/28 prior to the DHCS due date of 12/31/23. 2) Conducted Bi-weekly meetings with OCDE to identify and prioritize SBHIP activities to be discussed during the monthly OCDE SBHIP collaborative meeting. 3) Received and reviewed the quarterly progress reports from SBHIP partners CHOC, WYS, OCDE, and Hazel Health. 4) Received the DHCS statewide multi-payer school-linked fee schedule; forwarded to internally impacted departments. 5) Credentialing completed for Hazel Health leading to the completion and execution of the Hazel Health and CalOptima Health provider service contract effective Jan 2024. WYS will not be able to proceed with a contract until they are Medi-Cal enrolled. 6) Received funding in Oct from DHCS for the June 2023 biquarterly submission.	1) Gather 1st quarter 2024 SBHIP partners implementation status on the services they are building/designing via SBHIP funding - OCDE, WYS, CHOC, and Hazel Health. 2) Identify and track partner deliverables stemming from the monthly OCDE and SBHIP Partner meetings. 3) Prepare workflow for school districts to become COH contracted providers, including assistance from IT, contracting, claims, and provider relations. 4) Continue to support OCDE reviewing school districts' budget plans for their SBHIP funds.	
Quality of Clinical Care	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	1) Assess community infrastructure capacity for cancer screening and treatment 2) Establish the Comprehensive Cancer Screening and Support Program Stakeholder Collaborative (in our Case I want to leverage OC3) 3) Develop comprehensive outreach campaign to outreach to members due for cancer screenings (mobile mammography, outbound calls, community health workers) 4) Integrate new community health worker benefit into cancer outreach and treatment services.	1) 1Q2023 2) 2Q2023 2) 3Q2023 3) 4Q2023	Katie Balderas	1) Community infrastructure and capacity for cancer screening and treatment was accomplished in Q3, information from assessments was used to develop a funding opportunity to address barriers and opportunities 2) This activity was accomplished early in 2023 with a CalOptima Health staff joining the Orange County Cancer Coalition and continuing participating in these meetings to provide updates, share opportunities and develop collaborative partnerships with the 19+ organizations who attend the OC3 meetings. 3) Kick off discovery phase with vendor for development of the Comprehensive Community Cancer Screening Awareness and Education Campaign. Began collaborative meetings with Northgate Market to plan a mobile mammography screening event. 4) No progress on integration of CHW into Cancer Screening Program as of this quarter, but facilitated e-introductions between organizations doing cancer and our CalAIM team leading the CHW benefit rollout.	1) Seek Board approval of funding opportunity to address barriers and opportunities identified during the brainstorming sessions. Release Notice of Funding opportunity and launch a community grant program. 2) Continue to attend OC3 meetings 3) Engage community partners to inform discovery phase for the Comprehensive Community Cancer Screening Awareness and Education Campaign 4) Continue to work with the CalAIM for the integration of CHWs to support members with their cancer screening and treatment journey.	
Quality of Clinical Care	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP) Care Management, Comprehensive Diabetes Care (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	Linda Lee	Based on MY2002 results, prioritize new star measures and lower performing measures including: transitions of care, plan all cause readmissions, and follow up after ED visit for people with multiple high-risk chronic conditions.	Current interventions will continue for remainder of Q4. Identified measures will be carried over and prioritizd for improvement activities in CY2024.	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS MY2023 Goal: MC 30-Day: 54.51%; 7-day: 31.97% OC (Medicaid only)	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q4 (November): 30 day- 35.75%, 7 day- 21.28% 1) The main barrier has been not havng the bandwidth to outreach to members that we have been receiving on a daily basis. 2) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis. 3) BI-weekly Member text messaging campaign. a. 1st wave sent in late November 2023 b. 2nd wave sent in Mid December 2023	1) Pull data for Data Analyst to send out bi-weekly text messages based on real time ED data. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. BHI will conduct the outreach and provide information about case managment including ECM and referrals. 3) Develop 2024 text message campaign schedule	
Quality of Clinical Care	Blood Lead Screening DHCS APL	1) Comply with APL requirements including quarterly reports of members missing blood lead screening 2) Increase Rates of successfully screened members to #% 3) Put process in place ot identify refusal of blood lead consent forms	- PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. - Update Policy GG.1717 to include Health Network Attestation and conduct Health Network/Provider education - Add blood lead screening resources to CalOptima Health website: Comprehensive Health Assessment Forms, CDPH anticipatory guidance handout, - Launch IVR campaign to members with untested children - Member mailing campaign to members - Lead texting campaign for members - Medi-Cal member newsletter article(s)	All activities will be complete by 3Q, 2023	Helen Syn	**1) Quality Interventions** - Quality Committee approval for member health reward for lead testing at 12 and 24 months of age which is in alignment with the clinical recommendations for testing. Member health reward expected to launch in QI 2024. - November 2023: Member IVR campaign launched to target members not compliant with HEDIS. - Campaigns (dates vary): PBS TV Campaign ran November 2023; Social media ad campaign ran October & November 2023; Radio ad campaign ran October & November 2023; Digital ad campaign ran October & November 2023. - November 29, 2023: Participated in HCCN Clinical Quality Champion meeting to provide key clinics with an overview of blood lead testing, current clinic rates and best practices to support increased testing. - October, November, December 2023- (ongoing effort) Health Networks and CCN providers were issued Blood Lead Screening Reports with member detail data of members who have not tested for lead in alignment with clinical guidelines. Reports also proactivley identify the members that will be due for lead testing at 12 and 24 months within 1-3 months of the report issue date. - October 2023 - Notified Health Networks of the availability of CalOptima Health Pediatric Quality Guide which contains a Blood Lead Testing Guide to support clinical best practices for lead testing. **- October - December 2023: Bright Steps completed 6 month (66 members) and 12 month well child follow-ups (5 members) and provided parents/guardians with education and lead testing requirements at 12 months of age.** **2) Community Focused Efforts:** December 2023-Participated in CalOptima Health Bright Steps Program baby shower and provider lead screening education to parents/guardians of child members; Began discussions with Orange County Health Care Agency (OCHCA) to partner and develop joint strategies that support the increase of blood lead testing. **3) November Prospective Rate: 60.66% (non continuous enrollment rate):** This measure is faring slightly higher thatn the same time last year in November 2022 (59.95%). The final rate is still pending and is expected to be higher as this is a hybrid measure. We are projecting that the LSC measure will meet the MY2023 minimum performance level.	Next Steps: - Launch the blood lead screening health reward for lead testing at 12 and 24 months of age. - Continue with various member and public facing campaigns to support education efforts to increase awareness of the importance of lead testing. - Update existing Protect Your Family from Lead Poisoning member education piece to - Continue to develop provider based efforts to increase blood lead testing rates. - Continue to monitor prospective rates for testing rates and high opportunity providers for collaboration. - Continue to work with OCHCA to develop initiatives to support an increase in blood lead testing. - Continue issuing the Blood Lead Performance Report to support identifcation of members not tested for lead in accordance with state requirements.	

