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

**WEDNESDAY, SEPTEMBER 20, 2017**
**3:00 P.M.**

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

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

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

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

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

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

**CALL TO ORDER**
Pledge of Allegiance
Establish Quorum

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

**CONSENT CALENDAR**
1. Approve Minutes of the May 22, 2017 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee

**REPORTS**
2. Consider Recommending Board of Directors' Approval of the Proposed Pay for Value (P4V) Payment Methodology for CalOptima Community Network (CCN) Providers for Medi-Cal and OneCare Connect, and Distribution of Payments to Providers

3. Consider Recommending Board of Directors' Approval of Revised Medi-Cal Quality Improvement and Accreditation Activities during CalOptima Fiscal Year (FY) 2017-18 for Member and Provider Incentives

4. Consider Recommending Board of Directors' Approval of Proposed Fiscal Year (FY) 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect

5. Receive and File Updated 2016 Utilization Management Program Evaluation

6. Receive and File the 2016 Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment Performance Improvement Plan Evaluation

**INFORMATION ITEMS**
7. PACE Member Advisory Committee Update

8. HEDIS® 2017 Results

9. Behavioral Health Integration Update

10. CalOptima Program Updates: Shape Your Life and Perinatal Health Program

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

**COMMITTEE MEMBER COMMENTS**

**ADJOURNMENT**

# MINUTES

## SPECIAL MEETING
## OF THE
## CALOPTIMA BOARD OF DIRECTORS'
## QUALITY ASSURANCE COMMITTEE

## CALOPTIMA
## 505 CITY PARKWAY WEST
## ORANGE, CALIFORNIA

**May 22, 2017**

**CALL TO ORDER**
Chair Paul Yost called the meeting to order at 4:00 p.m. Director Berger led the pledge of Allegiance.

**Members Present:** Paul Yost, M.D., Chair; Ria Berger; Dr. Nikan Khatibi (at 4:18 p.m.); Alexander Nguyen M.D.

**Members Absent:** All members present

**Others Present:** Michael Schrader, Chief Executive Officer; Richard Helmer, M.D., Chief Medical Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Caryn Ireland, Executive Director Quality Analytics; Suzanne Turf, Clerk of the Board

**PUBLIC COMMENTS**
There were no requests for public comment.

**CONSENT CALENDAR**

1. Approve the Minutes of the February 15, 2017 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

***Action:*** ***On motion of Director Nguyen, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 3-0-0; Director Khatibi absent)***

**REPORTS**

2. Consider Recommending Board of Directors' Approval of the 2017 CalOptima Utilization Management (UM) Program and 2017 UM Work Plan
Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend Board of Directors' approval of the 2017 CalOptima UM Program and 2017 UM Work Plan. The 2017 UM Program is based on the Board approved 2016 UM Program. The following revisions were reviewed with the Committee: program descriptions and committee references are aligned with the Quality

Management Program; updated committee structure organization chart reflecting new structure and operational unit support; and a detailed description of metrics for measuring UM effectiveness.

The 2017 UM Work Plan projects and initiatives include: over/under utilization tracking and trending; enriched clinical decision making resources; medical management systems enhancements; improved coordination of services between CalOptima and County Mental Health Plan; oversight and internal auditing consistent with the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA); improved member notices; and continued development of Long-Term Support Services (LTSS) metrics.

***Action:*** ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the 2017 CalOptima UM Program and 2017 UM Work Plan as presented. (Motion carried 3-0-0; Director Khatibi absent)***

3. Receive and File 2016 Utilization Management Program Evaluation

Dr. Bock presented the recommended action to receive and file the 2016 Utilization Management Program Evaluation. Accomplishments during 2016 include the development of audit tools to monitor and improve UM processing quality and timeliness, Notice of Action Team instituted to improve quality and timeliness, established Hospitalist Program serving four highest volume facilities, and assembled a Health Network Denial Task Force to share best practices and challenges faced when drafting denial letters. The 2016 accomplishments in the areas of UM delegated provider oversight, and prior authorization and pharmacy operational performance were reviewed with the Committee.

***Action:*** ***On motion of Director Berger, seconded and carried, the Committee received and filed the 2016 Utilization Management Program Evaluation as presented. (Motion carried 3-0-0; Director Khatibi absent)***

4. Receive and File 2016 Quality Improvement Program Evaluation

Caryn Ireland, Executive Director, Quality Analytics, presented the recommended action to receive and file the 2016 Quality Improvement (QI) Program Evaluation. A review of the accomplishments during 2016 in the areas of behavioral health integration, case management, LTSS, cultural and linguistics, and grievance and appeals were reviewed with the Committee. Accomplishments around safety included the implementation of pharmacy management programs with regard to monitoring underutilization of asthma, diabetes, cardiovascular and osteoporosis medications, and monitoring the overutilization of opioid medications. Continued enhancement of disease management programs, participation in performance improvement projects, and continued actions to improve Consumer Assessment of Healthcare Providers & Systems (CAHPS) results were also noted.

***Action:*** ***On motion of Director Nguyen, seconded and carried, the Committee received and filed the 2016 Quality Improvement Program Evaluation as presented. (Motion carried 4-0-0)***

5. Consider Recommending Board of Directors' Approval of the 2017 Delegation Grid, Appendix B to 2017 Quality Improvement Program Description and Work Plan

Ms. Ireland presented the action to recommend Board of Directors' approval of the 2017 Delegation Grid, Appendix B to the 2017 Quality Improvement Program Description and Work Plan, which was

approved by the Board of Directors on March 2, 2017. The 2017 Delegation Grid outlines and updates CalOptima's delegation agreement with health networks to meet accreditation and regulatory requirements, and includes elements delegated to Magellan Healthcare.

***Action:*** ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors approval of the 2017 Delegation Grid, Appendix B to 2017 Quality Improvement Program Description and Work Plan as presented. (Motion carried 4-0-0)***

## INFORMATION ITEMS

6. CalOptima Care Network (CCN) Performance: Quality and Financial Analysis

Richard Helmer M.D., Chief Medical Officer, presented an overview of CCN performance including the background of CalOptima Direct and CCN, and membership growth in CCN for both the Medi-Cal and One Care Connect (OCC) programs. A review of performance on quality measures, and CCN financial performance were also reviewed with the Committee. Future considerations include the need to address OCC's high readmission rate, completion of incentive programs for CCN primary care providers, implementing a proposed Long Term Connect program to meet the unique needs of CalOptima's institutionalized members, and establishing appropriate funding for CCN Medi-Cal membership.

7. Behavioral Health Integration Update

Donald Sharps, M.D., Medical Director, provided an update on Behavioral Health Integration with Magellan Behavioral Healthcare, including a review of call center staffing, the results of a recent customer service audit, and the implementation of utilization management and quality assurance protocols in response to audit findings. It was noted that increased collaboration with the County Mental Health Plan includes a Memorandum of Understanding (MOU) with the Orange County Health Care Agency (OCHCA) to ensure the appropriate level of care. An addendum to the MOU is in development to ensure coordination of Substance Use Disorder (SUD) screening and the provision of services between CalOptima and the OCHCA, and supports integrated services with behavioral health and physical health.

8. 2016 Group Needs Assessment Final Results

Pshyra Jones, Health Education and Disease Management Director, provided a brief overview of the final results of the 2016 Group Needs Assessment (GNA). The DHCS requires health plans to conduct GNAs every five years to identify the needs of members, available health education, cultural and linguistic program resources, and gaps in services. The areas of focus included people who provide health care, medical interpreters, member health perception and health plan benefits, forms and health plan materials, and social determinants of health. CalOptima completed the assessment in October 2016 with over 3,000 responses. The top three health concerns identified were: not enough clinics and doctor's nearby, appointment time at doctor's office and clinics, and safe places to walk or play. Staff is sharing the survey results with the member health needs assessment initiative, work groups within CalOptima, and the Provider Advisory Committee.

9. PACE Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported on the activities at the March 6, 2017 PMAC meeting. A committee composed of PACE staff and

participants are currently working on a newsletter that will be published quarterly beginning in June 2017. PACE participants suggested an 'Employee of the Month' feature, and additional religious and spiritual services at the PACE Center.

10. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Report

Caryn Ireland provided a brief update on the first quarter progress on the HEDIS initiatives and the various incentive programs including: the roll-out of three public service announcements in Spanish, Vietnamese, and Farsi; and proposed changes in the member and provider incentive for breast cancer and cervical cancer screenings.

b. Member Trend Report

This Information Item was accepted as presented.

**COMMITTEE MEMBER COMMENTS**

Committee members thanked staff for the presentations provided and for all of their work.

**ADJOURNMENT**

Hearing no further business, Chair Yost adjourned the meeting at 6:12 p.m.

*/s/ Suzanne Turf*
Suzanne Turf
Clerk of the Board

*Approved: September 20, 2017*

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken September 20, 2017**
**Regular Meeting of the CalOptima Board of Directors'**
**Quality Assurance Committee**

## Report Item

2. Consider Recommending Board of Directors' Approval of the Proposed Pay for Value (P4V) Payment Methodology for CalOptima Community Network (CCN) Providers for Medi-Cal and OneCare Connect, and Distribution of Payments to Providers

## Contact

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

## Recommended Actions

Recommend that the Board of Directors:

1. Approve Measurement Years 2016 and 2017 payment methodology for the Pay for Value (P4V) Program for CalOptima Community Network (CCN) Providers for Medi-Cal and OneCare Connect (OCC), subject to regulatory approval, as applicable (Attachment 1)
2. Authorize distribution of P4V payments based on this methodology in an amount not to exceed $2.00 per member per month (pmpm) for CCN Medi-Cal and $20.00pmpm for CCN OneCare Connect membership.

## Background

CalOptima Community Network (CCN) was established in March 2015 as a health network as a component of CalOptima Direct (COD). Since then, CCN has been held accountable to the same standards as other delegated health networks and is routinely assessed by CalOptima's Audit and Oversight Department for regulatory, operational, and accreditation compliance. CCN now has over 3,500 contracted Specialists, 600 primary care providers (PCPs), and serves over 70,000 members. CalOptima did not establish a Pay for Value program or incentive payments for CCN in 2015, as time was needed to have at least a full year of meaningful data before performance measures could be calculated and comparisons made.

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care. CCN, as a Health Network, will potentially pay incentive dollars to 97% of its contracted and eligible PCPs through the 2016 P4V Program. The 2017 P4V program is still in process, so it it currently unknown what portion of contracted PCPs will be eligible for P4V incentive payments under the 2017 P4V plan. CCN intends to distribute earned P4V dollars directly to contracted Primary Care Providers (PCPs) in an effort to gain attention, involvement and investment in quality initiatives.

The purpose of CalOptima's P4V program for our Health Networks, which includes CalOptima Community Network as previously approved by the Board on April 7, 2016 (Attachment 2) and amended on October 6, 2016 for Fiscal Year (FY) 2016 (Attachment 3) and approved by the Board on March 2, 2017 for FY 2017 (Attachment 4), is three-fold:

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1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks and physicians on their quality improvement efforts.

Based on these previous staff recommendations, the Board approved the inclusion of CCN in the overarching P4V program and payment as a Health Network. This staff report provides the clarifying details on the scoring, payment methodology, and distribution of payments directly to the CCN PCPs. No elements of this plan changes CalOptima's overarching P4V Health Network program, as previously approved by the Board of Directors.

**Discussion**

In order to recognize individual provider performance, and gain involvement in improving quality measures, staff recommends that the scoring methodology for CCN providers be based on the following principles:

- The Medi-Cal CCN P4V program includes the same clinical performance measures as all other HN's included in CalOptima's MY 2016 and 2017 Pay for Value program – measured at the individual provider level;
- The Medi-Cal CCN P4V program includes the same measures of member satisfaction as all other HN's which assesses the parent's satisfaction with their child's care and adult members' satisfaction with their care, measured at the CCN (i.e., Health Network) level, as surveys were not conducted at the individual provider level;
- For the clinical measures, the program rewards performance by clinical measure – there will not be a measure for improvement, as 2016 is considered the baseline year for CCN; for 2017, the program will include a reward for improvement;
- Due to smaller denominators at the physician specific level for CCN, a minimum denominator size of 5 eligible members for each performance measure will be required to be eligible for incentive payment (Medi-Cal only);
- The Medi-Cal CCN Clinical measures payment calculations will include performance score by measure plus a factor for member months (recognizing the volume of members attributed to a particular provider);
- The Medi-Cal CCN CAHPS member satisfaction survey was only completed at the Health Network level, therefore, this component of the CCN P4V payment will be based on the provider's membership percentage of Medi-Cal CCN Health Network CAHPS funds and based on the overall CAHPS performance for CCN;
- An individual provider's distribution must be a minimum of $100 for payment to be made.
- The proposed methodology will be utilized for Measurement Years 2016 and 2017 P4V Medi-Cal and OCC programs

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Based on this distribution methodology, over 97% of CCN's contracted and eligible PCPs will earn P4V dollars based on their performance during MY 2016.

**Distribution of Incentive Dollars**

Performance allocations are distributed based upon final calculation and validation of each measurement rate. To qualify for payment for each of the clinical measures, the provider must meet the minimum denominator and distribution, as noted.

The Medi-Cal CCN provider payments for clinical measures will be based on the provider's measurement rate for each clinical performance measure and member months. As CalOptima did not obtain individual provider satisfaction data, staff recommends that CAHPS payments will be distributed based on the provider's percent of total CCN Medi-Cal membership.

Staff also recommends that the OneCare Connect CCN provider payments will be based on the provider's percent of total CCN OCC membership.

In order to qualify for payments, a physician or clinic must be contracted with CalOptima during the entire measurement period, and the period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

**Fiscal Impact**

The recommended action to approve the Measurement Year 2016 payment methodology and distribution strategy for the P4V Program for CCN Provisions for the Medi-Cal and OCC program is a budgeted item and included in the CalOptima FY 2017-18 Operating Budget approved by the Board on June 1, 2017 up to a maximum of $2.00 pmpm for CCN Medi-Cal and $20.00pmpm for CCN OneCare Connect membership. Since the distribution of incentive dollars for the MY 2017 P4V Programs for Medi-Cal and OneCare Connect will be made in FY 2018-19, Management plans to include expenses related to the MY 2017 P4V programs in the upcoming proposed FY 2018-19 operating budget.

**Rationale for Recommendation**

This alignment will leverage improvement efforts and efficiencies that the CalOptima Community Health Network implements in conjunction with the other Health Networks. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. PowerPoint Presentation - Pay for Value Program: CCN Provider Payment Methodology
2. Board Action dated October 6, 2016, Consider Approval of Amendment to the Measurement Year 2016 Pay for Value Program Payment Methodology for Medi-Cal
    a. Attachment - Board Action dated April 7, 2016, Approve Measurement Year CY2016 Pay for Value Programs for Medi-Cal and OneCare Connect

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3. Board Action dated March 2, 2017, Consider Approval of the Fiscal Year 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect

*/s/ Michael Schrader* — *9/14/2017*
**Authorized Signature** — **Date**

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# Pay for Value Program CCN Provider Payment Methodology

**Board of Directors' Quality Assurance Committee Meeting**

**September 20, 2017**

**Richard Bock, M.D., M.B.A.**

**Deputy Chief Medical Officer**

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# Medi-Cal Health Network Payment Methodology

## Population Included

Total Number of Adult Member Months (MM) and Total Number of Child MM

SPD Members Weighted 4x Non-SPD Members

## Payment Calculation

- **Allocated Funds =** Total MM for all health networks x the allocated PMPM.
- Allocated PMPM for 2016 is **$2.00**

### Clinical Funds = 60% of Allocated Funds ($1.20 PMPM)

- **Clinical Funds =** Performance Funds ($0.60 PMPM) + Improvement Funds ($0.60)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima overall improvement pct.

### CAHPS Funds = 40% of Allocated Funds ($0.80 PMPM)

- **CAHPS Funds =** Performance Funds ($0.40 PMPM) + Improvement Funds ($0.40)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima overall improvement pct.

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# Medi-Cal Health Network Payments
## Clinical Adult (No overall CalOptima Improvement)

| Health Network | Member Months | Perform Score | Perform Payment | Improv Score | Improv Payment | Clinical Payment | PMPM |
|---|---|---|---|---|---|---|---|
| CCN | 547,289 | 2 | $220,178 | NA | $0 | $220,178 | $0.40 |
| HN 1 | 7,581 | 8 | $11,243 | NA | $0 | $11,243 | $1.48 |
| HN 2 | 109,648 | 0 | $0 | 0 | $0 | $0 | $0 |
| HN 3 | 219,701 | 5 | $196,358 | 2 | $0 | $196,358 | $0.89 |
| HN 4 | 296,063 | 2 | $108,602 | 0 | $0 | $108,602 | $0.37 |
| HN 5 | 287,593 | 3 | $164,558 | 1 | $0 | $164,558 | $0.57 |
| HN 6 | 226,055 | 4 | $183,119 | 4 | $0 | $183,119 | $0.81 |
| HN 7 | 405,254 | 4 | $315,714 | 3 | $0 | $315,714 | $0.78 |
| HN 8 | 741,509 | 3 | $449,735 | 2 | $0 | $449,735 | $0.61 |
| HN 9 | 325,998 | 6 | $380,232 | 0 | $0 | $380,232 | $1.17 |
| HN 10 | 18,508 | 2 | $7,146 | NA | $0 | $7,146 | $0.39 |
| HN 11 | 312,981 | 1 | $59,005 | 0 | $0 | $59,005 | $0.19 |
| HN 12 | 567,125 | 3 | $343,293 | 5 | $0 | $343,293 | $0.61 |

Based upon December, 2016 Prospective Rates

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# Medi-Cal Health Network Payments
# Clinical Child (No overall CalOptima Improvement)

| Health Network | Member Months | Perform Score | Perform Payment | Improv Score | Improv Payment | Clinical Payment | PMPM |
|---|---|---|---|---|---|---|---|
| CCN | 191,455 | 4 | $129,091 | NA | $0 | $129,091 | $0.67 |
| HN 1 | 981 | 0 | $0 | NA | $0 | $0 | $0 |
| HN 2 | 1,746,424 | 4 | $1,184,357 | 0 | $0 | $1,184,357 | $0.68 |
| HN 3 | 83,468 | 4 | $54,191 | 0 | $0 | $54,191 | $0.65 |
| HN 4 | 134,557 | 3 | $65,731 | 0 | $0 | $65,731 | $0.49 |
| HN 5 | 145,805 | 3 | $71,172 | 2 | $0 | $71,172 | $0.49 |
| HN 6 | 95,644 | 4 | $62,279 | 0 | $0 | $62,279 | $0.65 |
| HN 7 | 196,515 | 4 | $127,724 | 1 | $0 | $127,724 | $0.65 |
| HN 8 | 351,055 | 3 | $174,356 | 0 | $0 | $174,356 | $0.50 |
| HN 9 | 108,542 | 3 | $52,493 | 0 | $0 | $52,493 | $0.48 |
| HN 10 | 4,140 | 0 | $0 | NA | $0 | $0 | $0 |
| HN 11 | 152,720 | 2 | $50,126 | 0 | $0 | $50,126 | $0.33 |
| HN 12 | 403,977 | 3 | $197,651 | 0 | $0 | $197,651 | $0.49 |

