CalOptima Health

2023

QUALITY IMPROVEMENT PROGRAM

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SIGNATURE PAGE

Quality Improvement Committee Chair:

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Board of Directors Chair:

Clayton M. Corwin — Date: 4-11-23

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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
	QIC	Quality Improvement Committee
	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
	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 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 agency and with our members and providers.

Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2023–2025 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.

Quality Mission: 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 Goals:

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 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 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

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

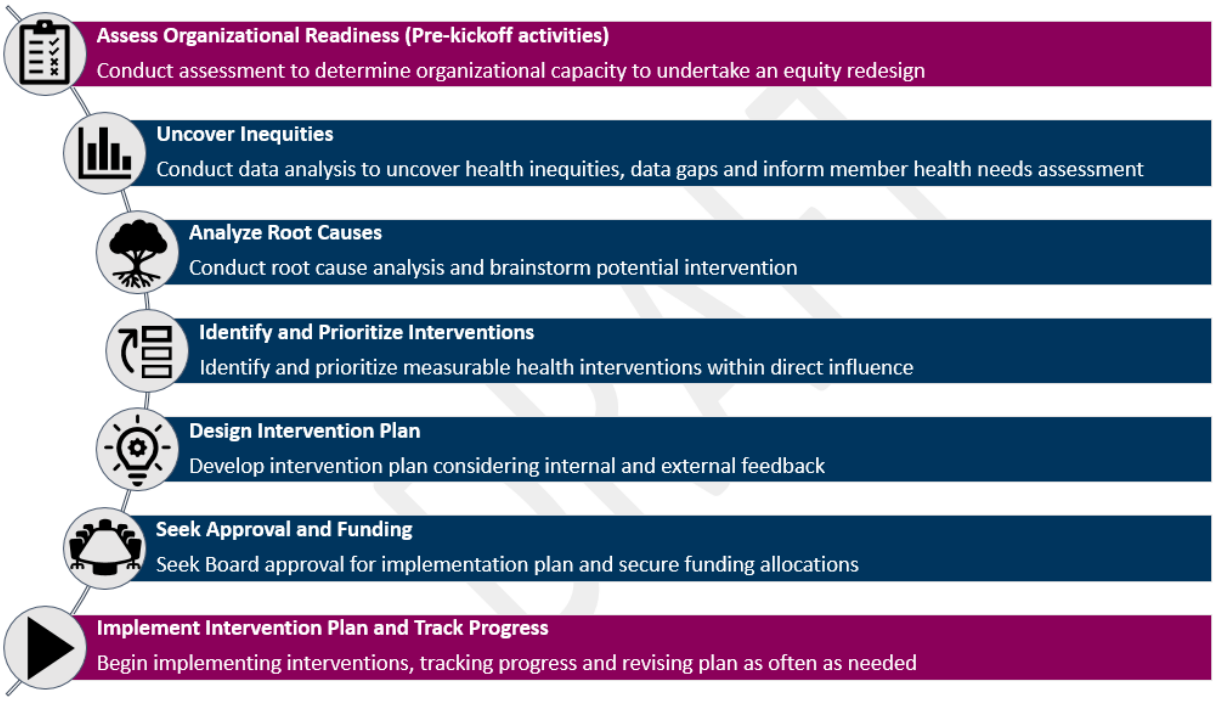
- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

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 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.



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.

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] https://www.science.org/doi/10.1126/science.abd3377

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.

CalOptima Health Programs

"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 in 2019.

CalOptima Health provides Enhanced Care Management and Community Supports services to address social drivers of health. 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 (HCA)
- Substance use disorder services are administered by 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 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 HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

In 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.

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)

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.