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Quality of Clinical Care	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2023 Goal: Postpartum: 84.18% Prenatal: 91.89%	1) Track member health reward impact on HEDIS rates for postpartum care measure. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 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) Expand member engagement through direct services such as the Doula benefit and educational classes	1) Annual Evaluation 2) Per quality initiatives calendar - ongoing updates 3) Ongoing updates 4) 4Q2023 5) 3Q2023	Ann Mino/ Helen Syn	**1) Quality Interventions** - Bright Steps Program: 762 PNRs received, 810 assessment completed, 681 unique members served during Q4 2023. - Postpartum Care Incentive: A total of 511 postpartum incentives have been processed through Q4 (cumulative) - October 2023 Pospartum Text Campaign to 219 members that were not compliant with postpartum care that still had time to get the care. - October 2023 Telephone Outreach campaign to 165 members that were not compliant with postpartum care that still had time to get the care. - December 2023: Bright Steps Program baby shower. Total of 450 attendees. Provided information on timely postpartum visits, postpartum care health reward. - Campaigns (dates vary): Social media ad campaign ran October for prenatal care and ran November and December 2023 for postpatum care. - New PBS TV ad for prenatal care in production and preparing for launch in 2024. - November 29, 2023: Participated in HCCN Clinical Quality Champion meeting to provide clinics with an overview of prenatal and postpartum care including best practices and current rates per clinic. - Doula Services: CCN has contracted with 2 doulas and an additional 11 LOAs have been approved for doula services to support the PPC measure. **2) Community Focused Efforts:** Began discussions with Orange County Health Care Agency (OCHCA) to partner and develop joint strategies that support maternal mental health. **3) November Prospective Rates:** Timeliness of Prenatal Care: 46.15% and is performing lower than this same time last year in November 2022. Postpartum Care: 63.74% and is performing higher that this same time last year in November 2022.	Next Steps: - Continue with various member and public facing campaigns to support education efforts on prenatal and postpartum care - Continue to monitor prospective rates - Continue to work with OCHCA to develop initiatives to support comprehensive maternal mental health - Strategize delivery data to support targeted member outreach for postpartum care and the identification of early pregnancies. - Work with HNs and HEDIS team to identify root causes of low prenatal rate	
Quality of Clinical Care	COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (18 and over).	1) Communication Strategy of COVID vaccination incentive program through December 31, 2023, end date, focusing on unvaccinated, and updated dosage opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for updated doses.	1) end of 2Q2023 2) end of 3Q2023	Helen Syn	1. Internal communication to member-facing staff of program end date. 2. Texting campaign to address eligibility guidelines and end date of the program - goal met. 3. Reached 70% vaccination rate for CalOptima members (18 and older).	COVID-19 VIP processing continues - official end date of the program is 12/31/2023.	
Quality of Clinical Care	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	HEDIS MY2023 Goals: Blood Glucose-All Ages:54.36% Cholesterol-All Ages: 36.17% Glucose and Cholesterol Combined-All Ages: 34.30%	1) Communication Strategy of COVID vaccination incentive program through December 31, 2023, end date, focusing on unvaccinated, and updated dosage opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for updated doses.	2Q2023 update(7/11)	Diane Ramos/ Natalie Zavala	PR HEDIS RATES Q4 : Blood Glucose all ages: 53.61%, Cholesterol all ages: 35.32%, Glucose & Cholesterol Combined all ages: 34.13% 1) Barriers included: Receiving timely data and accurate information. 2) Identified members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report. 3) The following materials have been disseminated to Providers: a) Provider Best Practices Letter. b) APM Provider Tip Sheet. 4) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 6) Text Messaging Campaign was sent out to members in the month of December.	1) Develop 2024 text message campaign schedule. 2) Pull data for Data Analyst to send out monthly text messages. 3) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits.	
Quality of Clinical Care	Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	MY 2023 Goals: CCS: MC 62.53% BCS: MC 61.27% OC 70% COL: OC 71%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	1) Quarterly Updates 2) Per Quality Initiatives Calendar - ongoing updates	Helen Syn	1) 2023 Member Health Rewards processed as of 1/22/2023: CCS: Processed 1564 approved 1412 for MC; BCS: Procesed 1538 approved 1383 for MC Processed 282 approved 264 for OC; COL: Processed 196 approved 154 for OC 2) Member, Community and Provider Engagement Mailing: CCS Texting: BCS, CCS (women Screening) Live Call Campaign for OC Medication Adherence Cohort: OC members due for BCS and COL Digital Ad: BCS Print Ad: BCS Radio: CCS Social Media (Paid): BCS, CCS Social Media (Passive); BCS Community Update: BCS 3) 2023 November Prospective Rates (PR): Cervical Cancer Screening MC: 52.24% Breast Cancer Screening MC: 54.29% OC: 63.23% Colorectal Cancer Screening OC: 60.28%	1) Continue to track member health reward impact on HEDIS rates for cancer screening measures. New Colorectal Cancer Screening Reward added for Medi-Cal LOB. 2) Continue multimodal member engagement and outreach campaigns. 3) Addition of provider and health network engagement and collaborative efforts. 4) Development of new text message campaigns for cancer screening with new Vendor.	
Quality of Clinical Care	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)	MY2023 HEDIS Goals:: MC 63.75% OC: 79%;	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures 3) VSP Collaborative gaps in care bridging efforts.	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation 3) End of Q2 2023	Helen Syn	1) 2023 Member Health Rewards processed as of 1/22/23: EED: Processed 1341 approved 1243 for MC; Processed 139 and approved 126 for OC 2) Member, Community and Provider Engagement Live Call Campaign: OC Medication Adherence population for EED Digital Ad Print Ad Radio Ad Social Media (Paid) Television Ad: Diabetes PBS ad video in review 3)VSP Eye Exam Reminder Letters: MC Total sent in Q4 2023: xx, OC Total sent in Q4 2023: xx 4)PR Report Nov 2023 Eye Exam for Patients with Diabetes (EED): 48.68 MC: % OC: 64.84%	1) Continue to track member health reward impact on HEDIS rates for EED. 2) Continue multimodal member engagement and outreach campaigns. 3) Initiate Emerging Risk Diabetes Cohort. 4) Addition of provider and health network engagement and collaborative efforts. 5) Development of new text message campaigns for cancer screening with new Vendor.	