Based upon December, 2016 Prospective Rates

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# Medi-Cal Health Network Payments
# CAHPS Adult

| Health Network | Member Months | Perform Score | Perform Payment | Improv Score | Improv Payment | CAHPS Payment | PMPM |
|---|---|---|---|---|---|---|---|
| CCN | 547,289 | 5 | $619,108 | NA | $0 | $619,108 | $1.13 |
| HN 1 | 7,581 | 0 | $0 | NA | $0 | $0 | $0 |
| HN 2 | 109,648 | 5 | $112,358 | 1 | $3,463 | $115,821 | $1.06 |
| HN 3 | 219,701 | 0 | $0 | 0 | $0 | $0 | $0 |
| HN 4 | 296,063 | 0 | $0 | 2 | $18,826 | $18,826 | $0.06 |
| HN 5 | 287,593 | 0 | $0 | 0 | $0 | $0 | $0 |
| HN 6 | 226,055 | 4 | $205,961 | 1 | $7,936 | $213,897 | $0.95 |
| HN 7 | 405,254 | 2 | $177,548 | 3 | $41,045 | $218,593 | $0.54 |
| HN 8 | 741,509 | 1 | $168,611 | 5 | $129,932 | $298,543 | $0.40 |
| HN 9 | 325,998 | 3 | $213,831 | 7 | $79,896 | $290,727 | $0.89 |
| HN 10 | 18,508 | 0 | $0 | NA | $0 | $0 | $0 |
| HN 11 | 312,981 | 0 | $0 | 3 | $30,685 | $30,685 | $0.10 |
| HN 12 | 567,125 | 1 | $128,705 | 2 | $39,672 | $168,377 | $0.30 |

Based upon measurement years 2015 and 2014 results

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# Medi-Cal Health Network Payments
# CAHPS Child

| Health Network | Member Months | Perform Score | Perform Payment | Improv Score | Improv Payment | CAHPS Payment | PMPM |
|---|---|---|---|---|---|---|---|
| CCN | 191,455 | 2 | 134,939 | NA | $0 | $134,939 | $0.70 |
| HN 1 | 981 | 0 | 0 | NA | $0 | $0 | $0 |
| HN 2 | 1,746,424 | 2 | 1,238,013 | 2 | $0 | $1,238,013 | $0.71 |
| HN 3 | 83,468 | 0 | 0 | 0 | $0 | $0 | $0 |
| HN 4 | 134,557 | 0 | 0 | 0 | $0 | $0 | $0 |
| HN 5 | 145,805 | 0 | 0 | 0 | $0 | $0 | $0 |
| HN 6 | 95,644 | 0 | 0 | 1 | $0 | $0 | $0 |
| HN 7 | 196,515 | 0 | 0 | 0 | $0 | $0 | $0 |
| HN 8 | 351,055 | 0 | 0 | 3 | $0 | $0 | $0 |
| HN 9 | 108,542 | 2 | 73,161 | 5 | $0 | $73,161 | $0.67 |
| HN 10 | 4,140 | 0 | 0 | NA | $0 | $0 | $0 |
| HN 11 | 152,720 | 0 | 0 | 0 | $0 | $0 | $0 |
| HN 12 | 403,977 | 0 | 0 | 3 | $0 | $0 | $0 |

Based upon measurement years 2015 and 2014 results

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# Medi-Cal CCN Providers

- Paying over 200 providers
- Clinical Payment
  - Provider clinical performance and membership
- CAHPS Payment
  - Provider membership
- Not all CCN providers will be paid due to:
  - Small membership
  - Did not achieve 50th percentile

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# Medi-Cal CCN Health Network Payment

| CCN | Member Months | Payment | PMPM |
|---|---|---|---|
| **Clinical** | | | |
| Adult Clinical Performance | 547,289 | $220,178 | $0.40 |
| Adult Clinical Improvement | | NA | |
| Child Clinical Performance | 191,455 | $129,091 | $0.67 |
| Child Clinical Improvement | | NA | |
| **Total Clinical Payment** | **738,744** | **$349,269** | **$0.47** |
| **CAHPS** | | | |
| Adult CAHPS Performance | 547,289 | $619,108 | $1.13 |
| Adult CAHPS Improvement | | NA | |
| Child CAHPS Performance | 191,455 | $134,939 | $0.70 |
| Child CAHPS Improvement | | NA | |
| **Total CAHPS Payment** | **738,744** | **$754,047** | **$1.02** |
| **Total CCN Payment** | **738,744** | **1,103,316** | **$1.49** |

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# Medi-Cal CCN Provider Payment Methodology

## Population Included

Total Number of Adult Member Months (MM) and Total Number of Child MM

## Payment Calculation

- **Clinical Funds =** Total Clinical Payment for CCN Health Network (adult and child)
- **CAHPS Funds =** Total CAHPS Payment for CCN Health Network (adult and child)

### Clinical Provider Payment

- **Clinical Payment =** MM **x** Perform % **x** Clinical % **x** Clinical Funds

### CAHPS Provider Payment

- **CAHPS Payment =** Membership Percentage **x** CAHPS Funds

### Total CCN Provider Payment

- **Provider Payment =** Clinical Payment **+** CAHPS Payment
  (Minimum payment of $100)

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# Medi-Cal P4V Clinical Measures

| 2016 and 2017 Year Measures | |
|---|---|
| **Adult** | **Child** |
| Adult  Access to Preventive Care Services | Adolescent Well-Care Visits |
| Breast Cancer Screening | Appropriate Testing for Children with Pharyngitis |
| Cervical Cancer Screening | Appropriate Treatment for Children with URI |
| Diabetes Care: A1C Testing | Childhood Immunizations: Combo 10 |
| Diabetes Care: Retinal Eye Exams | Children's Access to Primary Care Providers |
| Medication Management for People with Asthma: Total 75% Compliance | Medication Management for People with Asthma: Total 75% Compliance |
| | Well-Child Visits 3–6 Years |

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# Medi-Cal CCN Provider Payment Methodology Clinical Calculation

- Adult and Child P4V Health Network Measures
- Included Measures
  - Number of measures with a minimum denominator of 5
  - 6 adult measures
  - 7 child measures
- Qualified Measures
  - Minimum of 50th percentile

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# Medi-Cal CCN Provider Payment
# Adult Clinical Calculation Example

| Provider C Measure | Denom | Percentile | Included Measure | Qualified Measure |
|---|---|---|---|---|
| Adult Access to Preventive Care Services | 15 | 75th | 1 | 1 |
| Breast Cancer Screening | 20 | 75th | 1 | 1 |
| Cervical Cancer Screening | 25 | 50th | 1 | 1 |
| Diabetes Care: A1C Testing | 10 | 25th | 1 | 0 |
| Diabetes Care: Retinal Eye Exams | 3 | 75th | 0 | 0 |
| Medication Management for People with Asthma | 0 | NA | 0 | 0 |
| **Total** | | | **4** | **3** |

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# Medi-Cal CCN Provider Payment
# Adult Clinical Calculation Example

| Provider | Included Measures | Qualified Measures | MM | Clinical Perform | Perform & MM Weight | Clinical Percent | Clinical Payment |
|---|---|---|---|---|---|---|---|
| Provider A | 6 | 5 | 400,000 | 83.33% | 333,333 | 83.86% | $184,636 |
| Provider B | 6 | 2 | 80,000 | 33.33% | 26,667 | 6.71% | $14,770 |
| Provider C | 4 | 3 | 50,000 | 75.00% | 37,500 | 9.43% | $20,772 |
| Provider D | 2 | 0 | 17,289 | 0% | 0 | 0% | $0 |
| **Total** | | | | | **397,500** | | **$220,178** |

**Provider A**

MM * Clinical Perform = Perform & MM Weight
400,000 * 83.33% = 333,333

Perform & MM Weight / Total Perform & MM Weight = Clinical Percent
333,333 / 397,500 = 83.86%

Clinical Percent * CCN Clinical Funds = Clinical Payment
83.86% * $220,178 = $184,636

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# Medi-Cal CCN Provider Payment
# Child Clinical Calculation Example

| Provider C Measure | Denom | Percentile | Included Measure | Qualified Measure |
|---|---|---|---|---|
| Children's Access to Primary Care Providers | 25 | 25th | 1 | 0 |
| Well-Child Visits 3–6 Years | 50 | 50th | 1 | 1 |
| Adolescent Well-Care Visits | 10 | 50th | 1 | 1 |
| Childhood Immunizations: Combo 10 | 4 | 75th | 0 | 0 |
| Appropriate Testing for Children with Pharyngitis | 2 | 25th | 0 | 0 |
| Appropriate Treatment for Children with URI | 0 | NA | 0 | 0 |
| Medication Management for People with Asthma | 0 | NA | 0 | 0 |
| **Total** | | | **3** | **2** |

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# Medi-Cal CCN Provider Payment
# Child Clinical Calculation Example

| Provider | Included Measures | Qualified Measures | MM | Clinical Perform | Perform & MM Weight | Clinical Percent | Clinical Payment |
|---|---|---|---|---|---|---|---|
| Provider A | 7 | 6 | 60,000 | 85.71% | 51,429 | 51.18% | $66,075 |
| Provider B | 7 | 2 | 55,000 | 28.57% | 15,714 | 15.64% | $20,190 |
| Provider C | 3 | 2 | 50,000 | 66.67% | 33,333 | 33.18% | $42,826 |
| Provider D | 2 | 0 | 26,455 | 0% | 0 | 0% | $0 |
| **Total** | | | | | **100,476** | | **$129,091** |

**Provider A**

MM * Clinical Perform = Perform & MM Weight
60,000 * 85.71% = 51,429

Perform & MM Weight / Total Perform & MM Weight = Clinical Percent
51,429 / 100,476 = 51.18%

Clinical Percent * CCN Clinical Funds = Clinical Payment
51.18% * $129,091 = $66,075

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# Medi-Cal CCN Provider Clinical Payment

| Provider | Adult and Child Member Months | Adult Payment | Child Payment | Clinical Payment | PMPM |
|---|---|---|---|---|---|
| Provider A | 460,000 | $184,636 | $66,075 | $250,711 | |
| Provider B | 135,000 | $14,771 | $20,190 | $34,960 | |
| Provider C | 100,000 | $20,772 | $42,826 | $63,598 | |
| Provider D | 43,744 | $0 | $0 | $0 | |
| **Total** | **738,744** | **$220,178** | **$129,091** | **$349,269** | **$0.47** |

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# Medi-Cal P4V CAHPS Measures

| 2016 Measurement Year Measures |
| --- |
| **Adult and Child Measures** |
| Getting Appointment with a Specialist |
| Timely Care and Service (composite) |
| Rating of PCP |
| Rating of all Health Care |

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# Medi-Cal CCN Provider Payment CAHPS Calculation Example

| Provider | Member Months | Member Month Percent | CAHPS Payment |
|---|---|---|---|
| Provider A | 460,000 | 62.27% | $469,529 |
| Provider B | 135,000 | 18.27% | $137,797 |
| Provider C | 100,000 | 13.54% | $102,071 |
| Provider D | 43,744 | 5.92% | $44,650 |
| **Total** | **738,744** | | **$754,047** |

**Provider A**

MM / Total MM = MM Percent

460,000 / 738,744 = 62.27%

MM Percent * CCN CAHPS Funds = CAHPS Payment

62.27% * $754,047 = $469,529

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# Medi-Cal CCN Provider Total Payment

| Provider | Member Months | Clinical Payment | CAHPS Payment | Total Payment | PMPM |
|---|---|---|---|---|---|
| Provider A | 460,000 | $250,711 | $469,529 | $720,240 | |
| Provider B | 135,000 | $34,960 | $137,797 | $172,757 | |
| Provider C | 100,000 | $63,598 | $102,071 | $165,669 | |
| Provider D | 43,744 | $0 | $44,650 | $44,650 | |
| **Total** | **738,744** | **$349,269** | **$754,047** | **$1,103,316** | **$1.49** |

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# OneCare Connect Health Network Payment Methodology

| Population Included |
| --- |
| Total Number of Member Months (MM) |
| **Payment Calculation** |
| • **Allocated Funds =** Total MM for all Health Networks x the Allocated PMPM.<br>• Allocated PMPM for 2016 is **$20**. |
| **Clinical Funds = 100% of Allocated Funds ($20 PMPM)**<br>• **Clinical Funds =** Performance Funds ($10 PMPM) + Improvement Funds ($10)<br>• **Performance Payments =** Performance Funds<br>• **Improvement Payments =** Improvement Funds **x** CalOptima Overall Improvement Pct. |

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# OneCare Connect CCN Health Network Payment

| CCN | Payment | PMPM |
|---|---|---|
| **Clinical** | | |
| Clinical Performance | $139,246 | $6.15 |
| Clinical Improvement | $0 | $0 |
| **Total Clinical Payment** | **$139,246** | **$6.15** |

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# OneCare Connect Provider Payment Methodology

| Population Included |
| --- |
| Total Number Member Months (MM) |
| **Payment Calculation** |
| • **Funds =** Total Clinical Payment for CCN Health Network |
| **Clinical Provider Payment** |
| • **Provider Payment =** Membership Percentage **x** Funds (Minimum payment of $100) |

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# OneCare Connect P4V Measures

| 2016 Measurement Year Measures |
| --- |
| Antidepressant Medication Management: Effective Acute Phase Treatment |
| Antidepressant Medication Management: Effective Continuation Phase Treatment |
| Controlling High Blood Pressure |
| Part D Medication Adherence for Oral Diabetes Medications |
| Plan All-Cause Readmissions |

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# OneCare Connect CCN
# Provider Calculation and Payment Example

| Provider | MM | MM Percent | Payment | PMPM |
|---|---|---|---|---|
| Provider A | 15,000 | 66.25% | $92,248 | |
| Provider B | 4,000 | 17.67% | $24,600 | |
| Provider C | 2,000 | 8.83% | $12,300 | |
| Provider D | 1,642 | 7.25% | $10,098 | |
| **Total** | **22,642** | | **$139,246** | **$6.15** |

**Provider A**

| MM | / | Total MM | = | MM Percent |
|---|---|---|---|---|
| 15,000 | / | 22,642 | = | 66.25% |

| MM Percent | * | CCN Funds | = | Provider Payment |
|---|---|---|---|---|
| 66.25% | * | $139,246 | = | $92,248 |

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action to Be Taken October 6, 2016**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**

7. Consider Approval of Amendment to the Measurement Year 2016 Pay for Value Program Payment Methodology for Medi-Cal

**Contact**

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

**Recommended Action**

Approve amendment to Measurement Year CY 2016 Pay for Value (P4V) for Medi-Cal, which defines the allocations, scoring methodology and distribution for both performance and improvement, as described below, subject to regulatory approval, as applicable.

**Background**

CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care.

The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on April 7, 2016, is three-fold:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance and improvement;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks on their quality improvement efforts.

Staff is now proposing to add additional details on the scoring and payment methodology which was not previously addressed.

**Discussion**

As indicated, the Board approved the Measurement Year CY 2016 P4V programs for Medi Cal and OneCare Connect at its April 2016 meeting. As indicated at that time, staff recommended that the scoring methodology be based on the following principles:

- Address the need to consider the complexity or member acuity (Seniors and Persons with Disabilities (SPD) compared to Non-SPD members) and the subsequent higher consumption of physician/health network resources to care for SPD members;
- Reward both performance and improvement;
- Improvement funding will be contingent upon CalOptima's overall improvement (New);
- Include both Adult and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and increase the value of these measures in the program, thereby expanding our focus on the member experience.

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| Population Included: | |
|---|---|
| Total # of Adults in Health Network | Total # of Children in Health Network |
| Apply Acuity Score (SPD Weight 4X, TANF Weight 1X) | |
| **Payment** | |
| 50% based on Performance score and 50% based on Improvement score<br>Improvement score will be weighted by CalOptima's overall improvement | |
| Clinical Measures = 60% of the Total | CAHPS Measures = 40% of the Total |
| **Proposed Scoring for Measure Performance:** | |
| • A relative point system by measure, based on:<br>• NCQA National HEDIS Percentiles (clinical measures)<br>• NCQA National CAHPS Percentiles (satisfaction measures)<br>• Final score is the sum of points for each measure<br>• Improvement score based on improvement from previous year (receiving 1 point for increasing each percentile level and negative 1 point for decreasing) | |

| P4V Scoring - NEW |
|---|
| **Performance Points – HEDIS & CAHPS** |
| 1 point: >= 50th percentile<br>2 points: >= 75th percentile<br>3 points: >= 90th percentile<br>No points <50th percentile |
| **Improvement points – HEDIS & CAHPS** |
| 1 point for increasing 1 percentile level<br>(e.g. 1 point for 25th percentile to 50th percentile;<br>2 points for 50th percentile to 90th percentile, etc.)<br><br>Negative one (-1) point for decreasing 1 percentile level<br>(e.g. -1 point for 75th percentile to 50th percentile;<br>-2 points for 50th percentile to 10th percentile, etc.) |

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The proposed Measurement Year CY 2016 Medi-Cal Pay for Value program is a one-year program which uses calendar year (CY) 2016 HEDIS and CAHPS measurements and for which payments will be made in 2017.

The program has been shared and vetted with various stakeholder groups including the Quality Improvement Committee, Provider Advisory Committee, and Health Network medical directors and Quality team members.

Staff will recommend the scoring and payment methodology for the approved 2016 OneCare Connect and Windstone Pay-for-Value programs separately. Staff will return to the Quality Assurance Committee with future recommendations.

**Distribution of Incentive Dollars**
Performance allocations are distributed based on final calculation and validation of each measurement rate. Payment for Medi-Cal P4V will be paid in proportion to acuity level, as determined by aid category. To qualify for payment for each of the clinical and CAHPS measures, the Health Network must have a minimum denominator in accordance with HEDIS principles.

In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period and the period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

**Fiscal Impact**
The fiscal impact of the Medi-Cal P4V payment methodology for the Measurement Year of January 1, 2016, through December 31, 2016, will not exceed $2 per member per month. This is a budgeted item under the CalOptima Fiscal Year 2016-17 Operating Budget approved by the Board on June 2, 2016. Distribution of budgeted funds for this program will be dependent on actual performance and improvement of Health Network scores.