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 Services:
- CBAS: 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, as well as its role in diverting members from institutionalization.
- 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 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 the frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must 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. 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 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

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 through CalOptima Health Direct, CalOptima Health Direct-Administrative and/or CalOptima Health Community Network (CCN) and/or contract with a CalOptima Health Network (HN). CalOptima Health members can choose CCN or one of 12 HNs representing more than 9,400 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 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 1,500 PCPs, more than 7,900 specialists, 40 acute and rehabilitative hospitals, 31 community health centers and nearly 100 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	PHC	-
AMVI/Prospect Medical Group	-	SRG
CHOC Health Alliance	PHC	-
Family Choice Medical Group	PHC	SRG
HPN-Regal Medical Group	HMO	-
Kaiser Permanente	HMO	-
Noble Mid-Orange County	SRG	SRG
Optum Care Network - Arta	SRG	SRG
Optum Care Network - Monarch	HMO	SRG
Optum Care Network - Talbert	SRG	SRG
Prospect Medical Group	HMO	-
United Care Medical Group	SRG	SRG
Delegated 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

- Contracting
- Credentialing of practitioners
- Customer service

Membership Demographics

Membership Data* (as of December 31, 2022)

Total CalOptima Health Membership

944,975

Program	Members
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.

Member Demographics (as of December 31, 2022)

Member Age	
0 to 5	9%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65 +	12%

Language Preference	
English	59%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	40%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Quality Improvement Program

CalOptima Health's Quality Improvement (QI) Program 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 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 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 Program Purpose

The purpose of the CalOptima Health QI Program 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 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.

The CalOptima Health QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima Health's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program 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 QI 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 practices that support accreditation by NCQA and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the 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 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.

- Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

- Ensuring certain contracted facilities 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 that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement culture at CalOptima Health.

- Ensure the annual review and acceptance of the UM Program Description, 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 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 strategic quality and business goals by utilizing 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.

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

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 QI Committee 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 QI Program annually.

The 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 QI Program. Such recommendations shall be aligned 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. QAC routinely receives progress reports from the QIC 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 of the QI Program 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

The Member Advisory Committee (MAC) has 15 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, 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 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
- Member Advocate
- County of Orange Social Services Agency (OC SSA)
- OneCare Member (2 seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 15 positions — held by OC SSA — is a standing seat. Each of the remaining 14 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 HCA, 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
- HCA (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 (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 age 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 (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 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 (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 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 and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI 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 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* (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The Medical Director provides

direction and support to CalOptima Health's Quality teams to ensure QI Program objectives 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 (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, 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, 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.

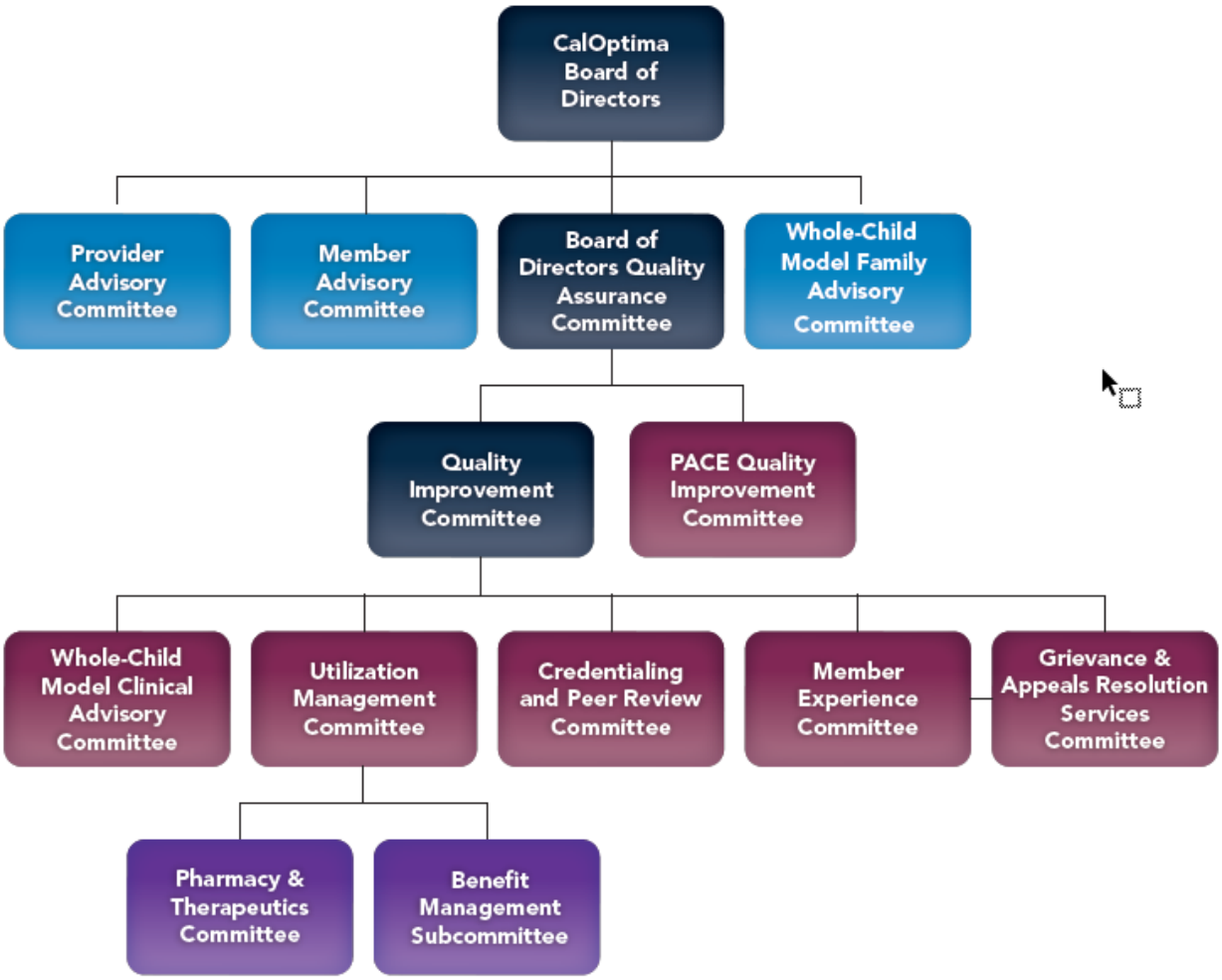
Executive Director, Medicare Programs (ED MP) is responsible for strategic and operational oversight of Medicare programs including OneCare and PACE.