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Quality of Clinical Care	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2023** Goals: MC: 30.9%; OC: 17%	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation	Helen Syn	1)2023 Member Health Rewards processed as of 1/22/2024: A1C Test: Processed 1556 approved 1498 for MC; Processed 337 approved 329 for OC 2) Member, Community and Provider Engagement IVR Live Call Campaign for OC medication Adherence population for HBD poor control measure Digit Ad Print Ad Radio Ad Social Media (Paid) Television Ad: Diabetes PBS ad video in review Live Call Campaign: OC members due for HBD 3) PR Report Nov 2023 HbA1C Poor Control Total (HBD) MC: 53.4% OC: 40.56%	1) Continue to track member health reward impact on HEDIS rates for HBD. 2) Continue multimodal member engagement and outreach campaigns. 3) Initiate Emerging Risk Diabetes Cohort. 4) Addition of provider and health network engagement and collaborative efforts. 5) Development of new text message campaigns for cancer screening with new Vendor.	
Quality of Clinical Care	MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs	Meet and exceed MPL for DHCS MCAS Corrective Action	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.	Quarterly Status update on modules as they are completed.	Helen Syn	Well-Child Visits in the First 30 Months (W30-2+) PDSA Cycle 3: 7/31/23 – 11/30/23. Intervention included an in-house telephonic call campaign and a birthday card mailer. SMART Aim Goal: By October 31, 2023, successfully outreach to 45% of members who completed PDSA Cycle 2 (n=104) and who meet outreach criteria. Intervention Implementation Period: 09/25/23 – 10/26/23. Telephonic call campaign completed by 1 staff member, in-house. Results: 54.55% confirmed they attended their scheduled WCV. 46.94% confirmed they scheduled their child's next WCV. Outreach success rate of 50.96% to confirm Cycle 2 outcomes. The SMART Aim Goal of successfully met.	W30-2+ PDSA was approved on 1/21/2024. The findings concluded members who had 2 successful telephonic outreaches is impactful. Will plan to continue with telephonic outreach calls in the future.	
Quality of Clinical Care	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 **MY2023** Goal CIS-Combo 10: 49.76% IMA-Combo 2: 48.42% W30-First 15 Months: 55.72% W30-15 to 30 Months: 69.84% WCV (Total): 57.44%	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. Examples: EPSDT DHCS promotional campaign; Back-to-School Immunization Clinics with Community Relations; expansion of Bright steps comprehensive maternal health program through 1 year postparum to include infant health, well-child visits, and immunization education and support 3) Early Identification and Data Gap Bridging Remediation for early intervention.	1) 3Q2023 2) Per quality initiatives calendar - ongoing updates 3) End of Q22023	Helen Syn	1)Pediatric telephonic call campaigns. Phase 4: 9/25 – 11/1, outreached to 722 members. 2)1st and 2nd Birthday Card Mailing in October, November and December to 5,262 members. 3)W30 Member Detail Report continues to be available to health networks in alignment with PR data. 4)WCV 3-17 Years Text Campaign 10/6/23 to 67,891 members. 5)WCV 3-17 Years IVR Campaign 11/6/23 to 33,823 members. 6)November 2023 Prospective Rate (noCE): CIS-Combo 10: 28.95%, performing lower than last year (30.93%), have not met MPL, did not meet goal 49.76% pending medical record review*; IMA-Combo 2: 42.52%, performing lower than last year (44.90%), met MPL, have not met goal 48.42%. There has been an uptick in vaccine hesitancy in 2023. W30-First 15 Months: 41.96%, performing higher than last year (35.91%), has not met MPL, has not met goal (55.72%); W30-15 to 30 Months: 65.66%, performing lower than last year (68.37%), has not met MPL, has not met goal (69.84%); WCV-Total: 41.36%, performing lower than last year (42.34%), has not met MPL, has not met goal (57.44%). Well care visits continue to be a challenege.	1) Continue targeted member engagement and outreach campaigns. Leverage new avenues to reach members and providers. 2) Continue providing W30 Member Detail Report to health networks as aligned with Prospective Rates Report. 3) Build out new age-based, growth and development milestones text message campaign for pediatric and adolescent group.	
Quality of Clinical Care	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2023 Goal: MC 77.48% OC (Medicaid only)	1) Identify members through internal data reports in need of diabetes screening test. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) 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.	1. 2Q2023 2. 3Q2023 3. 2Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q4 (Nov): M/C:70.75% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report. 2) Conducted telephonic outreach to prescribing providers, then sent 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). 3) Barriers included: Receiving timely data, obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. Other difficulties we have come to know is that some members with this diagnosis do not see their PCP regularly. 4) In process of developing new outreach strategies working with internal depts (Case Management) to help reach out to members. 5) Text messaging outreach capaign sent out in December.	1) 1st Quarter Report will be pulled in April 2024 2) Continue tracking members in need of diabetes screening test. 3) Continue outreach to prescibing providers. 4) Data Analyst pull data for text messaging. 5) Text Messaging Campaign will continue on a monthly basis. 6) Use provider portal to communicate follow-up best practice and guidelines for Diabetes screening. 7) Develop 2024 text message campaign schedule	
Quality of Clinical Care	Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot	1) Lower HbA1c to avoid complications (baseline: A1c ≥ 8%; varies by individual); 2) Improve member and provider satisfaction	<u>Final Pilot Program Design:</u> 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement <u>Planned Activities:</u> Finalize member stratification Outreach to high volume PCPs Launch the pilot program	Finalize member stratification - end of Jan 2023 Outreach to high volume PCPs - end of Q1 Launch the pilot program - end of Q1	Joanne Ku	Although the pilot program received interest from one provider, due to the overall lack of provider engagement, CalOptima Health's senior leadership decided that it was in our best interest to sunset this pilot project and re-strategize future efforts.	N/A	
Quality of Clinical Care	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	MY2023 Goals: MC: 30-days: 21.24%; 7-days: 8.93%	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q4 (November): 30 day- 20.53%, 7 day- 10.79% 1) The main barrier has been not havng the bandwidth to outreach to members that we have been receiving on a daily basis. 2) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis. 3) BI-weekly Member text messaging. a. 1st wave sent in late November 2023 b. 2nd wave sent in Mid December 2023	1) Pull data for Data Analyst to send out bi-weekly text messages based on real time ED data. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. BHI will conduct the outreach and provide informatio 3) Develop 2024 text message campaign schedule	

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Quality of Clinical Care	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2023 Goal: MC - Init Phase - 42.77% MC -Cont Phase - 51.78%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on provider responsibilities on related to follow-up visits. 3) Continue member outreach (through multiple modalities telephonic, newsletter, mobile device) to improve appointment follow up adherence.	1. 2Q2023 2. 4Q2023 3. 3Q2023	Diane Ramos/ Natalie Zavala	PR HEDIS Rates Q3 (November): Initiation Phase- 48.15%, Continuation and Maintenance Phase- 53.66% 1) In process of developing new outreach strategies for members regarding medication compliance. 2) Continued member telephonic outreach for members that filled ADHD Rx. 3) Text messaging outreach campaign sent in December.	1) Pull monthly data for data analyst to scrub for text messaging. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Member Health Reward Incentives. 4) Develop 2024 text message campaign schedule	
Quality of Clinical Care	Reporting of Communicable Diseases	Improve provider reporting of communicable disease	1) Educate provider on the requirements and process to report communicable disease	1. 2Q2023 2. 4Q2023 3. 3Q2023	Marsha Choo	A Communication was developed explaining the responsibility for contracted Providers to report any suspected case(s) of any diseases or conditions listed on the California Department of Public Health (CDPH) website to the local health officer. The address, phone, and fax number was provided to the local Orange County Local Health Department. The communication was sent over to the Communications Department and provided in the January Provider Newsletter .	Work with our communciations department to set up a standing article for regular provider education on this topic.	
Quality of Service	Increase primary care utilization	Increase rates of Initial Health Appointments for new members, annual wellness visits for all members.	1) Increased Health Network/Provider education and oversight 2) Enhanced member outreach (IVR, digital engagement)	1) 1Q2023 2) 2Q2023	Katie Balderas	Activities presented in Q3 were accomplished as follows: 1a. Chart review process was transitioned from pilot to regular implementation. 1b. IHA Reference Guide was updated on the provider website page. 1c. Quarterly communications were sent to providers/health networks on relevant IHA updates. 1d. New data logic was validated. The Health Networks and providers/stakeholders were informed of new performance measure expectation. Challenges: The logic change was not shared with the Health Networks or providers/stakeholders as it held no relevance to the current goal. The focus was placed on educating the Health Networks and Providers of the new goal for the IHA completion rate. 2a. IVR were implemented as an interactive campaign for unengaged members. 2b. ITS developed a report on the provider portal that shows new members and the IHA due date. Challenges: In 2a. above, the plan from Q3 was to develop regular process for monitoring outcomes of the interactive campaign for unengaged members. However, this process has not started as the implementation of chart review took up more resources and time. We still plan on reviewing this data and decide on an appropriate intervention in 2024.	1) Track IHA completion rate among Health Networks and share results with the Health Networks, providers and QIHEC quarterly. 2) Monitor outcomes of the interactive campaigns for unengaged members and establish a follow up intervention.	
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS to meet goal	1) Issue an RFI to obtain information on CAHPS improvement vendors and strategies, contract and launch program 2) Member outreach to all OneCare members 3) Track measures for monitoring individual provider performance (ie. number of grievances, number of CAPs issued) and take action based on committee action	by end of 3Q, 2023	Mike Wilson	1) Contract was signed with Ushur/Decision Point. Implementation in process.	1) Met goal - initial call campaigns either have begun or will begin early Q1 2024, mailers are in final stages of approval before being sent to identified membership	
Quality of Service	STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan	1) by end of 4Q2023	Linda Lee	2023 CAHPS scores remain largely unchanged compared to prior year results. One rate, Rating of Health Care Quality, improved significantly from one to three stars. Other member experience measures demonstrating improvement include: members choosing to leave the plan, timely decisions about appeals, reviewing appeals decisions, and call center foreign language interpreter and TTY availability.	Current interventions will continue for remainder of Q4. Identified measures will be carried over and prioritizd for improvement activities in CY2024.	
Quality of Service	Provider Data Improvement	Improve Provider Data in Facets	1) Develop and implement a process to utilize Lexis Nexis data correct provider data errors 3)Establish process for ongoing review and maintenance of data	by end of 4Q, 2023	Debra Gonzalez	Goals were not met. Resources needed to work with the vendor to understand the data output and develop a process for utilizing the data.	Meetings with Lexis Nexis to understand data specs. Pend until resources are availlable.	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Reduce OON requests by 25%	1) LOA project to outreach and recruit providers that are currently receiving letters of agreements.	by end of 4Q, 2023	Adriana Ramos	Met - Developed and implemented process for Letters of Interest Packets Met - Established application process for all provider types, streamline and expediting application through credentialing and contracting of new providers	Continue with plan and monitoring internvetntions being developed to address the letter of interest process.	
Quality of Service	Improve Timely Access: Appointment Availability	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	1) Provider incentive to meet timely access standards 2) Provider incentive for extending office hours	by end of 2Q, 2023	Mike Wilson	Timely access was still an area with many opportunities for improvement with our provider community. The most recent data (collected in Fall 2022) was shared with providers and health networks in Q4. This is still an area of emphasis and a point that is being addressed in multiple ways with our external partners.	Provided scripting to assist offices with scheduling, education for providers and health networks around the timely access standards, increased monitoring to have better access to real-time data	
Quality of Service	Provider Data Improvement	Improve HN Provider data	1) Develop and implement process for auditing HN Directory data to meet SB 137 requirements 2) Create score cards for HN directory data accuracy 3) Establish process for auditing provider directory attestations	by end of 4Q, 2023	Silvia Peralta	Met - Developed and implemented process for auditing HN Directory data to meet SB 137 requirements Met - Created score cards for HN directory data accuracy Met - Established process for auditing provider directory attestations	Plan will continue to be as listed.	
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Submit SNC to DHCS 2) Develop a process for remediating and Capping efforts 3) Communicate results and remediation process to HN 4) Monitor for improvement	by end of 4Q, 2023	Quynh Nguyen/Mike Wilson	SNC was submitted on time in Q4 and Health Networks were sent CAPs for non-compliance related to SNC. Work is ongoing to improve all areas of non-compliance including network adequacy and timely access.	Continue with plan with additional interventions being developed to address deficiencies.	