**Rationale for Recommendation**
This alignment of the referenced measures with incentive dollars leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima staff has modified each program for applicability to the membership, measurement methodology, strategic priorities and regulatory compliance

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

**Attachments**
1. PowerPoint Presentation – 2016 Pay for Value Programs
2. Board Action dated April 7, 2016, Approve Measurement Year CY 2016 Pay for Value Programs for Medi-Cal and OneCare Connect

*/s/ Michael Schrader* — *09/29/2016*
**Authorized Signature** — **Date**

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# Pay-for-Value 2016

**Board of Directors Meeting**
**October 6, 2016**

**Richard Helmer, M.D., Chief Medical Officer**

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# Pay for *Value* - 2016

- Goals of the current program & methodology
  - Adult & Child measures are included for every Health Network
  - Populations are weighted based on the acuity of the membership
  - Payment considers the resources required for the membership
  - Payment methodology scores for performance and improvement
  - Adult & Child CAHPS scores are used in the methodology
  - Payment is not earned for poor performance
  - Design incentive payments to optimize quality improvement

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# Medi-Cal P4V Clinical Measures

| 2016 Measurement Year Measures | |
|---|---|
| Adult Measures | Child Measures |
| Adult Access to Preventive Care Services | Children's Access to Primary Care Physicians |
| Breast Cancer Screening | Well Child Visits 3-6 Years |
| Cervical Cancer Screening | Adolescent Well Care Visits |
| Diabetes Care: A1C Testing | Childhood Immunizations (Combo 10) |
| Diabetes Care: Retinal Eye Exams | Appropriate Testing for Children with Pharyngitis |
| Medication Management for People with Asthma | Appropriate Treatment for Children with URI |
| | Medication Management for People with Asthma |

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# MediCal P4V CAHPS Measures

| 2016 Measurement Year Measures |
| --- |
| Child & Adult Measures |
| Getting Appointment with a Specialist |
| Timely Care & Service |
| Rating of PCP |
| Rating of all HealthCare |

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# Introduced Display Measures

- Display Measures are new measures that may be included in future pay for value programs. These measures are not eligible for payment for 2016 measurement year performance.
- Cal Optima has included these measures on the monthly HN HEDIS incentive measures rate reports for monitoring purposes.
- Display Measures:
  - Ambulatory Care (Outpatient and ER visits)
  - Readmissions
  - IHA completion rates

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# Payment Methodology

| Population Included: | |
|---|---|
| Total # of Adults in Health Network | Total # of Children in Health Network |
| Apply Acuity Score (SPD Weight 4X, TANF Weight 1X) | |
| **Payment** | |
| 50% based on Performance score and 50% based on Improvement score<br>Improvement score will be weighted by CalOptima's overall improvement | |
| Clinical Measures = 60% of the Total | CAHPS Measures = 40% of the Total |
| **Proposed Scoring for Measure Performance:** | |
| • A relative point system by measure, based on:<br>• NCQA National HEDIS Percentiles (clinical measures)<br>• NCQA National CAHPS Percentiles (satisfaction measures)<br>• Final score is the sum of points for each measure<br>• Improvement score based on improvement from previous year (receiving 1 point for increasing each percentile level and negative 1 point for decreasing) | |

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# Recommended Scoring - Amended

| P4V Scoring - NEW |
| --- |
| **Performance Points – HEDIS & CAHPS** |
| 1 point: >= 50th percentile<br>2 points: >= 75th percentile<br>3 points: >= 90th percentile<br>No points <50th percentile |
| **Improvement points – HEDIS & CAHPS** |
| 1 point for increasing 1 percentile level<br>(e.g. 1 point for 25th percentile to 50th percentile;<br>2 points for 50th percentile to 90th percentile, etc.)<br><br>Negative one (-1) point for decreasing 1 percentile level<br>(e.g. -1 point for 75th percentile to 50th percentile;<br>-2 points for 50th percentile to 10th percentile, etc.) |

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# 2016 MY OneCare P4P Clinical Measures (Retire Program for MY2016)

| | |
|---|---|
| Breast Cancer Screening | Diabetes Care: A1 Screening |
| Colorectal Cancer Screening | Diabetes Care: A1C Good control (<8%) |
| Adults' Access to Preventive/Ambulatory Health services | Diabetes Care: Retinal Eye Exams |
| | Diabetes Care: Nephropathy Screening |

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# OneCare Connect P4V Clinical Measures

| 2016 Measurement Year Measures – OneCare Connect |
| --- |
| 1. Plan All Cause Readmissions |
| 2. Behavioral Health:<br>• Antidepressant Medication Management |
| 3. Blood Pressure Control |
| 4. Part D Medication Adherence for Diabetes |

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# Where Do We Go From Here?

- 2017 & Beyond…..Meaningful Change with Meaningful Improvement
  - Are there new goals?
  - Do we have the right measures?
  - How can we all be successful?
  - Focus on Overall Improvement

- Next Steps

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken April 7, 2016**
**Regular Meeting of the CalOptima Board of Directors**

## Consent Calendar
7. Approve Measurement Year CY 2016 Pay for Value Programs for Medi-Cal and OneCare Connect

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

## Recommended Action
Approve Measurement Year CY 2016 "Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect (OCC)" which defines measures and allocations for performance, as described in Attachment 1, subject to regulatory approval, as applicable.

## Background
CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care.

The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on March 1, 2014, is three-fold:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks on their quality improvement efforts.

## Discussion
For the Measurement Year CY 2016 programs, staff recommends maintaining many of the elements from the prior year with some modifications. Changes to measures and scoring methodology address the need to consider the complexity or member acuity (SPD compared to Non-SPD members) and the subsequent higher consumption of physician/health network resources to care for SPD members. Additionally, the scoring methodology will reward performance and improvement. The program will include both Adult and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, thereby expanding our focus on the member experience.

In order to sustain improvements and leverage resources that the health networks have allocated towards improvement in P4V measures, staff recommends the following modifications:

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**Medi-Cal Changes**:

- All health networks will have performance measures for both adult and child care. This addresses the unique needs of children in all networks.

- Introduction of an "acuity" calculation to address the unique health needs in the populations.

- Addition of access to care measures:
  - Adults Access to Preventative/Ambulatory Care Services
  - Children's Access to Primary Care Physicians

- Retirement of the "provider satisfaction with the health network and UM process" measure.

- The weighting of each domain in the Medi-Cal Pay for Performance program has been adjusted accordingly. Increased weighting has been allocated to member experience. This aligns with CalOptima's increased focus on improving member experience.

The proposed Measurement Year CY 2016 Medi-Cal Pay for Value program is a one year program which uses calendar year (CY) 2016 HEDIS measurements and for which payments will be made in 2017.

**OneCare:**
The OneCare Pay for value program will be retired due to the transition of the majority of former OneCare members to OneCare Connect. Quality Performance metrics for the One Care population of approximately 1200 members will continue to be reported via our annually required HEDIS submission to CMS. However, the reduced OneCare membership is too small to produce statistically significant results by individual health network. In lieu of an allocated incentive fund, OneCare health network capitation rates were increased 1% on January 1, 2016.

**OneCare Connect**:

- To incentivize quality care in our new OneCare Connect program and to better align with the CMC Quality withhold program, four new measures are proposed. Included in the proposed measure set for OneCare Connect is also a new measure type with an emphasis on clinical outcomes (blood pressure control).

- OneCare Connect measures are pending regulatory approval.

**Windstone:**

- Reinstate pay for value measures for Windstone Behavioral Health.

**Distribution of Incentive Dollars**
Performance allocations are distributed upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. To qualify for payment for each of the clinical and CAHPS measures, the Health Network must have a minimum denominator in accordance with statistical principles.

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In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

Any separate OCC Quality Withhold incentive dollars earned will be distributed based upon Board of Directors approved methodology developed by staff and approved by CMS.

**Fiscal Impact**
Staff estimates that the fiscal impact of the Medi-Cal P4V will be no more than $2 pmpm for the Measurement period of January 1, 2016 through December 31, 2016 and expects to present these expenses with the CalOptima FY 2016-2017 Operating Budget.

Staff estimates that the fiscal impact of the OneCare Connect P4V will be no more than $20 pmpm for the Measurement period of January 1, 2016 through December 31, 2016, and expects to present these expenses with the CalOptima FY 2016-2017 Operating Budget.

**Rationale for Recommendation**
This alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

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

**Attachments**
2016 Medi-Cal, Windstone, and OneCare Connect Pay for Value Programs
PowerPoint Presentation – 2016 Pay for Value Programs

*/s/ Michael Schrader* — **Authorized Signature**

*04/01/2016* — **Date**

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**Attachment to:**
**2016 Medi-Cal Pay for Value Program**
**Measurement Set**

| **Adult Measures** | **2016 Measurement Year**<br><br>**HEDIS 2017 Specifications**<br>**Anticipated Payment Date: Q4 2017** | **Measurement Assessment Methodology** |
|---|---|---|
| Clinical Domain-HEDIS<br><br>Weight: 60.00%<br><br>SPD Weight 4.0<br><br>TANF Weight 1.0 | Prevention<br>• Breast Cancer Screening (BCS)<br>• Cervical Cancer Screening (CCS)<br><br>Diabetes<br>• HbA1c Testing<br>• Retinal Eye Exams<br><br>Access to Care:<br>• Adults Access to Preventive/Ambulatory Care<br><br>Adult & Child Measure:<br>• Medication Management for People with Asthma | A relative point system by measure based on:<br>• NCQA National HEDIS Percentiles<br>• Percent improvement |
| Patient Experience Domain-CAHPS<br><br>Weight: 40% | Adult Satisfaction Survey<br>1. Getting Appointment with a Specialist<br>2. Timely Care and Service<br>3. Rating of PCP<br>4. Rating of All Healthcare | A relative point system by measure based on:<br>• NCQA National CAHPS Percentiles<br>• Percent improvement |



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| Pediatric Measures | 2016 Measurement Year<br><br>HEDIS 2017 Specifications<br>Anticipated Payment Date: Q4 2017 | Measurement Assessment Methodology |
|---|---|---|
| Clinical Domain HEDIS<br><br>Weight: 60.00%<br><br>SPD Weight 4.0<br><br>TANF Weight 1.0 | Respiratory<br>• Medication Management for People with Asthma<br>• Appropriate Testing for Children with Pharyngitis (CWP)<br>• Appropriate Treatment for Children with Upper Respiratory Infection (URI)<br><br>Prevention<br>• Childhood Immunization Status Hepatitis Combo 10 (CIS)<br>• Well-Care Visits in the 3-6 Years of Life (W34)<br>• Adolescent Well-Care Visits (AWC)<br><br>Access to Care<br>• Children's Access to Primary Care Physicians | A relative point system by measure based on:<br>• NCQA National HEDIS Percentiles<br>• Percent improvement |
| Patient Experience Domain-CAHPS<br><br>Weight: 40% | Child Satisfaction Survey (Child CAHPS)<br><br>1. Getting Appointment with a Specialist<br>2. Timely Care and Service<br>3. Rating of PCP<br>4. Rating of All Healthcare | A relative point system by measure based on:<br>• NCQA National CAHPS Percentiles<br>• Percent improvement |

**Windstone Behavioral Health**

**Calculations for these measures will be the responsibility of CalOptima.**

| Measures | Allocation CY 2016 | Data Source | Anticipated Payment Date | Benchmark |
|---|---|---|---|---|
| **Quality of Care** | | | | |
| 1. Follow-up After Hospitalization for Mental Illness<br>• Follow-up Visit after 7 days<br><br>• Follow-up Visit after 30 days | $15,000<br>• 50% at 50th percentile-<br>• 100% if score is at or above 75th percentile<br><br>$15,000<br>• 50% at 50th percentile | HEDIS 2017 | October 2017 | Most current NCQA Quality Compass Medicare Percentiles |
| 2. Reduction in ED use for Seriously Mentally Ill and Substance Use Disorders | $30,000 | CA State Defined Measure | October 2017 | Significant improvement based on CMS methodology. |

| OneCare Connect | 2016 Measurement Year<br><br>Anticipated Payment Date: (Q4) | Measurement Assessment Methodology |
|---|---|---|
| Clinical Domain Weight:100%<br><br>Each measure weighted equally | Measures:<br>• Plan All Cause Readmissions<br>• Antidepressant Medication Management Outcome Measures:<br>• Blood Pressure Control<br>• Part D Medication Adherence for Diabetes | A relative point system by measure based on:<br>• NCQA National HEDIS Percentiles<br>• Percent improvement<br><br>**For the Part D Medication Adherence Measure:**<br>A relative point system by measure based on:<br>• CMS Star Rating Percentiles<br>• Percent improvement |

**Participation in Quality Improvement Initiatives**

For each measure in which a Health Network/medical group performs below the 50th percentile, Health Networks/medical groups must submit a corrective action plan to CalOptima which outlines, at a minimum, the following items:

- Interim measures and goals
- Measurement cycle
- Member interventions including education and outreach
- Provider interventions including education and training
- Timeline for interventions

Health networks/medical groups must submit quarterly work plans which document implementation of the corrective action plan and progress made towards goals.
In conjunction with the Health Networks, CalOptima will lead quality improvement initiatives for measures that fall below the 50th percentile. Funding for these initiatives will come from forfeited dollars.

**MEASUREMENT DETAILS:**

**I. Clinical Domain (HEDIS measures)**

**Program Specific Measurement Sets**
Performance measures were selected as appropriate per program based on the following criteria:

- Measures are appropriate for membership covered by the program
- Measures are based on regulatory requirements
- Measures are used by the industry for performance measurement and incentive payment

Criteria
The following criteria were considered in selecting these indicators:

- Each of these indicators measures the delivery of services that are critical to the health of the respective segments of CalOptima's membership. In addition, these measures collectively address the range of age appropriate services.
- The measures use administrative data for all except Blood Pressure only reporting since they are single point of service measures.
- CBP will be captured with a specific chart review activity for this P4V program.

Each measure is calculated per HEDIS methodology except that continuous enrollment is assessed at the health network level instead of at the health plan level

**Incentive Measure Definition**
Please refer to HEDIS Technical Specifications Volume 2 for measure definitions. For each HEDIS indicator, members will be identified according to the most recent HEDIS technical specifications.

## II. Customer Satisfaction

### Member Satisfaction

Background

CalOptima conducts annual member satisfaction surveys that are carefully designed to provide network-level satisfaction information to meet precision requirements and to support comparisons between networks and at the CalOptima agency level. The goal is to survey different subsets of the CalOptima membership (e.g. Children, persons with disabilities) on a rotating basis so that we develop 1) trend information over time about individual networks' performance for a specific population and 2) comparable performance information across networks both for a specific time period as well as trended over time.

Survey Methodology

The surveys are administered using the CAHPS protocol, including a mixed-mode methodology of mail and telephone contact to notify members of the study, distribute questionnaires, and encourage participation by non-respondents. Both surveys have been conducted in three threshold languages as defined by our Medi-Cal contract.

CalOptima has worked with outside technical and substantive consultants to refine its survey instruments and sampling and weighting strategies and has employed a nationally known survey research group to conduct both surveys.

The samples consisted of randomly selected Medi-Cal members who met specific requirements for inclusion as specified by the CAHPS and by our interest in targeted subgroups. The sample is a disproportionately stratified random sample with strata defined by health network. CalOptima required sample sizes and allocations across strata be developed to provide estimates of population proportions at the network level that were within 2.5 percentage points of the true value with 95% statistical confidence.

# 2016 Pay For Value Programs

**Board of Directors Meeting**

**April 7, 2016**

**Richard Bock, M.D.**

**Deputy Chief Medical Officer**

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# Pay for Performance - Current

- We identified opportunities to build on the current P4P program:
  - Half of our children are linked to Health Networks outside of CHOC
  - There wasn't the ability to recognize performance and improvement efforts
  - Only Child CAHPS was used to measure member experience; Adult CAHPS was not included in the program
  - The current methodology resulted in inadequate incentive for improved performance

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# Pay for *Value* - 2016

- Goals of the new program and methodology
  - Adult and Child measures are included for every Health Network
  - Populations are weighted based on the acuity of the membership
  - Payment considers the resources required for the membership
  - Payment methodology scores for performance and improvement
  - Adult and Child CAHPS scores are used in the methodology
  - Payment is not earned for poor performance
  - More allocated funds are converted to incentive payments

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# Medi-Cal P4V Clinical Measures

| 2016 Measurement Year Measures | |
|---|---|
| Adult Measures | Child Measures |
| Adult Access to Preventive Care Services | Children's Access to Primary Care Physicians |
| Breast Cancer Screening | Well Child Visits 3-6 Years |
| Cervical Cancer Screening | Adolescent Well Care Visits |
| Diabetes Care: A1C Testing | Childhood Immunizations (Combo 10) |
| Diabetes Care: Retinal Eye Exams | Appropriate Testing for Children with Pharyngitis |
| Medication Management for People with Asthma | Appropriate Treatment for Children with URI |
| | Medication Management for People with Asthma |

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# MediCal P4V CAHPS Measures

| 2016 Measurement Year Measures |
| --- |
| Child and Adult Measures |
| Getting Appointment with a Specialist |
| Timely Care & Service |
| Rating of PCP |
| Rating of all HealthCare |

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# Introducing Display Measures

- Display Measures are new measures that may be included in future pay for value programs. These measures are not eligible for payment for 2016 measurement year performance.
- CalOptima will include these measures on the monthly HN HEDIS incentive measures rate reports for monitoring purposes.
- Proposed Measures:
  - Ambulatory Care (Outpatient and ER visits)
  - Readmissions
  - IHA completion rates

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# Payment Methodology

| Population Included: | |
|---|---|
| Total # of Adults in Health Network | Total # of Children in Health Network |
| Apply Acuity Score (SPD Weight 4X, TANF Weight 1X) | |
| **Proposed Scoring for Measure Performance:** | |
| A relative point system by measure, based on:<br>• NCQA National HEDIS Percentiles (clinical measures)<br>• NCQA National CAHPS Percentiles (satisfaction measures)<br>• Percent Improvement year over year | |
| Final score for each measure is determined by weight and acuity | |
| Clinical Measures = 60% of the Total | CAHPS Measures = 40% of the Total |

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# 2016 MY OneCare P4P Clinical Measures (Retire Program for MY2016)

| | |
|---|---|
| Breast Cancer Screening | Diabetes Care: A1 Screening |
| Colorectal Cancer Screening | Diabetes Care: A1C Good control (<8%) |
| Adults' Access to Preventive/Ambulatory Health services | Diabetes Care: Retinal Eye Exams |
| | Diabetes Care: Nephropathy Screening |

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# OneCare Connect P4V Clinical Measures

| 2016 Measurement Year Measures – OneCare Connect |
| --- |
| 1. Plan All Cause Readmissions |
| 2. Behavioral Health:<br>• Antidepressant Medication Management |
| 3. Blood Pressure Control |
| 4. Part D Medication Adherence for Diabetes |

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# OneCare Connect P4V: Windstone Behavioral Health

## 2016 Measurement Year Measures – Windstone

1. Follow-up After Hospitalization for Mental Illness:
   - Follow-up Visit after 7 days
   - Follow-up Visit after 30 days

2. Reduction in Emergency Department use for Seriously Mentally Ill and Substance Use Disorders (per CMS-defined standards)

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken March 2, 2017**
**Regular Meeting of the CalOptima Board of Directors**

## Consent Calendar

5. Consider Approval of the Fiscal Year (FY) 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect

## Contact

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

## Recommended Action

Approve the Fiscal Year 2018 (Measurement Year 2017) "Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect" which defines measures and allocations for performance, as described in Attachment 1 and 2, subject to regulatory approval, as applicable.

## Background

CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care.
The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on March 1, 2014, is three-fold:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks on their quality improvement efforts.