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). Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

Committee Organization Structure – Diagram



Quality Improvement Committees and Subcommittees

Quality Improvement Committee (QIC)

The QIC is the foundation of the QI Program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI 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 oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

The composition of the QIC includes participating 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 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 Projects, activities and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC.

Responsibilities of the QIC include:

- Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives
- Overseeing the analysis and evaluation of QI activities
- Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI Program activities
- Identifying and prioritizing needed actions and interventions to improve quality
- Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and intervention.
- Monitoring overall quality compliance for the organization to quickly resolve deficiencies that affect members

Practice patterns of providers, practitioners and delegated HNs are evaluated, such as UM over/under utilization in collaboration with Applied Behavior Analysis utilization. Recommendations are made to promote practices so that all members receive medical and behavioral health care that meets CalOptima Health standards.

The QIC oversees and coordinates member outcome-related QI actions. Member outcome-related QI actions consist of well-defined, planned QI projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima Health-contracted providers and practitioners, and delegated HNs.

The composition of the QIC is defined in the QIC 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 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 Executive Director, Quality
- CalOptima Health Executive Director, Population Health Management

- CalOptima Health Executive Director, Clinical Operations
- CalOptima Health Executive Director, Network Management
- CalOptima Health Executive Director, Operations

The QIC 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

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, participation by telephone or participation by video conference.

The QIC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

QIC and all QI 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 proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the QIC 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 meeting include but are not limited to:

- Goals and objectives outlined in the QIC charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate QI information to network providers and practitioners
- Tracking of QI Work Plan activities

All agendas, minutes, reports and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

The QIC provides to the QAC quarterly written progress reports of the QIC that describes actions taken, process in meetings QI Program objectives, and improvements made.

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. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

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 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 standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

* Behavioral Health 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. 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 2023, 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 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 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. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

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 QI 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 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 QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI 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 QI/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 Strategic Goals

2023 QI Goals and Objectives

CalOptima Health's QI Goals and Objectives are aligned with CalOptima Health's 2022–25 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational and community levels.
2) Improve quality of care and member experience by attaining an 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 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, COVID-19 and other immunizations, 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 measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and the Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI 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 QI Work Plan is the operational and functional component of the QI Program 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 guides the development and implementation of an annual QI Work Plan, which includes but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program 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

Priorities for QI 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 QI Work Plan.

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — 2023 QI Work Plan

Quality Improvement Projects

QI 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

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)
- 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, QIC, UMC, etc., based upon the scope of work and impact of the effort.
- 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.