Evaluation Category	2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	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
Safety of Clinical Care	Transitional Care Services (TCS)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving successful interactions for TCS high-risk members within 7 days of their discharge.	Planned Activities: 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Setting up the workgroup - end of 1Q 2023 Updating the UTC letter - end of 2Q 2023	Stacie Oakley Hannah Kim Scott Robinson	1) Initiated audits on completion of outreach for members in need of TCS for High Risk Members. 2) Automation of validation process for Health Network monthly TCS files used for oversight and DHCS reporting. 3) Discussed TCS during Hospital Info Series 12/14/2023 with providers. 4) UM-working on enhanced PCP discharge notice	1) Use of Usher platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting. 5) Revision of Goals and Activities for 2024 TCS	
Safety of Clinical Care	Emergency Department Diversion Pilot	Pilot has been implemented. In 2023 plan to expand the program to additional hospital partners.	1. Promoting communication and member access across all CalOptima Networks 2. Increase CalAIM Community Supports Referrals 3. Increase PCP follow-up visit within 30 days of an ED visit 4. Decrease inappropriate ED Utilization	by end of 4Q, 2023	Scott Robinson	The UCI ED pilot was not started due to the inability to create a secure teams channel and execute a data useage agreement. Ther are currently no metrics to report.	Continue to work with the ITS, legal and contracting. The goal is to implement this program in Q1 2024.	

Board of Directors' Quality Assurance Committee (QAC) Meeting
March 13, 2024

Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
Fourth Quarter 2024 Meeting Summaries

November 14, 2023: PACE Quality Improvement Committee (PQIC) and PACE Infection Control Subcommittee Summary of the Health Plan Monitoring Data and PACE Quality Initiatives

- Infection Control Subcommittee: PACE's Response to COVID-19:
  - PACE will continue to report on any updates in recommendations regarding COVID and any outbreaks or reporting trends for quality purposes
  - Q3 had the largest number of COVID cases since Q4 2022. (25 participant cases in August and September)
  - PACE Staff to report exposure/illness to their supervisor and HR, and not to come in if feeling sick
  - Q1 2023 new Quality Element was introduced to workplan with a goal of 80% PACE participants to receive Bivalent booster dose. At the end of Q3 2023, the rate was 62.9% vaccinated with Bivalent Booster dose, a decrease from 63.1% in Q2
  - In October 2023 the CDC began recommending a newly approved 1-dose COVID vaccine regardless of past vaccination history. This vaccine is referred to as the "2023–2024 updated COVID-19 vaccine" and is produced by Pfizer, Moderna and Novavax. Based on this update, PACE will no longer be providing COVID-19 booster dose and has ordered the new vaccine to be provided by nurses at PACE center when available
  - As of November 6, 2023, 142 participants have received the 2023-2024 update vaccine- approximately 32% of participants
- Presentation of Q3 2023 HPMS Elements:
  - Membership data presented. In terms of total membership, Q3 ended with 434 total enrolled. The goal of 469 was not met
  - Immunizations
    - Pneumococcal Immunization rate is at 81% (no exclusions) 350 received, 62 prior immunizations, 17 refused and 5 missed opportunities
    - The influenza Immunization rate is 45% (no exclusions). 195 received, 2 prior immunizations, 2 refused and 235 missed

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opportunities. **Note**- the vaccine only became available last month of Q3 2023

- Falls without Injury. Q3 ended with 77. An increase from 62 in Q2.
- Grievances. Decrease from 11 in Q2 to 3 in Q3. 2 were transportation related, 1 was Contracted Specialist related
- Emergency Room Visits. 98 ER visits, an increase of 11 from Q2. 46 were d/c to home without hospital admission. 52 admitted to hospital (4 for observation only). Trends in admission diagnoses: Chest Pain, Respiratory Failure and UTI/Kidney/Urinary Issues. Other common admission diagnoses include- Sepsis/Infection, Vomiting, Heart Disease
- Medication Errors Without Injury. No errors reported in Q3
- Quality Incidents with Root Cause Analysis. 5 Falls with Injury, 1 Burn Injuries and 2 Pressure Ulcer

- Presentation of the Q3 2023 PACE Quality Initiative Data
  - Advanced Health Care Directive
    - Goal: ≥ 50% of participants will have completed AHCD in 2023. Inaccurate data due to incorrect scanning of documents on TruChart. Though this initiative was not met Q3 2023, we will continue this initiative throughout 2023
  - Dental Satisfaction Quality Initiative.
    - Goal: ≤ 1 dental related grievance per quarter in 2023
    - 1 dental grievance reported, goal met
    - Information Regarding Q3 2023 Dental Grievance
      - Family member who filed grievance remained dissatisfied with grievance resolution, even after speaking with dentist who provided the care to participant
      - PACE QI opened a PQI investigation based on potential quality concerns in dental care provided by contracted dental technician
      - Potential Quality Issue was reviewed by PACE medical director, who discussed with other CalOptima Health medical directors including the Deputy Chief Medical Officer
      - The case was not deemed necessary to be presented to the CPRC (Credentialing and Peer Review Committee)
      - Dental Provider was given a best practices letter and PACE will continue to track and trend any dental complaints