## Discussion

For the Measurement Year CY 2017 programs, staff recommends maintaining many of the elements from the prior year with some modifications. As described in the 2016 P4V program, measures and scoring methodology address the need to consider the complexity or member acuity (SPD compared to non-SPD members) and the subsequent higher consumption of physician / health network resources to care for SPD members. In addition, the scoring methodology will continue to reward performance and improvement. The program will include both Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, thereby expanding our focus on the member experience. The proposed MY17 Medi-Cal and OneCare Connect Pay for Value programs are one year programs which use HEDIS 2018 specifications and for which payments will be made in 2018.

In order to sustain improvements and leverage resources that the health networks have allocated towards improvement in P4V measures, staff recommends the following modifications:

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Medi-Cal Changes:

- Revise minimum denominator size from 100 to 30 eligible members for each specified quality measure to be eligible for incentive payment
- Revise CAHPS minimum performance threshold to reflect CA benchmarks

OneCare Connect Changes:

To incentivize quality care in our new OneCare Connect program and to better align with the CMS Quality Withhold program, the four clinical incentive measures below remain in the OneCare Connect P4V program:

- Plan All Cause Readmissions
- Controlling Blood Pressure
- Medication Adherence for oral anti-diabetic medications (Part D measure)
- Behavioral Health: Antidepressant Medication Management

Starting in CY 2017, a member experience survey (CAHPS) is added to the program.

Clinical measures are weighted at 60%; member experience is weighted at 40%. In the Board approved 2016 P4V program, only clinical measures were included and were weighted at 100%.

Distribution of Incentive Dollars

Performance allocations are distributed to the Health Networks, including CCN, upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. To qualify for payment for each of the clinical and CAHPS measures, the Health Network must have a minimum denominator, as noted.

In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

Any separate OCC Quality Withhold incentive dollars earned by CalOptima will be distributed based upon a Board-approved methodology to be developed by staff and subject to any needed regulatory approvals.

**Fiscal Impact**

Since the distribution of incentive dollars for the MY 2017 P4V Programs for Medi-Cal and OneCare Connect will be made in FY 2017-18, there is no fiscal impact to the FY 2016-17 Operating Budget.

Staff estimates that the fiscal impact for the MY 2017 P4V Program will be no more than $2 per member per month (PMPM) for Medi-Cal, and no more than $20 PMPM for OneCare Connect. Staff will include expenses for the MY 2017 P4V Program for Medi-Cal and OneCare Connect in the upcoming FY 2017-18 CalOptima Operating Budget.

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Time of Payment
Payment of any reward under the P4V program will occur after CalOptima receives official notice of HEDIS and CAHPS scores for 2017, which is anticipated to be on or around 4th quarter, 2018. The time of payment is subject to change at CalOptima's discretion.

**Rationale for Recommendation**
This alignment will leverage improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

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

**Attachments**
1. FY 2018 (MY 2017) Medi-Cal Pay for Value Program
2. FY 2018 (MY 2017) OneCare Connect Pay for Value Program

*/s/ Michael Schrader* — **Authorized Signature**

*2/23/2017* — **Date**

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**Attachment 1: FY 2018 (MY 2017) Medi-Cal Pay for Value Program Measurement Set**

| **Adult Measures** | **2017 Measurement Year / HEDIS 2018 Specifications**<br><br>**Anticipated Payment Date: Q3 2018** | **Measurement Assessment Methodology** |
|---|---|---|
| Clinical Domain - HEDIS<br>Weight: 60.00%<br><br>SPD Weight 4.0<br><br>TANF Weight 1.0 | <u>Prevention:</u><br>• Breast Cancer Screening (BCS)<br>• Cervical Cancer Screening (CCS)<br><br><u>Diabetes:</u><br>• HbA1c Testing<br>• Retinal Eye Exams<br><br><u>Access to Care</u>:<br>• Adults Access to Preventive/Ambulatory Care<br><br><u>Respiratory</u>:<br>• Medication Management for People with Asthma (MMA) | A relative point system by measure based on:<br>• NCQA National HEDIS percentiles<br>• Percentile Improvement |
| Patient Experience Domain - CAHPS<br><br>Weight: 40% | <u>Adult Satisfaction Survey (Adult CAHPS):</u><br><br>1. Getting appointment with a Specialist<br>2. Timely Care and Service<br>3. Rating of PCP<br>4. Rating of all Healthcare | A relative point system by measure based on:<br>• NCQA California CAHPS percentiles<br>• Percentile Improvement |

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| **Pediatric Measures** | **2017 Measurement Year / HEDIS 2018 Specifications**<br><br>**Anticipated Payment Date: Q3 2018** | **Measurement Assessment Methodology** |
|---|---|---|
| Clinical Domain - HEDIS<br><br>Weight: 60.00%<br><br>SPD Weight 4.0<br><br>TANF Weight 1.0 | <u>Respiratory:</u><br>• Medication Management for People with Asthma (MMA)<br>• Appropriate Testing for Children with Pharyngitis (CWP)<br>• Appropriate Treatment for Children with Upper Respiratory Infection (URI)<br><br><u>Prevention:</u><br>• Childhood Immunization Status Combo 10 (CIS)<br>• Well-Care Visits in the 3-6 Years of Life (W34)<br>• Adolescent Well-Care Visits (AWC)<br><br><u>Access to Care:</u><br>• Children's Access to Primary Care Physician | A relative point system by measure based on:<br>• NCQA National HEDIS percentiles<br>• Percentile Improvement |
| Patient Experience Domain - CAHPS<br><br>Weight: 40% | <u>Child Satisfaction Survey (Child CAHPS)</u><br><br>• Getting Appointment with a Specialist<br>• Timely Care and Service<br>• Rating of PCP<br>• Rating of all Healthcare | A relative point system by measure based on:<br>• NCQA California CAHPS percentiles<br>• Percentile Improvement |

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**Attachment 2: FY 2018 (MY 2017) OneCare Connect Pay for Value Program**

| **OneCare Connect Measures** | **2017 Measurement Year / HEDIS 2018 Specifications**<br><br>**Anticipated Payment Date: Q3 2018** | **Measurement Assessment Methodology** |
|---|---|---|
| Clinical Domain - HEDIS<br><br>Weight: 60.00%<br><br>Each measure weighted equally | <u>Measures:</u><br><br>• Plan All Cause Readmissions<br>• Antidepressant Medication Management Outcome Measures<br>• Blood Pressure Control<br>• Part D Medication Adherence for Diabetes | A relative point system by measure based on:<br>• NCQA National HEDIS percentiles<br>• Percent Improvement<br><br>**For the Part D Medication Adherence Measure**:<br><br>A relative point system by measure based on:<br>• CMS Star Rating Percentiles<br>• Percentile Improvement |
| Patient Experience Domain - CAHPS<br><br>Weight: 40% | <u>Adult Satisfaction Survey (Adult CAHPS):</u><br><br>• Getting appointment with a Specialist<br>• Timely Care and Service<br>• Rating of PCP<br>• Rating of all Healthcare | A relative point system by measure based on:<br>• NCQA California CAHPS percentiles<br>• Percentile Improvement |

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**Participation in Quality Improvement Initiatives**

For each measure in which a Health Network/medical group performs below the 50th percentile, Health Networks/medical groups must submit a Corrective Action Plan (CAP) to CalOptima which outlines, at a minimum, the following items:

- Interim measures and goals
- Measurement cycle
- Member interventions including education and outreach
- Provider interventions including education and training
- Timeline for interventions

Health networks/medical groups must submit quarterly work plans which document implementation of the corrective action plan and progress made towards goals.

In conjunction with the Health Networks, CalOptima will lead quality improvement initiatives for measures that fall below the 50th percentile. Funding for these initiatives will come from forfeited dollars.

**MEASUREMENT DETAILS:**

**1. Clinical Domain (HEDIS measures)**

**Program Specific Measurement Sets**
Performance measures were selected as appropriate per program based on the following criteria:

- Measures are appropriate for membership covered by the program
- Measures are based on regulatory requirements
- Measures are used by the industry for performance measurement and incentive payment

**Criteria**
The following criteria were considered in selecting these indicators:

- Each of these indicators measures the delivery of services that are critical to the health of the respective segments of CalOptima's membership. In addition, these measures collectively address the range of age appropriate services.
- The measures use administrative data for all except Blood Pressure only reporting since they are single point of service measures.
- CBP will be captured with a specific chart review activity for this P4V program.

  Each measure is calculated per HEDIS methodology except that continuous enrollment is assessed at the health network level instead of at the health plan level.

**Incentive Measure Definition**
Please refer to HEDIS 2018 Technical Specifications Volume 2 for measure definitions. For each HEDIS indicator, members will be identified according to the most recent HEDIS technical specifications updates.

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## II. Customer Satisfaction

### Member Satisfaction

**Background**

CalOptima conducts annual member satisfaction surveys that are carefully designed to provide network-level satisfaction information to meet precision requirements and to support comparisons between networks and at the CalOptima agency level. The goal is to survey different subsets of the CalOptima membership (e.g. Children, Persons with disabilities, and Adults) on a rotating basis so that we develop:

- trend information over time about individual networks' performance for a specific population, and
- comparable performance information across networks both for a specific time period as well as trended over time.

**Survey Methodology**

The surveys are administered using the CAHPS protocol, including a mixed-mode methodology of mail and telephone contact to notify members of the study, distribute questionnaires, and encourage participation by non-respondents. Both surveys have been conducted in three threshold languages as defined by our Medi-Cal contract.

CalOptima has worked with outside technical and substantive consultants to refine its survey instruments and sampling and weighting strategies and has employed a nationally known survey research group to conduct both surveys.

The samples consisted of systematically selected Medi-Cal members who met specific requirements for inclusion as specified by the CAHPS and by our interest in targeted subgroups. The sample is a disproportionately stratified random sample with strata defined by health network. CalOptima required sample sizes and allocations across strata be developed to provide estimates of population proportions at the network level that were within 2.5 percentage points of the true value with 95% statistical confidence.

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken September 20, 2017**
**Regular Meeting of the CalOptima Board of Directors'**
**Quality Assurance Committee**

## Report Item

3. Consider Recommending Board of Directors' Approval of Revised Medi-Cal Quality Improvement and Accreditation Activities during CalOptima Fiscal Year (FY) 2017-18 for Member and Provider Incentives

## Contact

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

## Recommended Action

Recommend Board of Directors' approval of proposed revisions to Member and Provider incentive program start and end dates, subject to Regulatory Approval, as applicable.

## Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima staff has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members. At the November 16, 2016 meeting of the Quality Assurance Committee, approval of the plan for Medi-Cal Quality Improvement and Accreditation Activities during CalOptima Fiscal Year (FY) 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million was recommended, and Board approval was obtained on December, 1, 2016.

At the February 15, 2017 meeting of the Quality Assurance Committee, approval of the implementation plan for the proposed quality initiatives was recommended, and Board approval was obtained on March 2, 2017.

As of August 31, 2017, the majority of the proposed initiatives have been implemented; however there is one provider initiative that has had a delayed implementation due to challenges with provider engagement. In addition, the member incentives have had a slow uptake. Consequently, additional time is recommended to allow additional members to quality for the incentive.

## Discussion

The requested changes are all requests to extend the program or advise of a delayed start to a provider incentive.

Specifically:

- During the implementation of the two cervical cancer provider incentive programs, staff experienced challenges with engaging providers and appointment availability, resulting a request for the following extensions:
    - Cervical Cancer: Provider Extended Hours initiative implemented October 1 – December 15, 2017;
    - Cervical Cancer: Provider Office Staff incentive extended to December 31, 2017.

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- Staff recommends that member incentives be extended due to slow member uptake, to support an extension of the previously approved member incentives. This extension was also requested by the external providers who serve on the Quality Improvement Committee (QIC), upon review of the progress of the initiatives at the August 8, 2017 meeting. QIC discussed the importance of encouraging members to get needed services and requested these incentives to be extended as follows:
    - Breast Cancer Screening incentive extended until December 31, 2017;
    - Postpartum Care member incentive program extended until November 5, 2017. (incentive extension date aligns with HEDIS Postpartum Care measurement period)

There is no additional fiscal impact to the requests to extend or alter the initiative program length or start date. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives.

Regulatory approval was received from DHCS on February 23, 2017 for Postpartum Member Incentive, February 22, 2017 for Breast Cancer Screening Member Incentive and May 23, 2017 for Cervical Cancer Screening Member Incentive.

**Fiscal Impact**
The recommended action to revise the FY 2017-18 member and provider incentive program is budget neutral to CalOptima. Maximum expenditures covered by this initiative and previously approved are $10,000.00 for providers and $260,687.00 for members.

**Rationale for Recommendation**
CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. Board Action dated March 2, 2017, Consider Authorizing Staff to Develop and Implement Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17 for Member and Provider Incentives
    a. Attachment - Board Action dated December 1, 2016, Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

*/s/ Michael Schrader* — *9/14/2017*
**Authorized Signature** — **Date**

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken March 2, 2017**
**Regular Meeting of the CalOptima Board of Directors**

## Consent Calendar

6. Consider Authorizing Staff to Develop and Implement Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17 for Member and Provider Incentives

## Contact

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

## Recommended Action

Authorize staff to develop and implement Member and Provider incentive programs in the amounts listed on Attachment 1, subject to applicable regulatory approval and guidelines.

## Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members.

At the December 1, 2016, meeting, the CalOptima Board of Directors approved the Medi-Cal quality improvement and accreditation activities for Fiscal Year 2016-17. Specifically, the Board:

- Directed Staff to develop member and provider incentive programs in the amounts listed in Attachment 1, subject to applicable regulatory approval and guidelines, and final approval by the Board prior to implementation; and
- Authorized unbudgeted expenditures not to exceed $1.1 million to implement a budget augmentation for current quality initiatives (i.e., Surveys & NCQA fees, Consulting services, Quality Initiatives in flight, Required Training) and new requests for quality initiatives.

## Discussion

Attachment 1 provides the requested additional detail on the HEDIS measures and proposed member and provider incentives. During the development of these incentive programs, staff has been able to more precisely identify the scope and cost per incentive. Some incentives are designed as pilot programs, in order to evaluate their effectiveness prior to launching to a larger number of members or providers. As such, Attachment 2 provides further detail on the proposed revisions to the expenditures for Medi-Cal Quality Improvement and Accreditation activities from the December 1, 2016, Board action.

Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives.

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**Fiscal Impact**
There is no additional fiscal impact for the recommended action.

**Rationale for Recommendation**
CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

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

**Attachments**
1. PowerPoint Presentation: Proposed Member and Provider Incentive Plan
2. Revision to Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
3. Board Action dated December 1, 2016, Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

*/s/ Michael Schrader* — *2/23/2017*
**Authorized Signature** — **Date**

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# Proposed Member and Provider Incentive Plan

**Board of Directors Meeting**
**March 2, 2017**

**Caryn Ireland**
**Executive Director, Quality and Analytics**

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# Introduction

- All proposed incentives are pilot projects; results of each incentive will be brought back to the Board when analyzed
- No additional funds are requested
- Staff has refined the originally proposed costs to reflect expenditures during FY16-17 vs. through year end
- Staff has incorporated DHCS guidance on best practices for member incentives
  - Member incentives will be in the form of gift cards
- Offices/clinics identified for the Provider incentives will be based on the following criteria:
  - High Volume Providers, in good standing with CalOptima

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# Postpartum: Member Incentive

| | Description |
|---|---|
| **Objectives** | To increase the number of members who had a delivery to obtain their postpartum visit within the prescribed timeframe. CalOptima's goal is to increase the HEDIS postpartum visit rate to above the 25th percentile. |
| **Target Population** | Medi-Cal members with a delivery between March 1 – June 30, 2017 (postpartum visit may occur after July 1st) |
| **Requirements** | • Voluntary participation in the postpartum incentive program.<br>• Member must complete a postpartum visit with a provider within prescribed timeframe after delivery.<br>• Member must complete and return required form provided by CalOptima to verify postpartum visit to obtain member incentive. |
| **Incentive Type/Amount:** | • $25 gift card per participating member<br>•Additional entrance into a monthly opportunity drawing [50 members will be given a $100 gift card every month through opportunity drawing]. |
| **Duration:** | • March 1- June 30, 2017 |
| **Total Cost:** | **$90, 682**<br>Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017 |

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# Postpartum: Provider Office Staff Incentive

| | Description |
|---|---|
| **Objectives** | Provide “just in time” training on Medical Records documentation of postpartum visits in order to improve our postpartum chart review results. Incomplete medical record documentation contributes to our declining postpartum score. Staff have analyzed postpartum medical record documentation that contributed to lack of compliance. Goal is to raise rates on Postpartum Care. |
| **Target Population** | Three PCPs, Clinics or OB/GYN offices with the highest number of members who had a delivery between January-June, 2017 |
| **Requirements** | •Clinic staff must participate in a review 2016 medical record results with CalOptima staff for training on documentation which may lead to low rates. (March)<br>•Clinic staff will implement changes within their office processes to ensure complete documentation;<br>•Clinic staff will review sample of medical records with CalOptima team for training (April, May, June)<br>•Requires Office Manager & Clinical Staff participation in all sessions |
| **Incentive Type/Amount:** | • $1000 per provider office or clinic for participation in the program<br>• $1000 per provider office for demonstrated improvement |
| **Duration:** | 4 months (Mar-June 30, 2017) |
| **Total Cost:** | **$10,000 (includes payments to providers and chart review resources)** |

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# Cervical Cancer Screening: Member Incentive

| | Description |
|---|---|
| **Objectives** | To improve cervical cancer screening HEDIS rates |
| **Target Population** | Medi-Cal members between the ages of 21-64 years old. |
| **Requirements** | • Voluntary participation in the cervical cancer screening incentive program.<br>• Member must complete a cervical cancer screening between February 15 – August 31, 2017.<br>• Member must complete and return required form provided by CalOptima to verify cervical cancer screening to obtain member incentive. |
| **Incentive Type/Amount:** | • $15 gift card/member for completing cervical cancer screening.<br>• Additional entrance into a monthly opportunity drawing [75 members will be given a $100 gift card every month through opportunity drawing]. |
| **Duration:** | 6 months (February 15 - August 31, 2017) |
| Total Cost: | **$87,505 by June 30, 2017**<br>• 4,167 members to complete cervical cancer screening by June 30, 2017<br>• 4,167 members x 15 = $62,505, plus $25,000 in opportunity drawing = $87,505.<br>•Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017 |