QI 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.

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 include enhanced monitoring and/or re-measurement activities.

Types of QI 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

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 QI Projects

Documentation of all aspects of each QI 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

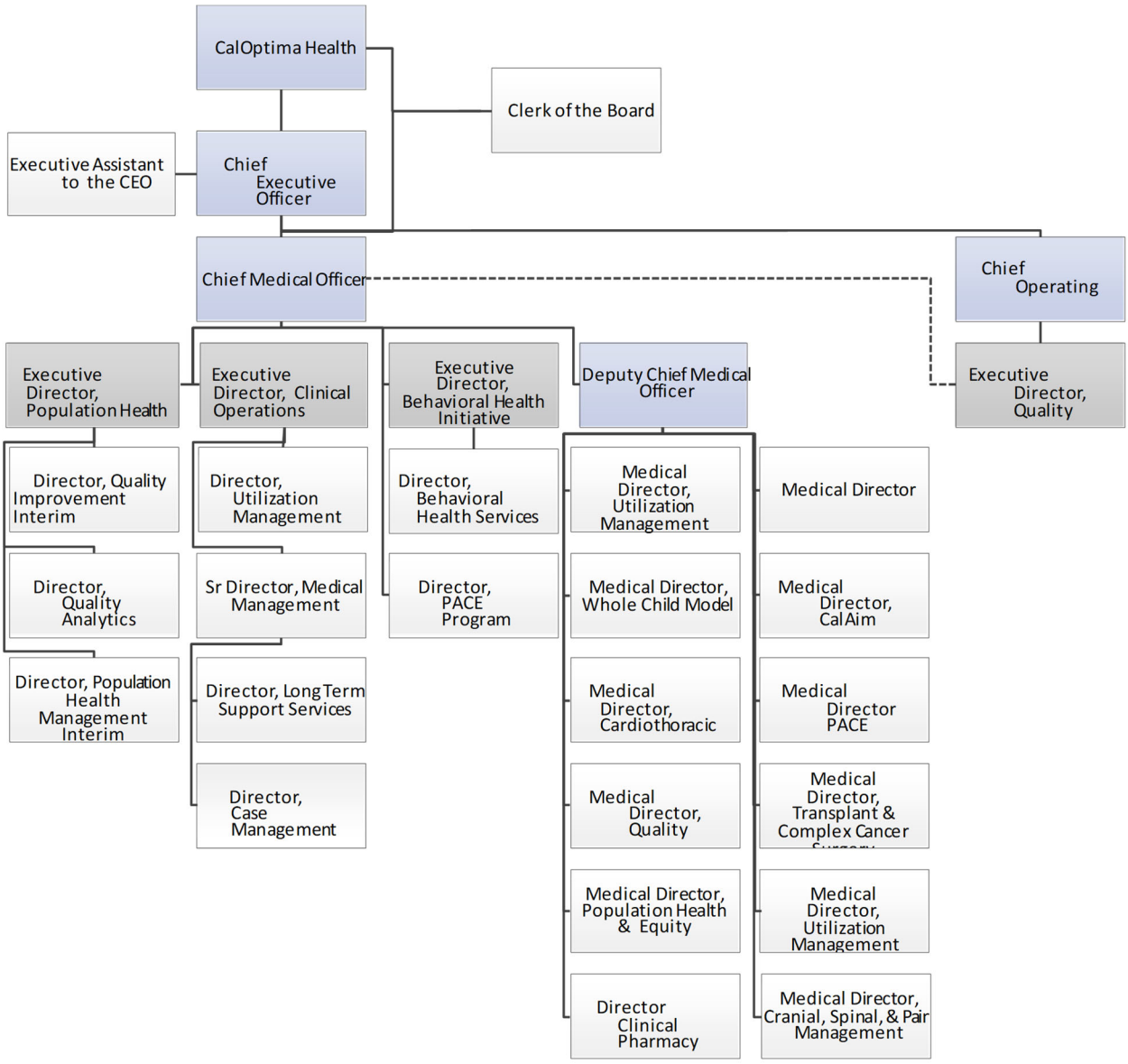
Communication of QI Activities

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 QI Work Plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC 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 and its subcommittees
- HN Forums, Medical Directors' Meetings, Quality Forums and other ongoing ad hoc meetings
- MAC, PAC and WCM FAC

Quality Program Organization Structure – Diagram

As of February 2023



Quality Improvement Program Resources

CalOptima Health's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima Health's QI Program.