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- Transportation Satisfaction Quality Initiative
  - Goal is ≤ 3 **valid** transportation related grievance per quarter in 2023
  - Valid transportation grievances received in Q3 2023: 1.
    - 2 received in total. Secure classified 1 as "valid", 1 was marked as "invalid"
  - Satisfaction: 2 of 2 participants/family reported satisfaction with grievance resolutions

November 14, 2023: PACE Quality Improvement Committee (PQIC) Summary Quality Assurance and Performance Improvement Work Plan

- Presentation of the 2023 Quality Work Plan Elements
  - *Elements 3 – 5: Immunizations*
    - Pneumococcal Immunization rate is at 91%. (Note, this % is different from HPMS vaccine reporting due to exclusion in our quality work plan). Goal of 94% was not met
    - The influenza Immunization rate is 46% (Note, this % is different from HPMS vaccine reporting due to exclusion in our quality work plan). Goal of 94% was not met
    - Covid-19 Bivalent Booster is at 62.9%. Goal of 80% by end of 2023. *Note: This goal is discontinued as of Q3 2023, since the bivalent booster no longer available as of September 2023
  - *Element 6: POLST.* Goal is 95%. In Q3, 98% of participants have POLST in their chart. Goal was met
  - *Elements 7 – 9: Diabetes Monitoring*
    - Blood Pressure Control. Goal is 84.21% participants will have a blood pressure of <140/90mm. Rate is 83.9%. Goal was not met
    - Diabetic Eye Exams. Goal of 85.24%. Rate is 90%. Goal met
    - Nephropathy Monitoring. Goal is 98.78%, Rate is 100%. Goal met
  - *Element 10: Osteoporosis Treatment.* Goal of 100%. The rate is 84% of participants with Osteoporosis receiving treatment. Goal not met
  - *Element 11: Reduce Percentage of Falls reported by PACE Enrollees.* Q3 2023 ended with 78 total falls, not meeting the Goal of <72 falls per quarter in 2023
  - *Elements 12 - 13: Potentially Harmful Drug/Disease Interactions in the Elderly*
    - **Dementia and drug interactions-** Goal of <26.64% % of participants with Dementia will be prescribed a tricyclic antidepressant or anticholinergic agent. Excluded are participants

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with Palliative Care Approach dx and those with schizophrenia or bipolar disorder
    - Goal is <26.64%. Rate is 19%. Goal met
    - **CKD and drug interactions–**Goal of <2.62% % of participants with CKD 3,4, or 5 (end stage) will be prescribed a Nonaspirin NSAIDS or Cox2 Selective NSAIDs. Rate is 0%. Goal met
- *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. Actual: Met goal. Only 1 participant received a dose greater than 90 MME and had PCP follow up each month in Quarter 2 2023
- *Element 15: Medication Reconciliation Post Discharge (MRP)*. Goal is 90% within 15 days. Rate is 100%. Goal Met
- *Element 16: Access to Specialty Care.* Goal is ≥ 88% to be scheduled within 14 business days. 92% in Q2 2023. Goal Met
- *Element 17: Acute Hospital Days.* Goal is <3,330 in 2022. Goal was not met. In Q3, bed days were 3337
- *Element 18: Emergency Room Visits.* Rate is 786. Goal of <850 emergency room visits per 1000 per year was met
- *Element 19: 30-Day All Cause Readmissions.* Goal is <14%. Rate was 26%. Goal was not met
- *Element 20: Long Term Care Placement.* Goal is <4%. Rate is 0.08% in Q2. Goal met. Long Term Care Placement are participants placed in custodial care in SNF in any period
- *Element 21: Enrollment Conversion*. Goal is >65%. Rate is 74%. Goal met
- *Element 22*: *90 Day Disenrollment* Goal is > 6.5%. Rate is 4%. Goal met
- *Element 23: Attrition Rate*. Goal is <10%. Rate is 5.81% Goal met
- *Element 24: Transportation <60 minutes.* Based on the data from Secure, there were 0 violations in Q3. Per Secure- Time stamps are recorded on IQ platform. Drivers are to inform dispatch if they are going to pass the 60-minute time frame
- *Element 25: Transportation on Time Performance.* On time performance data gathered directly from Secure transportation report to reflect on time trips with a +/- 15-minute window. The goal is ≥92% of all transportation rides will be on-time. Rate is 86%. Goal not met

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December 7, 2023: PACE Quality Improvement Committee (PQIC) Ad Hoc meeting to Discuss Proposed Clinical Changes to 2024 Quality Work Plan Elements and Clinical Quality Initiatives

- *Elements 3 – 5: Immunizations*
  - Influenza Element: No changes for 2024
  - Pneumococcal Element: No changes for 2024
  - COVID Element: Change the goal from 80% to 50% and follow CDC recommendations vs. previous goal of doing booster doses, per medical director
- *Element 6: POLST.* No changes for 2024
- *Elements 7 – 9: Diabetes Monitoring*
  - Blood Pressure Control. In 2024 will include not just diabetics in monitoring but also non-diabetic with hypertension diagnosis.
  - Diabetic Eye Exams. Change goal to 87.29%
  - Nephropathy Monitoring. Removing this element due to consistent goal meeting, per medical director
- *Element 10: Osteoporosis Treatment*
  - Changing element for 2024. New goal is that 75% of included participants (Diabetics, all women 55 to 85, and men over 70) will have a DEXA scan within the past 5 years or if not, will have one by end of year
- *Elements 12 - 13: Potentially Harmful Drug/Disease Interactions in the Elderly*
  - Dementia and drug interaction- Change goal to <25%
  - CKD and drug interactions– Removing this element due to consistently meeting goal, per medical director
- *Element 14: Decrease the Use of Opioids at High Dosage*
  - No change to element for 2024
- *Element 15: Medication Reconciliation Post Discharge (MRP)*
  - Change goal to 93% of participants will have med rec within 7 calendar days
- *Element 17-20: Utilization*
  - Hospital Days- No changes
  - ER Visits- Change goal to <825 visits
  - 30 day readmission- No changes
  - Long Term Placement- No changes
- *Dental Satisfaction Quality Initiative*
  - No changes for 2024
- *Proposed New Clinical Quality Work Plan Elements for 2024*
  - Colorectal Cancer Screening

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        - Goal is 65%
        - Measure: Colonoscopy every 10 years or Fit Test in the past year
        - Participants aged 55-74
        - Exclusions: Fragility, Palliative
    - Breast Cancer Screening
        - Mammogram every 2 years
        - Inclusions: Women aged 50-74
        - Exclusions: Exclusions: Palliative, Hospice Participants 76 years and older
    - HBA1C control for diabetics
        - Goal: 11.79%
        - Measure using HBA1C most recent
        - HbA1c poor control (>9.0%)
        - Inclusions: Participants aged 55-75 (by the end of the year)
        - Exclusions: Palliative, Hospice Participants 76 years and older

December 11, 2023: PACE Quality Improvement Committee (PQIC) Ad Hoc meeting to Discuss Proposed Non-Clinical Changes to 2024 Quality Work Plan Elements and Non-Clinical Quality Initiatives