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# Cervical Cancer: Provider Office Staff Incentive

| | Description |
|---|---|
| **Objectives** | 1) To improve cervical cancer screening rates (HEDIS CCS) at targeted office sites by incentivizing staff to assist CalOptima members to get a pap test in greater volume than their current monthly average. CalOptima staff to calculate monthly average of completed pap tests for each targeted office. This may include helping to schedule appts for members, helping with transportation services, providing follow-up reminder calls, etc.<br>2) To understand and learn about any barriers at the provider level in an effort to provide resources and support. |
| **Target Population** | 1) Target 5 High volume Medi-Cal provider offices, and 5 High volume Medi-Cal clinics, focus on office staff to help member get and keep appointments for pap tests.<br>2) Additional offices may be added to the campaign |
| **Requirements** | • Voluntary participation in the Provider Office Staff incentive program.<br>• Conduct member outreach efforts (outbound calling, scheduling, record-keeping, maintaining communication with CalOptima).<br>• Monthly communication/update with CalOptima. |
| **Incentive Type/Amount:** | • Two (2) meals will be provided at Provider Offices; Once at program launch and a second time at program completion.<br>• $10/member above the monthly cervical cancer screening average for the office |
| **Example for $10 incentive: Dr. John Smith** | Avg. # Cervical Cancer Screenings for CalOptima Members: 25<br>Completed # of Cervical Cancer Screenings in February, 2017: 55<br>Increase over average screening rate: 30 (validated via claim/encounter submission)<br><br>Total Incentive Earned for February, 2017: $300 (10 X $30=$300)<br>Incentive may be earned for each month of the program , but amount will vary depending upon the number of members screened above the monthly average . |
| **Duration:** | 6 months (February 15 – August 31, 2017) |
| **Total Cost:** | **$ Up to 72,500;** Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017 |

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# Cervical Cancer: Extended Hours Initiative

| | Description |
|---|---|
| **Objectives** | To promote women's health (breast and cervical cancer screenings) and improve screening rates at targeted provider offices. |
| **Target Population** | Target 1-2 high volume PCP offices.<br>* Additional offices may be added to the campaign |
| **Requirements** | • Voluntary participation in the Provider Office Extended Hours Initiative.<br>• Extend office hours for CalOptima members at least two (2) times per month for 3 months. Extended hours could be evening or weekends; targeting 8 additional hours per month per provider office.<br>• Conduct member outreach efforts (outbound calling, scheduling appointments, record-keeping, maintaining communication with CalOptima).<br>• Conduct well-women exams to include pap test, exclusively for CalOptima members during extended hours. |
| **Incentive Type/Amount:** | • Each office may receive up to $200/hour (up to a maximum of 16 hours over 3 months) to cover the cost of extending office hours, staffing resources and others.<br>• Cost may vary between offices due to staffing resources and extended hours. |
| **Duration:** | 3 months (March 1 – June 30, 2017) |
| **Total Cost:** | **$10,000** |

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# Breast Cancer Screening: Member Incentive

| | Description |
|---|---|
| **Objectives** | To improve breast cancer screening HEDIS rates |
| **Target Population** | Medi-Cal members between the ages of 50 -74 years old. |
| **Requirements** | • Voluntary participation in the breast cancer screening incentive program.<br>• Member must complete a breast cancer screening between February 1 – August 31, 2017.<br>• Member must complete and return required form provided by CalOptima to verify breast cancer screening to obtain member incentive. |
| **Incentive Type/Amount:** | • $10 gift card/member for completing breast cancer screening.<br>• Additional entrance into a monthly opportunity drawing [50 members will be given a $100 gift card every month through opportunity drawing]. |
| **Duration:** | • 6 months (February 15 – August 31, 2017) |
| **Total Cost:** | **$82, 500 by June 30, 2017**<br>• 5,750 members to complete breast cancer screening by August 31, 2017<br>• 5,750 x 10 = $57,000; plus $25,000 in opportunity drawing = $82,500<br>•Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017 |

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**Attachment 2: Revision to Expenditures for Medi-Cal Quality Improvement and Accreditation Activities**

| | 12/1/16 Board Action | | Recommended Action | |
|---|---|---|---|---|
| **Item** | **Detail** | **Total Amount (Not to Exceed)** | **Detail** | **Total Amount (Not to Exceed)** |
| Member Programs | • Prenatal/postpartum incentive (Increase volume of outreach): $10,887<br>• Breast cancer screening (Downward trend; Reminder mailing & incentive): $99,900<br>• Cervical cancer screening (Below MPL; Reminder mailing & incentive): $149,900 | $260,687 | • Prenatal/postpartum incentive: $90,682<br>• Breast cancer screening: $82,500<br>• Cervical cancer screening: $87,505 | $260,687 |
| Provider Programs | • Physician office extended hours pilot project - MPL measures: $10,000<br>• Prenatal/postpartum provider office incentive: $5,000<br>• PCP office staff incentives for well women visits/screenings: $75,000<br>• Physician office extended hours initiative mailing: $2,500 | $92,500 | • Postpartum provider office staff incentive: $10,000<br>• Cervical cancer provider office staff incentive: $72,500<br>• Cervical cancer extended hours initiative: $10,000 | $92,500 |

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken December 1, 2016**
**Regular Meeting of the CalOptima Board of Directors**

## Consent Calendar

5. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

## Contact

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

## Recommended Actions

1. Approve the Quality Improvement activities listed on Attachment 1;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with new vendors and amend existing vendor contracts, as appropriate, for quality improvement-related services, including NCQA consulting and provider coaching services, incentive distribution and tracking services, PSA development services, survey implementation services, and material and print services selected consistent with CalOptima's Board-approved procurement process;
3. Direct staff to develop Member and Provider incentive programs in the amounts listed on Attachment 1., subject to applicable regulatory approval and guidelines, and final approval by the CalOptima Board prior to implementation; and
4. Authorize unbudgeted expenditures not to exceed $1.1 million to implement these initiatives.

## Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members.

One of the areas of focus within Quality Programs and Services is CalOptima's performance in the National Committee for Quality Assurance (NCQA) accreditation and ratings. The evaluation criterion for the NCQA health plan ratings consists of three dimensions: Prevention, Treatment and Member Satisfaction. According to the most recent NCQA Health Plan Ratings, (NCQA's Medicaid Health Insurance Plan Ratings 2015-2016) CalOptima scored 4 out of 5 on Prevention, 3.5 out of 5 on Treatment, and 2.5 out of 5 in Customer Service. Health Plans are rated on a 5 point scale. CalOptima achieved an overall rating of 4 out of 5. CalOptima has the distinction of being the top rated Medicaid Health plan in California for the past three years. CalOptima is proud to be the only California Medicaid health plan accredited at the "commendable" level by NCQA. Additionally, CalOptima has achieved a 3.5 out of 5.0 "STAR" rating for Medicare by the Centers for Medicare & Medicaid Services (CMS).

Although CalOptima has achieved much success in our quality programs, we have also identified two measures that were below the minimum performance level (MPL) established by the California

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Department of Health Care Services (DHCS), and we have prospectively identified other quality measures on the decline that are required for NCQA accreditation and health plan ratings. In order to maintain or exceed our quality performance levels, it is imperative to consider additional interventions which are necessary to achieve these goals, as referenced in our 2016 QI Program Description (Clinical Data Warehouse section, pg 41). These include utilizing multiple levers (direct-to-member, direct-to-provider, incentives, communication strategies, etc.) and programs planned as ongoing strategies throughout the calendar year.

In preparing the CalOptima FY 2016-17 Operating Budget, staff applied the regular budgeting methodology which used the past year's actual run-rate assumptions to allocate funds to various categories, units and lines of business. Upon further review, it became clear that additional funding was necessary to meet existing program commitments for Medi-Cal quality monitoring, reporting and improvement as well as new and expanded quality programs.

**Discussion**

Maintaining CalOptima's "commendable" accreditation status and rating by NCQA as a top Medicaid plan in California requires ongoing investment in innovative quality initiatives focused on underperforming measures as well as measures aligned with NCQA accreditation, health plan ratings, as well as DHCS and CMS requirements. Funding is also requested to maintain current vendor contracts utilized for quality reporting and to support annually required trainings for quality staff.

Expenditures requested are classified as:

| | |
|---|---|
| • Budget augmentation for current quality initiatives: | $ 457,740 |
| • New requests for quality initiatives: | $ 605,839 |
| Total Request | $1,063,579 |

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities provides additional detail on the quality related programs, initiatives and proposed incentives. Member and provider incentive programs will be established by CalOptima. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives. All member and provider incentive programs will be fully developed and returned for Board approval prior to implementation, as well as regulatory approval, as applicable.

**Fiscal Impact**

The recommended action to appropriate and authorize expenditures of up to $1.1 million for Medi-Cal quality improvement and accreditation activities is an unbudgeted item. Management is requesting Board approval to authorize an additional amount of up to $1.1 million in medical expenses to fund the cost of the quality improvement activities.

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**Rationale for Recommendation**

CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

**Concurrence**

Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer
Board of Directors' Quality Assurance Committee
Board of Directors' Finance and Audit Committee

**Attachments**

- Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
- PowerPoint Presentation: Quality Analytics Budget

*/s/ Michael Schrader* *11/22/2016*
**Authorized Signature** **Date**

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**Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities**

A. Budget Augmentation for Current Quality Initiatives

| Item | Detail | Amount (Not to Exceed) |
|---|---|---|
| Surveys & NCQA Fees | • Addition of CG CAHPs - Adult & Child<br>• Fee increases for regular CAHPS<br>• Implement SPD CAHPS<br>• Additional record retrieval for Medical Record Review<br>• Increase in NCQA required fees<br>• Timely Access Survey | $252,937 |
| NCQA Consultant | • RFP results did not produce viable option; completed bid exception for known entity due to timeframe | $17,375 |
| Quality Initiatives in Flight | • Flu/pneumococcal shot reminders<br>• Preventive care visits<br>• Pharyngitis kits<br>• Readmissions project (CMS QIP)<br>• Member & provider communications (more non-adherent members; more measures to move)<br>• | $138,793 |
| | • Member and provider incentives | $12,380 |
| Required Training | • Annual Inovalon & HEDIS Best Practices training<br>• CME expenses for physician training<br>• Provider education activities<br>• New hire equipment | $28,480 |
| Miscellaneous | | $7,775 |
| **Total** | | **$457,740** |

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**Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities**

B. New Request for Quality Initiatives

| Item | Detail | Amount (Not to Exceed) |
|---|---|---|
| Member Programs | • Prenatal/postpartum incentive (Increase volume of outreach; $10,887<br>• Breast cancer screening -Downward trend Reminder mailing & incentive; $99,900<br>• Cervical cancer screening -Below MPL Reminder mailing & incentive; $149,900 | $260,687 |
| Provider Programs | • Physician office extended hours pilot project - MPL measures ($10,000)<br>• Prenatal/postpartum provider office incentive ($5,000)<br>• PCP office staff incentives for well women visits/screenings ($75,000)<br>• Physician office extended hours initiative mailing ($2,500) | $92,500 |
| Member Experience Initiatives | • Member focus groups, supplemental survey, provider CME ($72,525)<br>• Practice coaches for member experience ($18,840) | $91,365 |
| Provider Toolkits | • AWARE toolkit on antibiotic use ($5,000)<br>• Provider Outreach/Education on AAB Measure (Below MPL; $1,500) | $6,500 |
| Outreach Projects | • PSA for well women visits (Feb & May) - Culturally-specific radio stations ($99,900)<br>• Child & Adolescent Outreach and Events for Childhood Immunizations (13% decrease; $44,887)<br>• Educational posters/print ads for physician offices for Women's Wellness Campaign ($10,000) | $154,787 |
| **Total** | | **$605,839** |

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# Quality Analytics Budget

**Board of Directors' Quality Assurance Committee Meeting**
**November 16, 2016**

**Board of Directors' Finance and Audit Committee Meeting**
**November 17, 2016**

**Richard Bock, MD, Deputy CMO**
**Caryn Ireland, Executive Director, Quality**

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# FY 2016-2017 Budget

- Budget augmentation for current quality initiatives: $457,740
  - Surveys & NCQA Fees
  - NCQA Consultant
  - Quality Initiatives in Flight
  - Required Training
  - Miscellaneous

- New requests for quality initiatives: $605,839
  - Member Programs
  - Provider Programs
  - Member Experience Initiatives
  - Provider Toolkits
  - Outreach Projects

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# Budget Augmentation for Current Quality Initiatives: $457,740

- Surveys & NCQA Fees: $252,937
  - Addition of CG CAHPS – Adult & Child
  - Fee increases for regular CAHPS
  - Implement SPD CAHPS
  - Additional record retrieval for Medical Record Review
  - Increase in NCQA required fees
  - Timely Access Survey
- NCQA Consultant: $17,375
  - RFP results did not produce viable option; completed bid exception for known entity due to timeframe
- Quality Initiatives in Flight: $151,173
  - Flu/pneumococcal shot reminders
  - Preventive care visits
  - Pharyngitis kits
  - Readmissions project (CMS QIP)
  - Member communications (more non-adherent members; more measures to move)
  - Member and provider incentives

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# Budget Augmentation for Current Quality Initiatives (cont.)

- Required Training $28,480
  - Annual Inovalon & HEDIS Best Practices training
  - CME expenses for physician training
  - Provider education activities
  - New hire equipment

- Miscellaneous $7,775

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# Funding for Additional Program: $605,839

- **Member Programs** — $260,687
  - Prenatal/postpartum incentive (Increase volume of outreach)
  - Breast Cancer Screening (Downward trend)
  - Cervical Cancer Screening (Below MPL)
- **Provider Programs** — $92,500
  - Physician office extended hours pilot project – MPL measures
  - Prenatal/postpartum provider office incentive
  - PCP office staff incentives for well women visits/screenings
  - Physician office extended hours initiative mailing
- **Member Experience Initiatives** — $91,365
  - Member focus groups, supplemental survey, provider CME
  - Practice coaches for member experience
- **Provider Toolkits** — $6,500
  - AWARE toolkit on antibiotic use
  - Provider outreach/education on AAB Measure (Below MPL)
- **Outreach Projects:** — $154,787
  - PSA for well women visits (Feb & May) – Culturally-specific radio stations
  - Child & adolescent outreach and events for childhood immunizations (13% decrease)
  - Educational posters/print ads for physician offices for Women's Wellness Campaign

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| Description of Additional Programs | Amount |
|---|---|
| Member Programs | $260,687 |
| Prenatal/postpartum incentive (Increase volume of outreach) | $10,887 |
| Breast cancer screening (Downward trend) | $99,900 |
| Cervical cancer screening (Below MPL) - Reminder mailing and member incentives | $149,900 |
| Provider Programs | $92,500 |
| Physician office extended hours pilot project – MPL measures | $10,000 |
| Prenatal/postpartum provider office incentive | $5,000 |
| PCP office staff incentives for well women visits/screenings | $75,000 |
| Physician office extended hours initiative mailing | $2,500 |
| Member Experience | $91,365 |
| Member focus groups ($50K), supplemental survey ($20,475), provider CME ($7K) | $72,525 |
| Practice coaches for member experience | $18,840 |
| Provider Tool Kits | $6,500 |
| AWARE Toolkit on antibiotic use | $5,000 |
| Provider outreach/education on AAB Measure (Below MPL) | $1,500 |
| Outreach Projects | $154,787 |
| PSA for well women visits (Feb & May) – Culturally-specific radio stations | $99,900 |
| Child & adolescent outreach and events for childhood immunizations (13% decrease) | $44,887 |
| Educational posters/print ads for physician offices for Women's Wellness Campaign | $10,000 |
| **Total** | **$605,839** |

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken September 20, 2017**
**Regular Meeting of the CalOptima Board of Directors'**
**Quality Assurance Committee**

## Report Item

4. Consider Recommending Board of Directors Approval of Proposed Fiscal Year (FY) 2019 (Measurement Year 2018) Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect

## Contact

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

## Recommended Action

Recommend Board of Directors' Approval Fiscal Year 2019 (Measurement Year (MY) 2018) "Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect (OCC)," which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable.

## Background

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program intended to recognize outstanding performance and support on-going improvement in the provision of quality health care. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis includes evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, staff analyzes the difficulty of improving a measure due to the size of the eligible population (such as Anti-Depressant Medication Management – AMM) or difficulty in data gathering (such as Controlling Blood Pressure). Additionally, staff evaluates any changes to the measures that are important to CalOptima's NCQA Accreditation status or overall Health Plan Rating.

The purpose of CalOptima's MY 2018 P4V program for the Health Networks, including CalOptima Community Network (CCN), is consistent with the P4V programs of the prior two years, which remains:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks and physicians on their quality improvement efforts.

## Discussion

For the MY 2018 programs, staff recommends maintaining the tenets from the prior year, with some modifications. As proposed, for the Medi-Cal line of business, both Adult and Child measures remain in the measurement set and weighting by acuity (Seniors and Persons with Disabilities (SPD) vs. non-SPD) will carry forward in the proposed 2018 P4V program.

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In order to sustain improvements and leverage resources that the Health Networks have allocated towards improvement in P4V measures, staff recommends the following modifications to the MY 2017 plan for MY 2018:

**Measurement Year 2018 Medi-Cal P4V Measures Changes**:

**Recommend replacing existing P4V measure**:
- Medication Management for People with Asthma (MMA) - Total 75% compliance
  - With:
    - MMA 5-11 years (child)
    - MMA 19-50 years (adult)

**Recommend retiring**:
- Comprehensive Diabetes Care (CDC) - HbA1c testing
- CAHPS
  - Getting Appointment with a Specialist
  - Timely Care and Service Composite
  - Rating of all Healthcare

**Recommend adding three new Clinical measures**:
- Well Child visits in the first 15 months of Life (W15) - six well child visits
- Comprehensive Diabetes Care (CDC) - HbA1c <8 (adequate control)
- Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)

**Recommend adding three new Member Experience measures**: (CAHPS Surveys - Medi-Cal Adult and Child)
  - Getting Needed Care
  - Getting Care Quickly
  - How well Doctors Communicate

**Measurement Year 2018 OneCare Connect P4V Measures Changes:**

**Recommend retiring two existing measures**
- Antidepressant Medication Management (AMM) – Continuation and Acute Phase Treatment
  - small denominator measure
- Controlling Blood Pressure (CBP)
  - requires chart review, which makes it resource intensive to get a statistically significant sample size of chart review data across all health networks

**Recommend adding two new measures**:
- Breast Cancer Screening (BCS)
  - Model of Care and STAR measure
- Comprehensive Diabetes Care (CDC) - HbA1c ~~<8 good control~~ >9 poor control
  - STAR measure

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Display measures are not eligible for P4V payments. The intent of including them in the data set is to raise awareness of the measure and provide time for the Health Networks to evaluate, educate, monitor and implement actions to improve the rates. The CalOptima P4V team will also monitor the performance of these display measures throughout the year and offer recommendations to potentially include them as payment measures for MY 2019. As proposed, the display measures for Medi-Cal will remain the same for MY 2018; however, staff is recommending adding one new Display Measure for the OneCare Connect program:

- Colorectal Cancer Screening (COL)
    - Model of Care and STAR measure

**Distribution of Incentive Dollars**

The following P4V program requirements will remain for MY 2018:

- All health networks will continue to have performance measures for both adult and child care.

- Performance and improvement allocations are distributed upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid in proportion to acuity level, as determined by aid category. Weighting of performance and improvement may be adjusted based on overall CalOptima performance.

- To qualify for payment for each of the Clinical and CAHPS measures, the Health Network must have a minimum denominator size of 30 eligible members for Medi-Cal line of business and 5 eligible members for each specified quality measure for the OneCare Connect line of business.

- In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period and the period of pay for value accrual and must be in good standing with CalOptima at the time of disbursement of payment.