The QI staff directly impacts and influences the QI 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 Q and ED PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management functions, including credentialing, facility site reviews (FSRs), physical accessibility compliance and working with the ED Quality 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.

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
Provides data 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. Provides coordination and support to the QIC and other committees to ensure compliance with regulatory and accreditation agencies.

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (P4V)
- Manager, Quality Analytics (Network Adequacy)
- Manager, Quality Analytics (Data Analytics)

- Data Analysts
- Project Managers
- Program Coordinators
- Program Specialists
- 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 QIC and other committees to support compliance with regulatory and accreditation agency 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 Supervisors
- Program Managers
- Health Coaches
- Registered Dieticians
- Senior Health Educators
- Health Educators
- Quality Analysts
- Program Specialists
- Program Assistants

Director, Behavioral Health Integration
Provides 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 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 and the BMSC.

Director, Clinical Pharmacy Management

Leads 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.

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
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency, Reducing Bias and Promoting Inclusion Training
- Trauma-Informed Care training

Affected employees, contracted providers and practitioner networks 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.

Annual Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected in the QI 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 QI 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 QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QI 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 QI activities, including QIPs, PIPs, PDSAs and CCIPs.
- An evaluation of member satisfaction surveys and initiatives.
- A report to the QIC and QAC summarizing all quality measures and identifying significant trends.
- A critical review of the organizational resources involved in the QI Program through the CalOptima Health strategic planning process
- Recommended changes included in the revised QI Program Description for the subsequent year for QIC, 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 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 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
- Preventive care, including:
  - Initial Health Appointment
  - Behavioral Assessment
- Diagnosis, care and treatment of acute and chronic conditions
- Care management including complex care management
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management
- Member experience
- Patient safety

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- 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 monitoring quality of care issues and assuring the 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 to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services. The 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
- 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 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.

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 site 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 20-006 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. 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.

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 cause
- 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, 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

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

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.

Population Health Management

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 streamlined interaction will ultimately result in optimized member care. CalOptima Health's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Patient safety or outcomes across settings
4. Managing 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.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima Health members. 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.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including 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 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 may include QIPs, PIPs, PDSAs and CCIPs. Quality Initiatives for 2022 are tracked in the QI Work Plan and reported to the QIC.

In 2023, the PHM Strategy 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 Orange County's Equity in OC Initiative.
- Implementing new Medi-Cal benefits that cover doula and community health worker services.
- Resuming in-person group health education classes in the community to promote healthy eating and active living.
- Implementing a multidisciplinary diabetes program and initiating additional interventions for gestational diabetes and chronic kidney disease.
- Launching the Comprehensive Cancer Screening and Support program to create an ethos of cancer screening across Orange County.

Health Education and Promotion

The PHM department provides program development and implementation for agencywide 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 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, 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
- Ongoing assessment of outcomes

CalOptima Health's Care Management 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 — 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

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 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 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

OneCareBH 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

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 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 2023 UM 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

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 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

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' expectation and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both Medi-Cal and dual-eligible 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.

Quality of Service

Access to Care

With the rapid growth in CalOptima Health's membership, access to care is a major area of concern for the plan and hence the organization has dedicated a significant amount of resources to measuring and improving access to care. CalOptima Health monitors the following to ensure that members have timely access to care:

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, 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 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 on quarterly basis.
- In order 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

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 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; and member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio.

The seven most common languages spoken for all CalOptima Health programs are: English, 59%; Spanish, 26%; Vietnamese, 10%; Farsi, 1%; Korean, 1%; Chinese, less than 1%; and Arabic, less than 1%. 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 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 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
- Providing information, training and tools to staff and practitioners to support culturally competent communication

Delegated And Non-Delegated Activities

CalOptima Health has an annual and continuing 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. 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 following:

- QI – Kaiser only, Care Management, Network Management, Credentialing, Utilization Management, Member Experience, 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 for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- 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 — 2023 QI Work Plan