- *Element 11: Reduce Percentage of Falls Reported by PACE Enrollees*
    - No changes to element for 2024
- *Element 21-23: Enrollments/Disenrollment*
    - The Qualified Leads to Enrollment Conversion Rate
        - Increased goal to 70%
    - Controllable Disenrollments
        - Less than 6% of newly enrolled participants will disenroll (For Controllable Reasons), within their first 90 days of enrollment
        - Change goal from 6.5% to 6% in 2024
    - Attrition Rate
        - Change from >=10% to <=8% attrition in 2024
- *Element 24 – 25: Transportation*
    - No changes to either transportation performance element
- *Element 26-28: Annual Satisfaction Elements*
    - Only changes will be to align new goal percentages with the 2023 PACE annual averages for each domain, once available
- *Advance Health Care Directive Quality Initiative*

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        - Increase the goal to 70%
        - Exclusions: Participants without capacity (MMC less than 16) and Participants enrolled less than 6 months
        - 2 staff are now trained notaries to be able to provide services in 2024
    - *Advance Health Care Directive Quality Initiative*
        - No change to goals
    - *Proposed New Non-Clinical Quality Work Plan Element for 2024*
        - Participants attending Alternative Care Setting sites in 2024
            - Goal: 15% of PACE enrollees to attend an ACS by end of 2024
            - Exclusion: Participants in custodial care

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Member Trend Report 4th Quarter 2023

Quality Assurance Committee Meeting
March 13, 2024

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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Overview of Presentation

- Definitions
- Grievances by Line of Business
  - Per 1,000 Member Month (M/M)
  - Trends
- Remediation Activities and Quarterly Comparison

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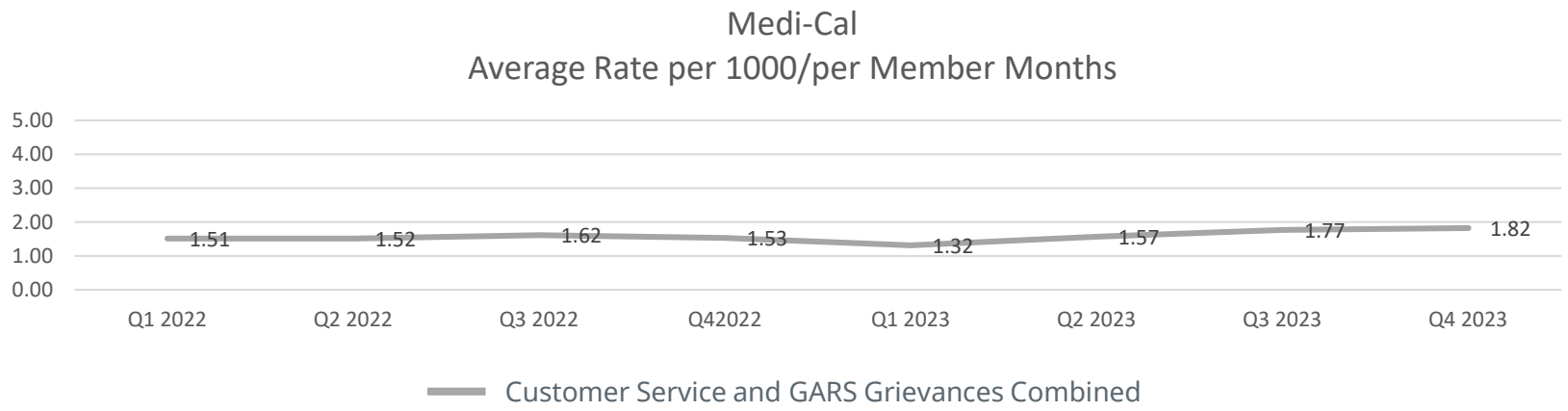
Definitions

- Grievance: An oral or written expression indicating dissatisfaction with any aspect of a CalOptima program
  - Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction
  - Quality of Care (QOC): Concerns regarding care the member received or feels should have been received

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Medi-Cal Grievances Rate per 1,000

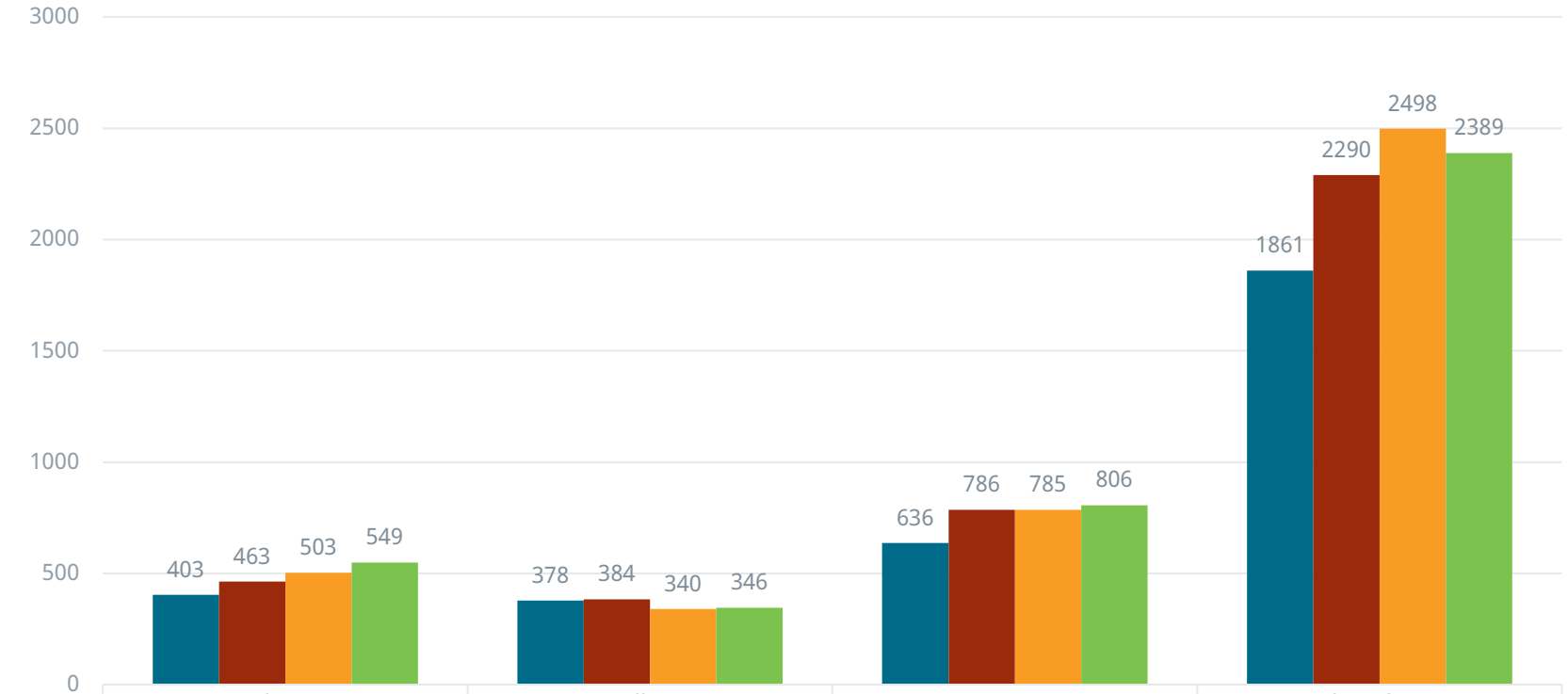


Quarter	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Customer Serv. r/1000	.17	.16	.17	.20	.18	.24	.34	.38
Customer Serv. Ct	428	438	461	553	507	719	995	1030
GARS r/1000	1.35	1.35	1.45	1.33	1.14	1.33	1.42	1.44
GARS Ct.	3491	3599	3940	3694	3278	3923	4127	4090
Combined r/1000	1.51	1.52	1.62	1.53	1.32	1.57	1.76	1.82
Combined Ct.	3919	4037	4401	4247	3785	4642	5122	5180