- Any separate OCC Quality Withhold incentive dollars earned will be distributed based upon Board of Directors--approved methodology developed by staff and approved by CMS.

- Payment of any reward under the P4V program will occur after CalOptima receives official notice of HEDIS and CAHPS scores for 2018, which is anticipated to be on or around 4th quarter, 2019. The time of payment is subject to change at CalOptima's discretion.

- Distribution methodology to CCN providers for measurement years 2016 and 2017 payout will remain the same as approved by Board of Directors.

**Fiscal Impact**

The fiscal impact of the Medi-Cal P4V program will not exceed $2.00 per member per month (PMPM) and the OneCare Connect P4V program will not exceed $20.00 PMPM for the Measurement Year of January 1, 2018 through December 31, 2018. Since the distribution of incentive dollars for the MY

2018 P4V programs for Medi-Cal and OneCare Connect will be made in FY 2019-20, Management will include expenses related to the MY 2018 P4V program in a future operating budget.

**Rationale for Recommendation**

This alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. 2018 Medi-Cal and OCC P4V Program Measurement Set
2. PowerPoint Presentation - 2018 Medi-Cal and OneCare Connect Pay for Value Programs
3. Board Action dated March 2, 2017, Consider Approval of the Fiscal Year 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect

*/s/ Michael Schrader* — *9/14/2017*

**Authorized Signature** — **Date**

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**Attachment 1: FY 20189 (MY 20178) Medi-Cal and OCC**
**Pay for Value Program Measurement Set**

| Adult Measures | 2017 2018 Measurement Year / HEDIS 2018 2019 Specifications<br><br>Anticipated Payment Date: Q3 20182019 | Measurement Assessment Methodology |
|---|---|---|
| Clinical Domain - HEDIS Weight: 60.00%<br><br>SPD Weight 4.0<br><br>TANF Weight 1.0 | Prevention:<br>• Breast Cancer Screening (BCS)<br>• Cervical Cancer Screening (CCS)<br><br>Diabetes:<br>• HbA1c Testing<8 (adequate control)<br>• Retinal Eye Exams<br><br>Access to Care:<br>• Adults Access to Preventive/Ambulatory Care (AAP)<br><br>Respiratory:<br>• Medication Management for People with Asthma (MMA) – 19-50 years 75% compliance<br>• Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB) | A relative point system by measure based on:<br>• NCQA National HEDIS percentiles<br>• Percentile Improvement |

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| **Adult Measures** | **2018 Measurement Year / HEDIS 2019 Specifications**<br><br>**Anticipated Payment Date: Q3 2019** | **Measurement Assessment Methodology** |
|---|---|---|
| Patient Experience Domain - CAHPS<br><br>Weight: 40% | Adult Satisfaction Survey (Adult CAHPS):<br><br>1. Getting ~~appointment with a Specialist~~Needed Care<br>2. ~~Timely Care and Service~~Getting Care Quickly<br>3. Rating of PCP<br>4. ~~Rating of all Healthcare~~How Well Doctors Communicate | A relative point system by measure based on:<br>• NCQA ~~National HEDIS~~California CAHPS percentiles<br>• Percent~~ile~~ Improvement |
| **Display Measure** | Initial Health Assessment | A relative point system by measure, based on:<br><br>• DHCS percentiles<br>• Percent Improvement |

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| Pediatric Measures | ~~2017~~ 2018 Measurement Year / HEDIS ~~2018~~ 2019 Specifications<br><br>Anticipated Payment Date: Q3 ~~2018~~2019 | Measurement Assessment Methodology |
|---|---|---|
| Clinical Domain - HEDIS<br><br>Weight: 60.00%<br><br>SPD Weight 4.0<br><br>TANF Weight 1.0 | Respiratory:<br>• Medication Management for People with Asthma (MMA) – 5-11 years 75% Compliance<br>• Appropriate Testing for Children with Pharyngitis (CWP)<br>• Appropriate Treatment for Children with Upper Respiratory Infection (URI)<br><br>Prevention:<br>• Childhood Immunization Status Combo 10 (CIS)<br>• Well-Care Visits in the 3-6 Years of Life (W34)<br>• Adolescent Well-Care Visits (AWC)<br>• Well Child Visits in the First 15 months of Life – six well child visits (W15)<br><br>Access to Care:<br>• Children's Access to Primary Care Physician (CAP) | A relative point system by measure based on:<br>• NCQA National HEDIS percentiles<br>• Percent~~ile~~ Improvement |

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| **Pediatric Measures** | **2018 Measurement Year / HEDIS 2019 Specifications**<br><br>**Anticipated Payment Date: Q3 2019** | **Measurement Assessment Methodology** |
|---|---|---|
| Patient Experience Domain - CAHPS<br><br>Weight: 40% | Child Satisfaction Survey (Child CAHPS)<br><br>• Getting ~~Appointment with a Specialist~~Needed Care<br>• ~~Timely Care and Service~~Getting Care Quickly<br>• Rating of PCP<br>• ~~Rating of all Healthcare~~How Well Doctors Communicate | A relative point system by measure based on:<br>• NCQA ~~National HEDIS~~ California CAHPS percentiles<br>• Percent~~ile~~ Improvement |

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| OneCare Connect Measures | ~~2017~~ 2018 Measurement Year / HEDIS ~~2018~~ 2019 Specifications<br><br>Anticipated Payment Date: Q3 ~~2018~~2019 | Measurement Assessment Methodology |
|---|---|---|
| Clinical Domain - HEDIS<br><br>Weight: 60.00%<br><br>Each measure weighted equally | Measures:<br><br>• Breast Cancer Screening (BCS)<br>• Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9)<br>• Plan All Cause Readmissions<br>• Part D Medication Adherence for Diabetes<br>•<br>~~• Antidepressant Medication Management Outcome Measures~~<br>~~• Blood Pressure Control~~<br>~~• Part D Medication Adherence for Diabetes~~ | A relative point system by measure based on:<br>• ~~NCQA National HEDIS~~CMS STAR thresholds ~~percentiles~~<br>• Percent Improvement<br><br>**For the Part D Medication Adherence Measure**:<br>A relative point system by measure based on:<br>• CMS Star Rating Percentiles<br>• Percent~~ile~~ Improvement |

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| | | |
|---|---|---|
| Patient Experience Domain – CAHPS<br><br>Weight: 40% | Adult Satisfaction Survey (Adult CAHPS):<br>• Annual Flu Vaccine<br>• Getting Appointments and Care Quickly<br>• Getting Needed Care<br>• Rating of Healthcare Quality | A relative point system by measure, based on:<br>• NCQA National HEDIS percentiles<br>• Percent Improvement |
| **Display Measures** | Colorectal Cancer Screening | CMS Technical Specifications and Benchmarks for STAR measures |

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# Measurement Year 2018 Pay for Value Program

**Board of Directors' Quality Assurance Committee Meeting**

**September 20, 2017**

**Richard Bock, M.D., M.B.A.**

**Deputy Chief Medical Officer**

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# Introduction

- Annually, staff conduct a review of CalOptima's performance on key quality performance metrics such as:
  - NCQA Accreditation
  - Pay4Value
  - Health Plan Ratings
  - Model of Care
  - CMS STARS
- This analysis includes evaluating the overall performance of the measure, improvement over time and the level of improvement left to achieve.

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# P4V Measure Set Considerations

- The P4V measure sets include a diverse set of measures including:
  - Preventive screenings for children and adults
  - Chronic Care Measures
  - Outcomes based Measures
  - Member Experience
  - Utilization/Readmissions
- Measures must be actionable by PCPs;
  - Monthly, staff provide industry benchmarks and data-driven feedback to Health Networks, including CCN physicians, on their performance on P4V measures.
- Reporting Administrative Data Only - obtaining chart review data can be challenging (cost- and labor-intensive)

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# Measures recommended for removal

**Medi-Cal:**

- Diabetes Care: HbA1c testing
- Medication Management for People with Asthma: Total 75% Compliance
  - Separated the measure by sub measure – Adult & Child

**OneCare Connect:**

- Antidepressant Medication Management Acute Phase
- Antidepressant Medication Management Continuation Phase
- Controlling Blood Pressure

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# Medi-Cal P4V Clinical Measures - Adult

| 2018 Measurement Year Measures | |
|---|---|
| **Adult** | **Quality Strategy** |
| Adult Access to Preventive Care Services | Area of HEDIS auditor focus due to declining rates; at 5th percentile Nationally |
| Breast Cancer Screening | Accreditation and Health Plan Rating |
| Cervical Cancer Screening | Accreditation, DHCS, and Health Plan Rating |
| **NEW:** Diabetes Care: HbA1c <8.0% (adequate control) | Accreditation and Health Plan Rating |
| Diabetes Care: Retinal Eye Exams | Accreditation, DHCS, and Health Plan Rating |
| **NEW** : Medication Management for People with Asthma: Age 19 – 50 years 75% Compliance | Accreditation, Health Plan Rating |
| **NEW:** Avoidance of Antibiotic Treatment in Adults with Bronchitis | Accreditation |

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# Medi-Cal P4V Clinical Measures - Child

| 2018 Measurement Year Measures | |
|---|---|
| **Child** | **Quality Strategy** |
| Adolescent Well-Care Visits | Health Plan Rating |
| Appropriate Testing for Children with Pharyngitis | Accreditation and Health Plan Rating |
| Appropriate Treatment for Children with URI | Accreditation and Health Plan Rating |
| Childhood Immunizations: Combo 10 | Accreditation and Health Plan Rating |
| Children's Access to Primary Care Providers | Area of HEDIS Auditor focus; below 50th percentile Nationally |
| **NEW** : Medication Management for People with Asthma: Age 5 – 11 years 75% Compliant | Accreditation, DHCS, and Health Plan Rating |
| Well-Child Visits 3–6 Years | DHCS and Health Plan Rating |
| **NEW:** Well Child Visits in the first 15 Months of Life | Health Plan Rating and HN performance dropped 7.66% from last year |

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# Medi-Cal P4V CAHPS Measures

| 2018 Measurement Year Measures | |
|---|---|
| **Adult and Child Measures** | |
| **NEW**: Getting Needed Care | Accreditation and Health Plan Rating |
| **NEW**: Getting Care Quickly | Accreditation and Health Plan Rating |
| Rating of PCP | Accreditation and Health Plan Rating |
| **NEW**: How well Doctors Communicate | Accreditation |

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# Medi-Cal P4V Display Measures

| 2018 Measurement Year Display Measures |
| --- |
| Initial Health Assessment |

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# Medi-Cal Health Network Payment Methodology - NO CHANGES

## Population Included

Total Number of Adult Member Months (MM) and Total Number of Child MM

SPD Members Weighted 4x Non-SPD Members

## Payment Calculation

- **Allocated Funds =** Total MM for all health networks x the allocated PMPM.
- Allocated PMPM for 2016 is **$2.00**

### Clinical Funds = 60% of Allocated Funds ($1.20 PMPM)

- **Clinical Funds =** Performance Funds ($0.60 PMPM) + Improvement Funds ($0.60)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima Overall Improvement Pct.

### CAHPS Funds = 40% of Allocated Funds ($0.80 PMPM)

- **CAHPS Funds =** Performance Funds ($0.40 PMPM) + Improvement Funds ($0.40)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima Overall Improvement Pct.

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# OneCare Connect P4V Measures

| 2018 Measurement Year Measures | |
|---|---|
| **NEW:** Breast Cancer Screening | Model of Care and STAR measure |
| **NEW:** Diabetes Care – HbA1c poor control (>9%) | STAR measure |
| Medication Adherence for Diabetes Medications (Part D measure) | Model of Care, STAR, and Quality Withhold |
| Plan All-Cause Readmissions | STAR and Quality Withhold measure |

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# OneCare Connect P4V
# CAHPS Measures

| 2018 Measurement Year Measures | |
|---|---|
| Annual Flu Vaccine | STAR |
| Getting Appointments and Care Quickly | Model of Care and STAR |
| Getting Needed Care | Model of Care and STAR |
| Rating of Healthcare Quality | Model of Care and STAR |

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# OneCare Connect P4V
# Display Measure - NEW

| 2018 Measurement Year Display Measure | |
|---|---|
| Colorectal Cancer Screening | Model of Care and STAR |

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# OneCare Connect Health Network Payment Methodology

## Population Included

Total Number of Member Months (MM)

## Payment Calculation

- **Allocated Funds =** Total MM for all Health Networks x the Allocated PMPM.
- Allocated PMPM for 2018 is **$20**.

### Clinical Funds = 60% of Allocated Funds ($12.00 PMPM)

- **Clinical Funds =** Performance Funds ($6 PMPM) + Improvement Funds ($6)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima Overall Improvement Pct.

### CAHPS Funds = 40% of Allocated Funds ($8.00 PMPM)

- **CAHPS Funds =** Performance Funds ($4 PMPM) + Improvement Funds ($4)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima Overall Improvement Pct.

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken March 2, 2017**
**Regular Meeting of the CalOptima Board of Directors**

## Consent Calendar

5. Consider Approval of the Fiscal Year (FY) 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect

## Contact

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

## Recommended Action

Approve the Fiscal Year 2018 (Measurement Year 2017) "Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect" which defines measures and allocations for performance, as described in Attachment 1 and 2, subject to regulatory approval, as applicable.

## Background

CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care.
The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on March 1, 2014, is three-fold:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks on their quality improvement efforts.

## Discussion

For the Measurement Year CY 2017 programs, staff recommends maintaining many of the elements from the prior year with some modifications. As described in the 2016 P4V program, measures and scoring methodology address the need to consider the complexity or member acuity (SPD compared to non-SPD members) and the subsequent higher consumption of physician / health network resources to care for SPD members. In addition, the scoring methodology will continue to reward performance and improvement. The program will include both Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, thereby expanding our focus on the member experience. The proposed MY17 Medi-Cal and OneCare Connect Pay for Value programs are one year programs which use HEDIS 2018 specifications and for which payments will be made in 2018.

In order to sustain improvements and leverage resources that the health networks have allocated towards improvement in P4V measures, staff recommends the following modifications:

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Medi-Cal Changes:

- Revise minimum denominator size from 100 to 30 eligible members for each specified quality measure to be eligible for incentive payment
- Revise CAHPS minimum performance threshold to reflect CA benchmarks

OneCare Connect Changes:

To incentivize quality care in our new OneCare Connect program and to better align with the CMS Quality Withhold program, the four clinical incentive measures below remain in the OneCare Connect P4V program:

- Plan All Cause Readmissions
- Controlling Blood Pressure
- Medication Adherence for oral anti-diabetic medications (Part D measure)
- Behavioral Health: Antidepressant Medication Management

Starting in CY 2017, a member experience survey (CAHPS) is added to the program.

Clinical measures are weighted at 60%; member experience is weighted at 40%. In the Board approved 2016 P4V program, only clinical measures were included and were weighted at 100%.

Distribution of Incentive Dollars

Performance allocations are distributed to the Health Networks, including CCN, upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. To qualify for payment for each of the clinical and CAHPS measures, the Health Network must have a minimum denominator, as noted.

In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

Any separate OCC Quality Withhold incentive dollars earned by CalOptima will be distributed based upon a Board-approved methodology to be developed by staff and subject to any needed regulatory approvals.

**Fiscal Impact**

Since the distribution of incentive dollars for the MY 2017 P4V Programs for Medi-Cal and OneCare Connect will be made in FY 2017-18, there is no fiscal impact to the FY 2016-17 Operating Budget.

Staff estimates that the fiscal impact for the MY 2017 P4V Program will be no more than $2 per member per month (PMPM) for Medi-Cal, and no more than $20 PMPM for OneCare Connect. Staff will include expenses for the MY 2017 P4V Program for Medi-Cal and OneCare Connect in the upcoming FY 2017-18 CalOptima Operating Budget.

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Time of Payment
Payment of any reward under the P4V program will occur after CalOptima receives official notice of HEDIS and CAHPS scores for 2017, which is anticipated to be on or around 4th quarter, 2018. The time of payment is subject to change at CalOptima's discretion.

**Rationale for Recommendation**
This alignment will leverage improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

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

**Attachments**
1. FY 2018 (MY 2017) Medi-Cal Pay for Value Program
2. FY 2018 (MY 2017) OneCare Connect Pay for Value Program

*/s/ Michael Schrader* — **Authorized Signature**

*2/23/2017* — **Date**

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**Attachment 1: FY 2018 (MY 2017) Medi-Cal Pay for Value Program Measurement Set**

| **Adult Measures** | **2017 Measurement Year / HEDIS 2018 Specifications**<br><br>**Anticipated Payment Date: Q3 2018** | **Measurement Assessment Methodology** |
|---|---|---|
| Clinical Domain - HEDIS<br>Weight: 60.00%<br><br>SPD Weight 4.0<br><br>TANF Weight 1.0 | <u>Prevention:</u><br>• Breast Cancer Screening (BCS)<br>• Cervical Cancer Screening (CCS)<br><br><u>Diabetes:</u><br>• HbA1c Testing<br>• Retinal Eye Exams<br><br><u>Access to Care</u>:<br>• Adults Access to Preventive/Ambulatory Care<br><br><u>Respiratory</u>:<br>• Medication Management for People with Asthma (MMA) | A relative point system by measure based on:<br>• NCQA National HEDIS percentiles<br>• Percentile Improvement |
| Patient Experience Domain - CAHPS<br><br>Weight: 40% | <u>Adult Satisfaction Survey (Adult CAHPS):</u><br><br>1. Getting appointment with a Specialist<br>2. Timely Care and Service<br>3. Rating of PCP<br>4. Rating of all Healthcare | A relative point system by measure based on:<br>• NCQA California CAHPS percentiles<br>• Percentile Improvement |

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| **Pediatric Measures** | **2017 Measurement Year / HEDIS 2018 Specifications**<br><br>**Anticipated Payment Date: Q3 2018** | **Measurement Assessment Methodology** |
|---|---|---|
| Clinical Domain - HEDIS<br><br>Weight: 60.00%<br><br>SPD Weight 4.0<br><br>TANF Weight 1.0 | <u>Respiratory:</u><br>• Medication Management for People with Asthma (MMA)<br>• Appropriate Testing for Children with Pharyngitis (CWP)<br>• Appropriate Treatment for Children with Upper Respiratory Infection (URI)<br><br><u>Prevention:</u><br>• Childhood Immunization Status Combo 10 (CIS)<br>• Well-Care Visits in the 3-6 Years of Life (W34)<br>• Adolescent Well-Care Visits (AWC)<br><br><u>Access to Care:</u><br>• Children's Access to Primary Care Physician | A relative point system by measure based on:<br>• NCQA National HEDIS percentiles<br>• Percentile Improvement |
| Patient Experience Domain - CAHPS<br><br>Weight: 40% | <u>Child Satisfaction Survey (Child CAHPS)</u><br><br>• Getting Appointment with a Specialist<br>• Timely Care and Service<br>• Rating of PCP<br>• Rating of all Healthcare | A relative point system by measure based on:<br>• NCQA California CAHPS percentiles<br>• Percentile Improvement |

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**Attachment 2: FY 2018 (MY 2017) OneCare Connect Pay for Value Program**

| **OneCare Connect Measures** | **2017 Measurement Year / HEDIS 2018 Specifications**<br><br>**Anticipated Payment Date: Q3 2018** | **Measurement Assessment Methodology** |
|---|---|---|
| Clinical Domain - HEDIS<br><br>Weight: 60.00%<br><br>Each measure weighted equally | <u>Measures:</u><br><br>• Plan All Cause Readmissions<br>• Antidepressant Medication Management Outcome Measures<br>• Blood Pressure Control<br>• Part D Medication Adherence for Diabetes | A relative point system by measure based on:<br>• NCQA National HEDIS percentiles<br>• Percent Improvement<br><br>**For the Part D Medication Adherence Measure**:<br><br>A relative point system by measure based on:<br>• CMS Star Rating Percentiles<br>• Percentile Improvement |
| Patient Experience Domain - CAHPS<br><br>Weight: 40% | <u>Adult Satisfaction Survey (Adult CAHPS):</u><br><br>• Getting appointment with a Specialist<br>• Timely Care and Service<br>• Rating of PCP<br>• Rating of all Healthcare | A relative point system by measure based on:<br>• NCQA California CAHPS percentiles<br>• Percentile Improvement |

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**Participation in Quality Improvement Initiatives**

For each measure in which a Health Network/medical group performs below the 50th percentile, Health Networks/medical groups must submit a Corrective Action Plan (CAP) to CalOptima which outlines, at a minimum, the following items:

- Interim measures and goals
- Measurement cycle
- Member interventions including education and outreach
- Provider interventions including education and training
- Timeline for interventions

Health networks/medical groups must submit quarterly work plans which document implementation of the corrective action plan and progress made towards goals.