2023 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

A. 2023 QI Annual Oversight of Program and Work Plan
B. 2022 QI Program Evaluation
C. 2023 UM Program
D. 2022 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Managed Care Accountability Set (MCAS)
L. Health Network Quality Rating
M. OneCare Performance measures
N. Improvement Projects PIP
O. Improvement Projects PIP (BH)
P. Improvement Projects OneCare CCIP's
Q. PPME/QIPE: HRA's
R. CalAIM
S. Health Equity
T. NCQA Accreditation
U. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. CalOptima Health Comprehensive Community Cancer Screening Program
C. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. 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.
B. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)
C. Follow-Up After Emergency Department Visit for Mental Illness (FUM)
D. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
E. Depression Remission or Response for Adolescents and Adults (DRR-E)
F. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)
B. Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)
C. Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot
D. STARs Measures Improvement

V. QUALITY OF CLINICAL CARE- Maternal Child Health

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs
B. 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
C. Blood Lead Screening DHCS APL

INITIAL WORK PLAN AND APPROVAL:
Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:

Quality Improvement Committee Chairperson:

Richard Pitts, D.O., Ph.D. 04/05/2023
Richard Pitts, D.O., Ph.D. Date:

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. 3/15/23
Trieu Thanh Tran, M.D. Date:

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VII. QUALITY OF SERVICE- Access

A. Improve Network Adequacy: Reducing gaps in provider network
B. Improve Access: Timely Access (Appointment Availability)
C. Improve Access: Telephone Access
D. Improve Access: Access Dashboard
E. Improving Access: Subcontracted Network Certification
F. Increase primary care utilization

VIII. QUALITY OF SERVICE- Member Experience

A. STARs Measures Improvement
B. Improve Member Experience/CAHPS

IX. SAFETY OF CLINICAL CARE

A. Emergency Department Diversion Pilot
B. Plan All-Cause Readmissions (PCR)

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT										
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	QIC		X			
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	QIC		X			
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	QIC		X			
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	QIC		X			
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	QIC		X			
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	QIC	SDOH	X			
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	QIC	Health Equity	x			
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	QIC		X			
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	QIC		X			

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
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	QIC		X			
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)	Kelly Giardina	Utilization Management/ QIC		X			
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: 2/21 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	T.T. Nguyen, MD	QIC		X			
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	QIC					
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 Topic TBD	end of 1Q2023	Helen Syn	QIC		X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
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	QIC	Health Equity	X			
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	QIC					
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	QIC					
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	QIC					
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	QIC		X			

2023 QI Work Plan Element Description	Goals	**Planned Activities**	**Target Date(s) for Completion (i.e. 2Q 2023) for each activity**	**Responsible Business owner**	Report to Committee	Health Equity and/or SDOH	**Con't Monitoring from 2022**	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
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	QIC	Health Equity				
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	QIC	Health Equity				
II. QUALITY OF CLINICAL CARE- Adult Wellness										
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	QIC	Health Equity	X			
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	QIC					
COVID-19 Vaccination and Communication Strategy	Increase the rate of first time COVID vaccinated members by #%, and increase the rate of fully boosted vaccinated members to #%	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	QIC		X			
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	QIC		X			

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III. QUALITY OF CLINICAL CARE- Behavioral Health										
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	QIC					
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	QIC					
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	QIC					
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	QIC					
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	QIC					

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IV. QUALITY OF CLINICAL CARE- 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)	**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	QIC		X			
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	QIC		X			
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	QIC		X			
STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP), Care Management, Centers for Disease Control (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	TBD	QIC					
V. QUALITY OF CLINICAL CARE- Maternal Child Health										
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	QIC	Health Equity	X			

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VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
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	QIC	Health Equity				
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	QIC	Health Equity	X			
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	QIC		X			
VII. QUALITY OF SERVICE- Access										
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/Jennifer Bamberg	MEMX		X			
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/Jennifer Bamberg	MEMX		X			
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/Jennifer Bamberg	MEMX		X			
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	MEMX					

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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/Jennifer Bamberg	MEMX					
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	QIC					
VIII. QUALITY OF SERVICE- Member Experience										
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	by end of 4Q, 2023	TBD	QIC					
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	QIC					
IX. 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	QIC					
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 10% (focus on getting discharge plans w/ PCP appt from hospitals)	<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	UM Director CM Director LTC Director	QIC		X			