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Medi-Cal
CalOptima Health

Medi-Cal Member Grievances by Category



	Quality Care	Billing	Access	Quality of Service
Q1-23	403	378	636	1861
Q2-23	463	384	786	2290
Q3-23	503	340	785	2498
Q4-23	549	346	806	2389

Trends by Category:
Quality of Care: Question Treatment (209), Delay in Treatment (200),
Billing: Member Billing Issue – HN (150) Member Billing Issue – COD (94),
Access: Appointment and Availability, Telephone Accessibility (124)
Quality of Service: Transportation (526), Provider Services (261)

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Medi-Cal
CalOptima Health

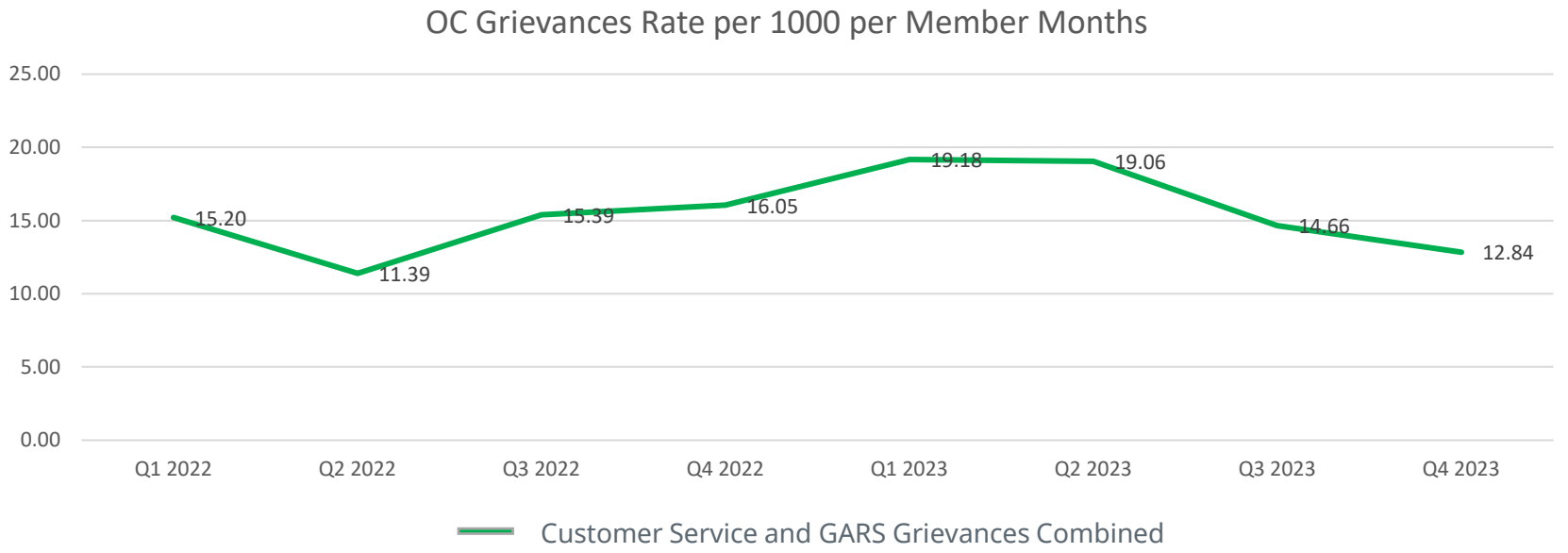
Medi-Cal Member Grievances

	Billing & Financial* 10%				Quality of Care 12%				Attitude/ Quality Service 58%				Access 20%							
Health Network	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	4th Qtr Total	4th Qtr Rate per 1000/ per MM	YTD Total	YTD Rate per 1000/ per MM
AltaMed	11	11	6	5	26	30	38	44	64	77	98	81	27	30	33	32	162	0.80	613	0.76
AMVI	3	4	4	6	4	10	11	6	6	15	16	11	7	3	5	8	31	0.36	119	0.35
Arta	9	12	8	9	20	16	16	23	68	86	64	70	25	39	41	41	143	0.77	547	0.73
CHA	18	20	17	17	29	31	28	27	58	72	58	59	28	30	40	27	130	0.27	559	0.29
Family Choice	5	5	4	6	10	13	16	14	30	30	32	28	7	12	13	12	60	0.42	237	0.42
Heritage	2	1	7	2	5	6	4	14	24	20	21	15	6	9	8	12	43	1.60	156	1.45
Kaiser^^^	114	114	77	74	21	30	16	25	341	390	355	298	67	98	56	74	471	2.65	2150	3.03
Monarch	71	64	59	61	70	71	103	71	283	292	282	228	134	152	122	107	467	1.47	2170	1.71
Noble	1	1	3	5	4	5	9	8	20	21	24	31	8	8	8	10	54	0.83	166	0.64
Prospect	10	7	7	18	17	17	20	25	44	52	90	52	27	23	33	30	125	0.97	472	0.92
Talbert	15	8	4	5	15	18	17	17	47	45	77	54	18	26	33	34	110	1.17	433	1.15
UCMG	8	11	2	8	6	8	6	19	34	33	44	40	17	17	35	28	95	0.72	316	0.60
CCN	69	56	82	75	141	150	152	191	470	562	613	726	196	271	302	321	1313	3.19	4377	2.66
COD	33	47	49	38	15	25	17	10	109	135	144	90	30	25	19	30	168	0.43	816	0.53
CalOptima Pharmacy	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0.00	1	0.00
Plan Provided Services																				
Vision Services	0	4	2	1	0	3	1	2	0	17	13	14	0	4	5	2	19	0.01	68	0.01
Behavioral Health	9	16	9	13	17	24	21	20	46	45	43	65	38	33	30	37	135	0.05	466	0.04
NMT Transportation	0	0	1	3	3	6	28	33	217	316	522	527	1	0	2	1	564	0.20	1660	0.15
Grand Total	378	384	341	**346**	403	463	503	**549**	1861	2290	2497	**2389**	636	786	785	**806**	**4090**	**1.44**	**15417**	**1.81**