In conjunction with the Health Networks, CalOptima will lead quality improvement initiatives for measures that fall below the 50th percentile. Funding for these initiatives will come from forfeited dollars.

**MEASUREMENT DETAILS:**

**1. Clinical Domain (HEDIS measures)**

**Program Specific Measurement Sets**
Performance measures were selected as appropriate per program based on the following criteria:

- Measures are appropriate for membership covered by the program
- Measures are based on regulatory requirements
- Measures are used by the industry for performance measurement and incentive payment

**Criteria**
The following criteria were considered in selecting these indicators:

- Each of these indicators measures the delivery of services that are critical to the health of the respective segments of CalOptima's membership. In addition, these measures collectively address the range of age appropriate services.
- The measures use administrative data for all except Blood Pressure only reporting since they are single point of service measures.
- CBP will be captured with a specific chart review activity for this P4V program.

  Each measure is calculated per HEDIS methodology except that continuous enrollment is assessed at the health network level instead of at the health plan level.

**Incentive Measure Definition**
Please refer to HEDIS 2018 Technical Specifications Volume 2 for measure definitions. For each HEDIS indicator, members will be identified according to the most recent HEDIS technical specifications updates.

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## II. Customer Satisfaction

### Member Satisfaction

**Background**

CalOptima conducts annual member satisfaction surveys that are carefully designed to provide network-level satisfaction information to meet precision requirements and to support comparisons between networks and at the CalOptima agency level. The goal is to survey different subsets of the CalOptima membership (e.g. Children, Persons with disabilities, and Adults) on a rotating basis so that we develop:

- trend information over time about individual networks' performance for a specific population, and
- comparable performance information across networks both for a specific time period as well as trended over time.

**Survey Methodology**

The surveys are administered using the CAHPS protocol, including a mixed-mode methodology of mail and telephone contact to notify members of the study, distribute questionnaires, and encourage participation by non-respondents. Both surveys have been conducted in three threshold languages as defined by our Medi-Cal contract.

CalOptima has worked with outside technical and substantive consultants to refine its survey instruments and sampling and weighting strategies and has employed a nationally known survey research group to conduct both surveys.

The samples consisted of systematically selected Medi-Cal members who met specific requirements for inclusion as specified by the CAHPS and by our interest in targeted subgroups. The sample is a disproportionately stratified random sample with strata defined by health network. CalOptima required sample sizes and allocations across strata be developed to provide estimates of population proportions at the network level that were within 2.5 percentage points of the true value with 95% statistical confidence.

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# Update: 2016 Utilization Management Program Evaluation

**Board of Directors' Quality Assurance Committee Meeting**
**September 20, 2017**

**Tracy Hitzeman, RN CCM**
**Executive Director, Clinical Operations**

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# UM Program Evaluation

- Completed annually to assess the performance of CalOptima's UM Program
- Maintains focus on quality and effective initiatives
- Approved by the Quality Improvement Committee on March 8, 2017
- Approved by the Board of Directors' Quality Assurance Committee May 22, 2017

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# Rationale for Update

- CalOptima's NCQA re-accreditation preparation leverages consultant reviews, including the following 2016 UM documents:
  - Program Plan
  - Work Plan
  - Program Evaluation
- All required elements present
- Additional narrative detail requested for UM Program Evaluation

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# Summary of Revisions

- Enhancement of Utilization Outlier Trend tables
  - Goals included for ease of comparison
  - Formatting improvements
- Detail added to acute and LTSS facility utilization evaluation, by line of business, including:
  - Trends
  - Drivers
- Expanded narrative regarding member and provider satisfaction
- Approved by UMC in August 2017

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# Recommended Action

Receive and file the updated 2016 Utilization Management Program Evaluation

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**CalOptima**

**2016 Utilization Management Program Evaluation**

**OneCare Connect, OneCare and Medi-Cal**

**Date: February 23, 2017**

**Revised Date: September 5, 2017**

## Utilization Management Program and Work Plan Overview

This overview supports and evaluates the UM Program and UM Work Plan on an annual basis and is approved by the Utilization Management Committee (UMC).

## I Projects and Initiatives:

### A. Utilization Management

In 2016, Plan self-audit activities highlighted the needs for increased focus in several areas of the Utilization Management Program. As a result, department audit tools were developed to clearly identify negative trends and improve compliance. Additional efforts continue to improve the accurate trending and evaluation of adverse determinations. Some system reports have been identified as needing modification and/or remediation to capture complete UM data. A review of UM structure in 2016 led to the addition of new teams organized to support an "expert" approach to each line of businesses. In response to the increasing complexity of ensuring "member-friendly" verbiage in member facing notification letters and to improve the quality of the citation of appropriate evidence-based guidelines, a specialized team was formed to process all Adverse Benefit Determination letters. An evaluation was completed regarding the potential use of a vendor for network management of transplant candidates. The financial impact analysis demonstrated no advantage over current CalOptima contracting practices. UM has assumed accountability for managing the functions of the Benefit Management Subcommittee (BMSC). Implemented a RightFax configuration by which faxes are sent to email boxes. This increases transparency and facilitates better incoming referral activity.

In collaboration with the Chief Medical Officer, (CMO) the Medical Director of UM provides clinical oversight and administration of the UM Program and chairs the UM Committee. The Medical Director supports the UM process, evaluating program effectiveness through data trends to ensure performance of the UM Program against approved goals. For areas not meeting goals, program changes are proposed and approved by the UM Workgroup and UMC, and implemented by the UM Leadership staff. The UM Medical Director supports provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee, (BMSC) to evaluate new and changing benefits and determine the need for prior authorization. He also provides support and education to the UM Department staff through twice weekly concurrent review case rounds and review and decision for adverse determinations.

During 2016, the UM Medical Director provided the Prior Authorization team an educational in-service on benefit management and code research to determine regulatory prior authorization requirements. During twice weekly concurrent review case rounds, the UM Medical Director provided topics for discussion with the nursing and physician group. Topics discussed in 2016 included genetic testing, APR DRG vs. per-diem facilities, management of administrative days, appropriate LTAC criteria, Letter of Agreement (LOA) process, and one-day inpatient stays.

Overall for 2016, the UM Medical Director adequately supported the UM process and was able to meet the needs of the UM team through education, case review, and availability.

**B. Behavioral Health**

The Behavioral Health Integration (BHI) department manages the BHQI subcommittee, which reports to the Quality Improvement Committee (QIC). The BHQI meets quarterly to trend, analyze and identify improvement areas for member and provider Behavioral Health (BH) services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers.

The BHQI is chaired by the Medical Director of BHI and comprised of internal and external subcommittee members, including delegated network participants, community partners, behavioral health practitioners, and the Orange County Mental Health Plan (MHP) administered by the Orange County Health Care Agency (OC HCA). The Chair is responsible for leading and presenting subcommittee recommendations to the QIC. In addition, a BHQI workgroup met regularly throughout 2016 for additional work and analysis on the Quality initiatives. This group served to address suggestions from the BHQI that assisted with strengthening interventions, data review and key areas for improving the member experience. Overall, for 2016, the BHI Medical Director adequately supported the BH process and was able to meet the needs of the BHI team.

**C. UM Data Management**

Hospitalist program launched following data collection establishing the need for a hospitalist program. Communication was initiated with 3 hospitalist groups with the hospitalist program was launched mid-year.

Analysis of UM patterns for all health networks shows targets were not met. For 2017, CalOptima will re-evaluate benchmarks established for hospital bed day targets.

**D. UM Delegated Provider Oversight**

Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests – As expected with the change in auditing methodology, monitoring results showed that a decrease occurred in the majority of the audit areas with the exception of Urgent Letter scores and Timeliness for Deferrals, which remained consistent. The following are areas that contributed to the lower scores and where networks have been issued a corrective action plan request:

The lower scores for timeliness were due to the following reasons:

- Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
- Failure to meet timeframe for member notification (Routine – 2 business days);
- Failure to meet timeframe for provider initial notification (24 hours); and
- Failure to provide proof of successful initial written notification to requesting provider (24 hours).

The lower scores for clinical decision making (CDM) were due to the following reasons:

- Failure to cite the criteria utilized to make the decision;
- No indication of adequate clinical information obtained to make the decision to deny; and
- No indication that the medical reviewer was involved in the denial determination.

The lower letter scores were due to the following reasons:

- Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document;
- Failure to provide letter with description of services in lay language;
- Failure to provide letter in member's primary language;
- Failure to include name and contact information for health care professional responsible for decision to deny;
- Failure to provide information on how to file a grievance;
- Failure to outline reason for not meeting the criteria in lay language;
- Failure to provide referral back to Primary Care Provider (PCP) on denial letter; and
- Failure to notify provider of delayed decision and anticipated decision date.

• OneCare Utilization Management (UM): Prior Authorization (PA) Requests –Monitoring results showed an increase occurred in the majority of the audit areas with the exception of Timeliness for EIOD, Clinical Decision Making for EIOD, and Letter Sore for SOD. The following are areas that contributed to the lower scores and where networks have been issued a corrective action plan request:

The lower letter scores were due to the following reasons:

- Failure to use approved CMS letter template;
- Failure to provide letter with description of services in lay language;
- Failure to offer to discuss decision with a reviewer;
- Failure to outline reason for not meeting the criteria in lay language; and
- Failure to use the CalOptima logo on letter template.

The lower scores for timeliness were due to the following reasons:

- Failure to meet time frame for member oral notification (Expedited – 72 hours);
- Failure to meet time frame for member written notification (Expedited – 72 hours); and
- Failure to meet time frame for provider notification (Expedited – 24 hours).

The lower scores for clinical decision making (CDM) were due to the following reasons:

- Failure to cite the criteria utilized to make the decision;
- No indication of adequate clinical information obtained to make the decision to deny; and
- Failure to have evidence of appropriate professional making decision.

• OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests –Monitoring results showed an increase occurred in the majority of the audit areas with the exception of Timeliness for Urgent, Timeliness for Routine, and Timeliness for Denials. The following are areas that contributed to the lower scores and where networks have been issued a corrective action plan request:

The lower scores for timeliness were due to the following reasons:

- Failure to meet timeframe for member notification (Routine - 2 business days);
- Failure to meet timeframe for provider initial notification (24 hours); and
- Failure to provide proof of successful initial written notification to requesting provider (24 hours).

The lower letter scores were due to the following reasons:

- Failure to provide letter in member's primary language; and
- Failure to provide letter with description of services in lay language.

**E. Utilization Outlier Trends**

- For Medi-Cal, inpatient utilization goals were not consistently met.

| Shared Risk - MC | Goal | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| SPD | | | | | |
| ALOS | - | 5.6 | 5 | 4.5 | 4.7 |
| Bed Days/PTMPY | 894 | 1065 | 1147 | 946 | 921 |
| Readmissions | - | 28% | 28% | 21% | 23% |
| ED Visits/PTMPY | 700 | | 785 | 748 | 728 |
| TANF >18 | | | | | |
| ALOS | - | 4 | 3.9 | 3.9 | 3.7 |
| Bed Days/PMPY | 308 | 309 | 314 | 333 | 324 |
| Readmissions | - | 17% | 16% | 15% | 14% |
| ED Visits/PTMPY | 453 | | 438 | 456 | 444 |
| TANF<18 | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| ALOS | - | 3.1 | 2 | 2.8 | 2.6 |
| Bed Days/PTMPY | 14 | 51 | 20 | 20 | 38 |
| Readmissions | - | 3.8% | 5.9% | 2.5% | 5.1% |
| ED Visits/PTMPY | 367 | | 309 | 307 | 335 |

- On average goals are met for CCN-COD

| CCN | Goals | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| SPD | | | | | |
| ALOS | - | 6.4 | 7 | 6.6 | 4.6 |
| Bed Days/PTMPY | 1081 | 2407 | 1874 | 1663 | 1429 |
| Readmissions | - | 23% | 27% | 44% | 25% |
| ED Visits/PTMPY | 550 | 717 | 563 | 668 | 510 |
| TANF >18 | | | | | |
| ALOS | - | 4 | 4.5 | 4 | 3.9 |
| Bed Days/PMPY | 614 | 666 | 674 | 608 | 646 |
| Readmissions | - | 19% | 20% | 17% | 14% |
| ED Visits/PTMPY | 462 | 484 | 422 | 488 | 518 |
| TANF<18 | | | | | |
| ALOS | - | 3.1 | 2.4 | 2.4 | 2.8 |
| Bed Days/PTMPY | 67 | 150 | 67 | 53 | 84 |
| Readmissions | - | 10% | 0% | 3% | 0% |
| ED Visits/PTMPY | 513 | 667 | 434 | 458 | 499 |

| COD | Goals | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| SPD | | | | | |
| ALOS | - | 5.4 | 7.7 | 6 | 3.7 |
| Bed Days/PTMPY | 1516 | 1705 | 2541 | 1624 | 1160 |

| | | | | | |
|---|---|---|---|---|---|
| Readmissions | - | 20% | 29% | 11% | 13% |
| ED Visits/PTMPY | 1000 | 1098 | 1027 | 1255 | 1341 |
| **TANF >18** | | | | | |
| ALOS | - | 5.4 | 4.7 | 4.2 | 3.7 |
| Bed Days/PMPY | 543 | 542 | 535 | 536 | 508 |
| Readmissions | - | 14% | 14% | 11% | 13% |
| ED Visits/PTMPY | 440 | | | | |
| **TANF<18** | | | | | |
| ALOS | - | 3.2 | 2.4 | 2.8 | 1.9 |
| Bed Days/PTMPY | 68 | 115 | 73 | 67 | 76 |
| Readmissions | - | 11% | 0% | 8% | 4% |
| ED Visits/PTMPY | - | | | | |

- One Care Connect results

| Shared Risk - OCC | Goals | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| **SPD** | | | | | |
| **ALOS** | - | 6.4 | 6.4 | 6.6 | 9.7 |
| **Bed Days/PTMPY** | - | 3428 | 2305 | 2828 | 5539 |
| **Readmissions** | - | 19% | 32% | 25% | 22% |
| **ED Visits/PTMPY** | 559 | 788 | 877 | 697 | 1073 |
| **TANF>18** | | | | | |
| **ALOS** | - | 7.6 | 4.4 | 2.7 | 2.2 |
| **Bed Days/PTMPY** | - | 5768 | 2598 | 1964 | 1928 |
| **Readmissions** | - | 6.3 | 11.7 | 1.78 | 3.4 |
| **ED Visits/PTMPY** | 913 | 1559 | 900 | 1262 | 955 |

- OneCare population results

| OC | Goals | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| ALOS | - | 6 | 7.8 | 8.2 | 4.1 |
| Bed Days/PTMPY | - | 1236 | 1807 | 1661 | 843 |
| Readmissions | - | 10.4% | 10.3% | 14.2% | 14.6% |
| ED Visits/PTMPY | - | 420 | 593 | 668 | 403 |

Beginning in Q3 2016, increased efforts were made to ensure over and under utilization management activities were appropriately trended and evaluated. As a result, a UM/QI dashboard was drafted to capture data in a centralized location and reported to UMC for 2017.

| Monitoring | Narrative | Next Steps |
|---|---|---|
| Q1 | Successful implementation of MCG use in UM decisions<br>Successful monitoring of 1 day admissions<br>Monitoring LTAC stays | Working on hospitalists/admitting MDs |
| Q2 | Successful implementation of MCG use in UM decisions<br>Successful monitoring of 1 day admissions<br>Monitoring LTAC stays | Working on hospitalists/admitting MDs |
| Q3 | Rolling out enhanced hospitalist program | Implementation of the enhanced hospitalist program |
| Q4 | Monitoring hospitalist program at designated hospitals | Expand hospitalist program to more hospitals |
| Year End | Continue to monitor 1 day admissions, LTAC stays, and enhanced hospitalist program | Expanding hospitalist program to more hospitals |
| | | |
| **Outcomes** | **Results / Metrics** | **Next Steps** |
| Q1 | New bed day goals based on experience and informatics<br>Continued improvement with bed day management. | Focus on Per Diem vs APR-DRG facilities |
| Q2 | Will continue to monitor UM Facility performance through CCR, CM (hospitals), Hospitalist program. | • Focus on Per Diem vs APR-DRG facilities<br>• Focus on 1 day admission<br>• Focus on Hospitalist program implementation<br>• Focus on MCG Auth criteria |
| Q3 | Will continue to monitor UM Facility performance through CCR, CM (hospitals), Hospitalist program. | • Focus on Per Diem vs APR-DRG facilities<br>• Focus on 1 day admission<br>• Focus on Hospitalist program implementation |
| Q4 | Met some bed day goals | • Focus on Per Diem vs APR-DRG facilities<br>• Focus on 1 day admission<br>• Focus on Hospitalist program implementation |
| Year End | Improved bed day performance in general | To relook at some bed day goals. |

## II Operational Performance

### A. Prior Authorization for Expedited / Urgent / Routine / Retro Requests - UM - Non Pharmacy

Annual summary of referral volume, 4 quarter average - includes online referral submission:

| Authorization Processed | Referrals Processed | Turnaround Time Compliancy (TAT) |
|---|---|---|
| Routine: 30,184 | Faxed: 29,095 | Routine TAT: 4.09 days / 94.83% |
| Urgent: 4,508 | COLAS: 25,013 | Urgent TAT: 2.06 days / 97.37% |
| Retro: 2,167 | Total: 52,869 | Retro TAT: 16.34 days / 98.11% |
| Total: 36,871 | Online: 49.31% | |

Prior Authorization activity has remained relatively stable and within compliant turnaround times with expected fluctuations in volume depending on the time of the year. To maintain compliant turnaround times, overtime and temporary staff were needed. Prior Authorization metric targets were achieved for 2016.