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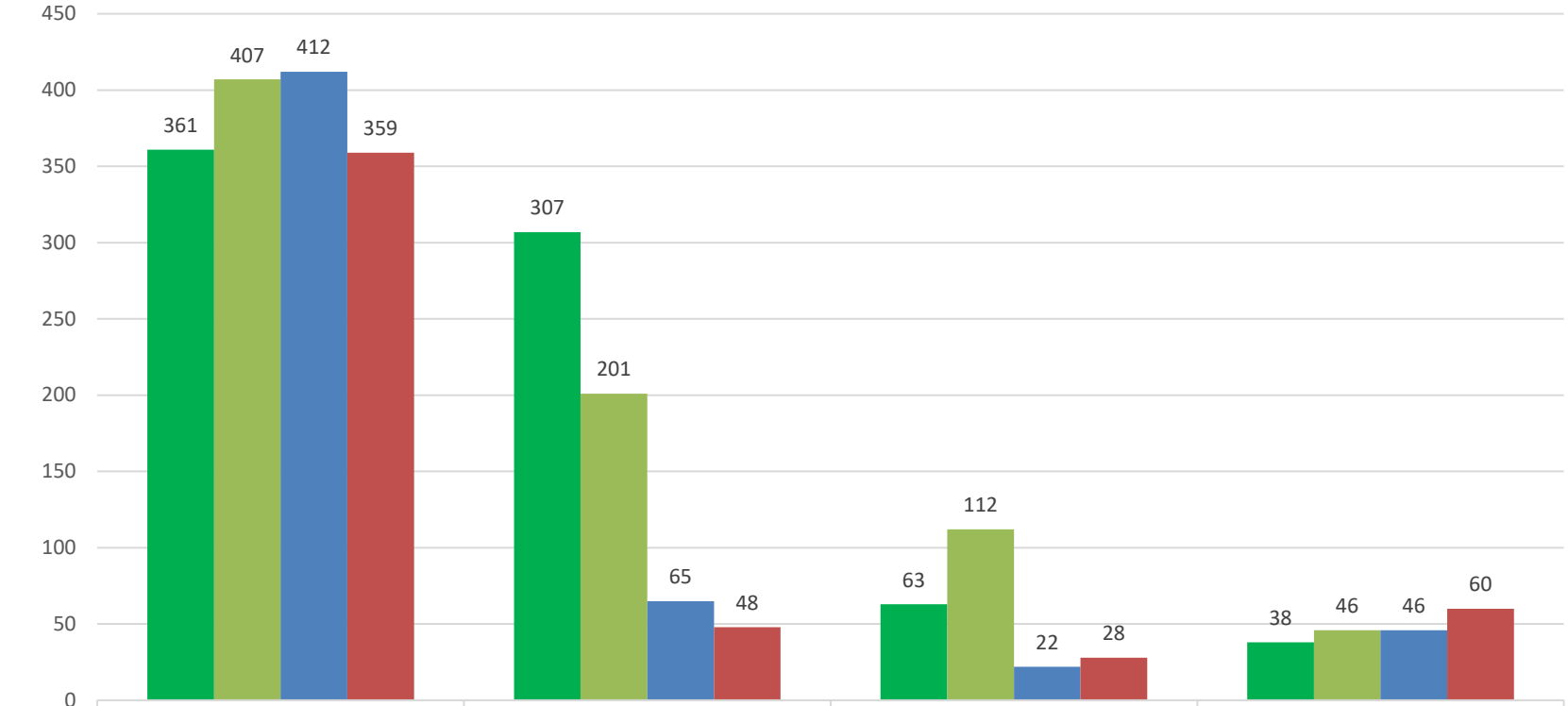
OneCare Grievances



Quarter	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
OC_Customer Serv. r/1000	11.85	8.58	12.22	11.51	4.45	4.70	4.43	3.48
OC-Customer Serv. Ct	85	67	104	104	232	251	236	184
OC-GARS r/1000	3.35	2.82	3.17	4.54	14.74	14.35	10.23	9.36
OC-GARS Ct.	24	22	27	41	769	766	545	495
Combined r/1000	15.20	11.39	15.39	16.05	19.18	19.06	14.66	12.84
Combined Ct.	109	89	131	145	1001	1017	781	679

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OneCare Member Grievances by Category



	Quality of Service	Access	Billing	Quality of Care
Q1-23	361	307	63	38
Q2-23	407	201	112	46
Q3-23	412	65	22	46
Q4-23	359	48	28	60

Trends by Category:
Quality of Care: Question Treatment (18), Delay in Treatment (13)
Billing: Member Billing COD (13), Member Billing HN (9)
Access: Referral related (22), Telephone Accessibility (13)
Quality of Service: Transportation (212), Provider Services (54)

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OneCare CalOptima Health

OneCare Member Grievances

	Billing/ Financial 9%				Quality of Care 6%				Attitude/ Quality Service 57%				Access 28%						
Health Network	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Qtr 4 Total**	**Qtr Rate per 1000 per month**	**Avg Membership**
Alta Med Health	3	0	0	1	3	3	1	8	6	8	16	2	11	6	6	0	**11**	3.8	961
AMVI Care	1	3	0	0	0	0	1	0	3	1	2	1	3	1	1	0	**1**	0.9	387
Arta Western	2	1	1	0	2	2	2	1	7	4	7	5	6	5	3	1	**7**	2.7	862
CCN OC	23	36	9	5	7	13	11	11	45	58	58	76	42	32	16	15	**107**	13.0	2,750
Family Choice	4	5	1	2	0	1	0	1	8	3	11	8	16	9	2	0	**11**	1.9	1,955
Monarch	20	34	5	13	14	14	20	13	85	73	87	42	86	59	19	18	**86**	5.1	5,668
Noble	3	2	0	0	1	0	3	1	1	1	1	0	5	1	0	0	**1**	0.9	351
Prospect	5	14	4	2	5	4	4	7	35	15	29	17	38	26	7	4	**30**	4.3	2,324
Regal	0	5	0	2	0	2	0	0	1	5	1	2	1	2	2	1	**5**	7.2	233
Talbert	1	7	1	1	3	5	2	6	20	14	16	7	27	12	6	4	**18**	4.3	1,383
UCMG	0	2	1	1	1	1	1	0	2	3	5	2	7	2	0	1	**4**	1.8	757
OneCare Pharmacy	0	0	0	0	0	0	0	0	6	6	6	6	5	4	0	2	**8**	0.2	17,630
Plan Provided																			
Behavioral Health	0	0	0	0	0	0	0	1	0	1	1	1	0	0	0	2	**4**	0.1	17,630
Convey Health (OTC)	1	0	0	0	0	0	0	0	16	17	12	0	34	9	2	0	**0**	0.0	17,630
Silver and Fit	0	0	0	0	0	0	0	0	1	1	1	0	14	12	0	0	**0**	0.0	17,630
Vision Services	0	1	0	0	1	0	0	1	3	8	1	3	1	2	1	0	**4**	0.1	17,630
NMT Transportation	0	0	0	1	1	1	1	10	122	146	158	187	11	4	0	0	**198**	3.7	17,630
Grand Total	**63**	**112**	**22**	**28**	**38**	**46**	**46**	**60**	**361**	**407**	**412**	**359**	**307**	**201**	**65**	**48**	**495**		**17,630**
YTD	**225**				**190**				**1539**				**621**						

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Remediation Activities and Quarterly Comparison

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Remediation Activities and Quarterly Comparison

Identified Issues	Remediation Activities
Veyo / MTM	• In Q4 the grievances were related to the following: - No show/canceled rides - Timeliness (to early pick up or late pick up) - Scheduling (wrong address, wrong time, passenger preference) - Driver Services (driver safety / attitude) - Vendor Customer Service (service / attitude) • Continued weekly collaboration meetings between CalOptima Health and MTM management team and discuss member escalations planning • Effective April 2024, Modivcare will be the new CalOptima Health transportation vendor. Both NMT and NEMT services will be transitioned to this vendor.
Quarterly Comparison	• *Q2 309 > Q3 612 > Q4 526* • *For Q3 Grievances in this area of transportation services increased by 98% for our Medi-Cal LOB. During this time there was a system transition by the vendor* • *Q4 Grievances in this area reported a decrease from Q3 by 14% for our Medi-Cal Line of Business*

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Remediation Activities and Quarterly Comparison Contd.

Identified Issues	Remediation Activities

Medi-Cal (LOB)
- Access Issues
- Billing
	• Provider Access trends include several of the FQHC's
	  • AltaMed Health Services, Camino Health, Central City Community Health Center, Share Our Selves Community Health Center, St Jude Neighborhood Health Center and UCI Family Health Center (each having multiple locations on the list.)
	  • Reviewing assignments as the assigned member totals tends to be higher to the FQHC
	• No trending providers for billing grievances (provider type tends to be Hospitalist and emergency service providers)
	• GARS continues to work with Provider Relations as we monitor the access trends and billing grievances.

Quarterly Comparison	• Q4 Access grievances increased by 3% • Q4 Billing grievances remained consistent at 346 total
OC (LOB) - Quality of Care	• GARS continues to work with the Quality Improvement Department on any quality of care issues • No provider trends were identified
Quarterly Comparison	• *Quality of Care cases increased from Q3 at 46 to Q4 at 60* • *Q4 QOC Grievances increased by 30%*

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