**A. Prior Authorization for Expedited / Urgent / Routine / Retro Requests - Pharmacy**

Annual summary of referral volume, 4 quarter average:

One Care: 100%
OnCare Connect: 99.98%
Medi-Cal: 99.45%

Pharmacy Prior Authorization turnaround time processing time are above goal of 99% for all lines of business. Pharmacy metric targets were achieved for 2016.

**A. Authorization for Expedited / Urgent / Routine / Retro Requests - LTSS (CBAS, LTC) Applies to CBAS Only (LTAC TAT in development)**

- LTSS consistently met or exceeded required turnaround times throughout the year. LTSS metric targets were achieved for 2016.
- CBAS CEDT TAT: Average of 14.60 days
- CBAS Routine TAT: Average of 2.11 days
- CBAS Expedited TAT: 1 processed throughout the year with a TAT of 2
- LTC Routine TAT: Average of 1.39 days
- LTC Urgent TAT: Zero (0) processed throughout the year.

**B. Online Referral Rate Submission Increase in Non-Network Providers (COD and CCN)**

Online referrals submissions over 4 quarters was 46.31%. Additional options being reviewed to enhance the usage of the Cerecons portal.

**C. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review in UM, CBAS, MSSP, LTC by annual review of scheduled authorizations**

The IRR was administered in compliance with the UM Program. IRR metric targets were achieved for 2016. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

UM - 100%
Physicians - 100%
Pharmacy - 100%
LTSS - 100%

**D. Denial Letter Process**

Performance has been steady throughout 2016. Timeliness has been compliant with regulatory standards. UM and A&O will continue to review audit findings prior to being posted. New processes have been implemented in 2016 to facilitate the audit process: a Member Material Approval Committee has been established for all member-facing materials to be vetted and approved. The audit template utilized by A&O has been revised to reflect correct fields to be audited. Ongoing application for lay language and criteria continue to be an issue and will be an ongoing effort for 2017.

- Turnaround times were compliant for 2016.

## III Utilization Performance

### A. Facility Utilization - Facility Acute Care

Analysis of inpatient data in 2016 identified a significant downward trend in Bed Days/PTMPY, although goals were not met. Specifically, for Medi-Cal CCN SPD members, in Q1 2016, the Bed Day goal was exceeded by 1326 (2407 PTMPY: Goal 1081). Subsequent quarters showed improvement, and by Q 4, 2016, the goal was exceeded by just 348 (1429 PTMPY: Goal 1081). Review of delegated HN Medi-Cal SPD utilization also evidenced improvement over the course of 2016, with the largest delegated HN exceeding the goal by 242 (1127 PTMPY: 894 Goal) in Q 1, and improving to 51 days (945 PTMPY:894 Goal) in Q4.

Improvement in inpatient utilization was supported by the following initiatives:

- Initiation of hospitalist program for CCN
- Pilot of on-site concurrent review nurses at three (3) high-volume hospitals
- Focused training on effective navigation and application of MCG 20$^{th}$ edition inpatient guidelines
- Review of trends for one-day inpatient stays
- Enhanced focus on Health Risk Assessment collection and interdisciplinary management of high risk members

For the OneCare Connect (OCC) Program, Inpatient Bed Days revealed consistently high utilization (Q 1: 3317 PTMPY Q 4: 4091 PTMPY) Contributing factors included the OCC enrollment method (passive), with many of the newly enrolled members and newly participating providers unfamiliar with managed care principles. For example, many new OCC members transitioned from Fee-For-Service Medicare, where there is open access to any Medicare provider, including specialists, with no authorization required for planned hospitalizations.

Medi-Cal CCN SPD ED Utilization showed improvement in 2016, with Q 1 results missing the goal by 167 (Result: 717 PTMPY: 550 Goal) and Q 4 improved to 40 better than goal (510 PTMPY: 550 Goal). Medi-Cal Delegated Networks showed variation amongst the individual networks, the largest experiencing consistently better than goal in 2016, in Q 1 by 79 (619 PTMPY: 700 Goal), ending Q 4 at 158 better than goal (542 PTMPY: Goal 700).

In OCC, ED Utilization was high (Q 1: 926 PTMPY, Q 4 919 PTMPY). Underlying factors also included the passive enrollment method, which includes members unfamiliar with establishing and maintaining a primary care provider relationship, including preventive screenings.

**A. Facility Utilization - LTSS Facility UM**

- In 2016, members participating in CBAS experienced variation in Facility Utilization:
  - Emergency Department Visits 151 PTMPY (Q1) to 564 PTMPY (Q4);
  - Inpatient admissions ranged from 983 PTMPY (Q 1) to 1320 PTMPY (Q4);
  - Readmissions: The established goal of 2.5% for was not met (22%);
  - Transitions to a Long Term Care Facility goal of no more than 2% of the population was met, equivalent to 0.6% of the population.

- Members accessing IHSS demonstrated the following:
  - Emergency Department visits varied from a low of 332 PTMPY (Q1) to a high of 679 PTMPY (Q3);
  - Admissions to inpatient facilities also varied in the calendar year: 1174 PTMPY (Q1) to 1495 PTMPY (Q3);
  - The readmission rate for these members ranged from 8% (Q2) to 24% (Q3).

- Members enrolled in the Multipurpose Senior Services Program (MSSP) experienced:
  - ED visits at a variable rate: 265 PTMPY (Q1) to 864 PTMPY (Q3 and Q4);
  - Inpatient Bed Days also showed a large variability, from 1470 PTMPY (Q1) to 2323 PTMPY (Q3);
  - Readmission rates for this group ranged from 0% (Q4) to 24% (Q3).

Challenges in evaluation of utilization in the LTSS population in 2016 included several factors:

- Identification of participants in IHSS derived from data supplied by the California Department of Aging (CDA) contained discrepancies, which could not be resolved.

- The Plan's 2015 implementation of a new medical management system required remediation to existing reports, requiring QA testing before promotion to production. This impacted the timeliness of UM performance review.
- Defined parameters developed in CY 2016 to improve data integrity and accuracy of reports.
- The small size of the MSSP population contributes to highly variable performance quarter to quarter.

**B. Pharmacy Utilization**

- Retail Pharmacy - $PMPM costs for all LOB are below goal
- Diabetes drug utilization is the highest drug class for OCC and second highest for MCAL. .
- Hepatitis C drug utilization has leveled off in CY16 but remains the highest cost drug class for MCAL
- Hydrocodone/APAP is the 5th highest drug for Medi-Cal by # Rxs, down from 4th highest in 1Q16.
- Physician-Administered Drug Claims
- Antineoplastics remain the highest cost class.

Medi-Cal: Goal $ PMPM $47.50, actual CY16 $46.67
OC: Goal $ PMPM $397.80, actual CY16 $365.43
OCC: Goal $ PMPM $397.80, actual CY16 $343.43

**C Member and Provider Satisfaction**

Member and Provider Satisfaction with the UM Program is important to CalOptima. The following approaches are incorporated into the UM Program to promote continuous improvement in this area:

- Providing information to members and providers about the UM Program
    - Members are informed about authorization requirements through the Member Handbook and Member Newsletters
    - New Member Orientation is available for all CalOptima Members to better understand their benefits
    - Access to a list of services requiring pre-authorization is also available on CalOptima's website
    - CalOptima Customer Service and clinical staff are available to assist Member's in accessing services, as needed
    - Providers receive on-site visits from CalOptima's Provider Relations Team, who provide tools and references for requesting authorizations for their Members
    - A Provider Toolkit is available on the CalOptima website for provider reference
    - CalOptima Link provides an easily accessed electronic means of requesting authorizations
- Ensuring timeliness and notification of UM decisions
    - Monitored and reported quarterly to UMC: In 2016, the percent of authorization requests completed in a timely manner ranged from 93.2% in Q 1 to 97.8% in Q 4.
- Consistent use of approved, evidence-based guidelines in clinical decision making
    - Monitored monthly by the Audit and Oversight Committee
    - Variation among the delegated Health Networks

- Additional training provided as needed
- Overall improvement in audit scores for clinical decision making in 2016

Satisfaction with the UM Program is evaluated based upon trending and analysis of Grievances and Appeals that are related to the UM Program. In 2016, complaints about the UM Program included some recurring themes:

- Pharmacy denials related to the need for certain medications being subject to prior authorization requirements- member education provided on the process
- Member assignment to Pharmacy Home/ quantity limits on prescription refills (part of the effort to address multiple prescriber/ multiple pharmacy usage by individuals receiving opioid medications
- Denials for non-emergency medical transportation (NEMT)
- Referral of children to the Local Education Agency (LEA) for occupational and physical therapy

## IV Summary

Overall, during 2016, enrollment started to level off. Programs have been in place for a full year cycle. This provides an opportunity to take a look at program effectiveness during 2017.

For 2016-2017:

- Staff oversight and internal auditing for UM to better align with NCQA, DHCS and CMS elements.
- Focus on over/under utilization tracking, trending and reporting has been enhanced and centralized to provide a global view of how initiatives have a relationship and what actions are needed based on trends identified.
- The Hospitalist Program has proven to be effective and will be continued in 2017.
- UM inpatient facility goals will be re-evaluated and set as identified through evaluation.
- Align denial language to be member friendly and regulatory compliant across the networks.
- Ongoing evaluation of the Prior Auth List to further streamline the authorization requirements to facilitate member/provider satisfaction.
- Enhancements to the Medical Management authorization module in Guiding Care to facilitate quicker turnaround times during the prior authorization process.
- MCG integration with Guiding Care to facilitate better flow with the prior authorization process.

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# 2016 PACE Quality Assurance Performance Improvement (QAPI) Plan Evaluation

**Board of Directors' Quality Assurance Committee Meeting**
**September 20, 2017**

**Miles Masatsugu, M.D.**
**Medical Director**

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# 2016 PACE QAPI Program Evaluation

- Quality Assessment Performance Improvement (QAPI) Plan Evaluation:
  - Represents the analysis of the core clinical and service PACE indicators
  - Based on elements of 2016 PACE QAPI Work Plan
  - Analysis provides guidance on opportunities for improvement in 2016
  - PACE reached its goal on 10 of 14 QAPI elements

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# 2016 Accomplishments

- Completed a successful Year 3 CMS/DHCS audit.
- Membership growth to 182 participants
- Met all Utilization Goals
- Preventative Care (CMS Goal: >90%)
  - 96% Influenza Immunization Rate
  - 93% Pneumococcal Immunization Rate
- Common infections in the elderly lower than national benchmarks.
- Improvement in the number of participants have completed a Physician Order's for Life Sustaining Treatment (POLST) to 86%. (Goal >65%)

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# 2016 Accomplishments (Cont)

- Improvement in 9 of the 10 Annual Participant Satisfaction Survey domains
- Added new family recreational therapy program and a new weight management program
- Diversity of Participants and Staff
  - Participants
    - Represent 22 different ethnicities
    - Speaking 8 languages
    - 62% of our Participants utilize English as their second language
  - PACE staff
    - 72% of PACE staff are Bilingual/Multilingual
    - Speaking 11 unique languages

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# Total Membership


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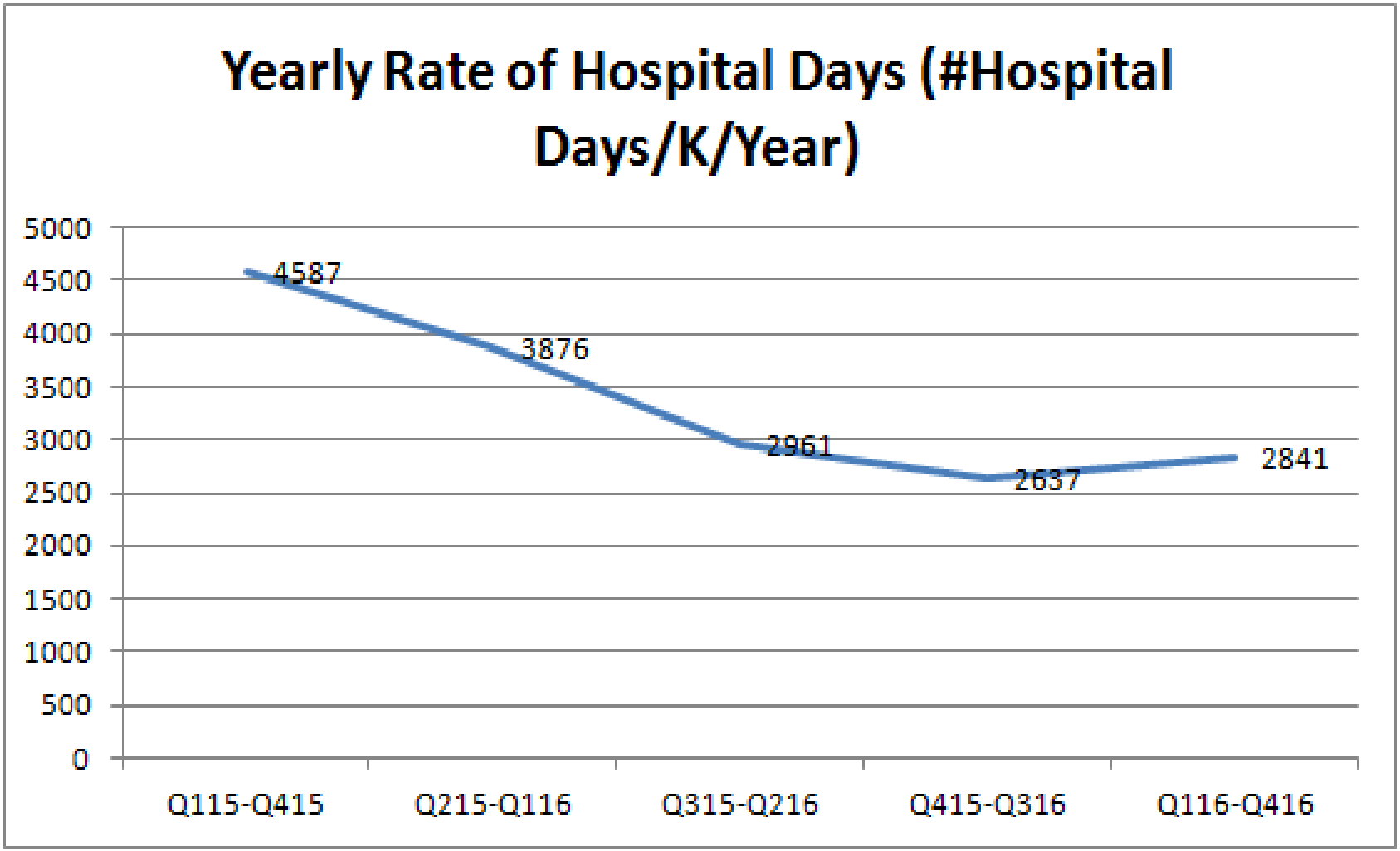
# 2016 Accomplishments: Hospital Bed Days (Goal: < 3462 Hospital Days /K/Y)

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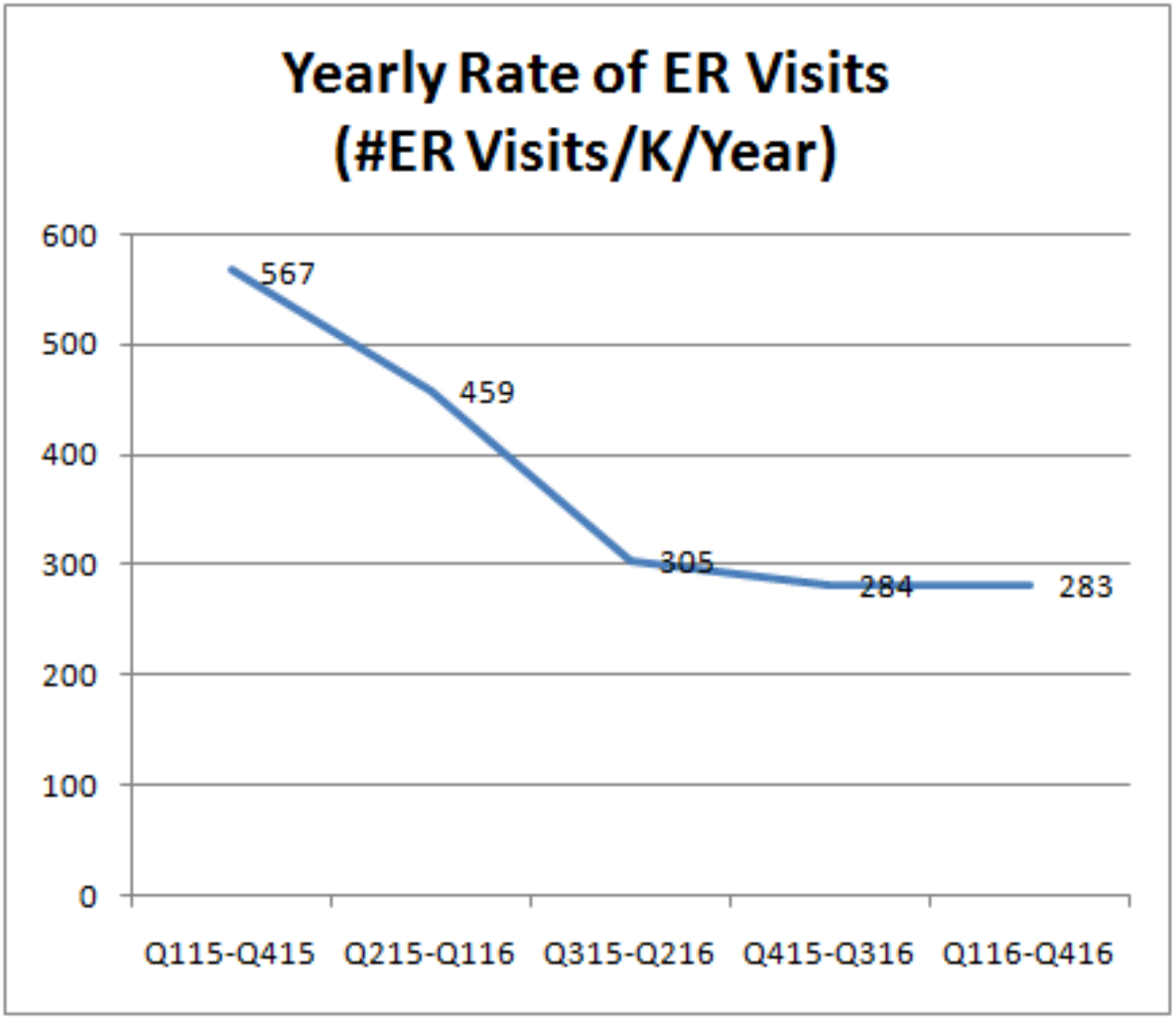
CalOptima A Public Agency Better. Together.

# 2016 Accomplishments: ER 428Visits/K/Y

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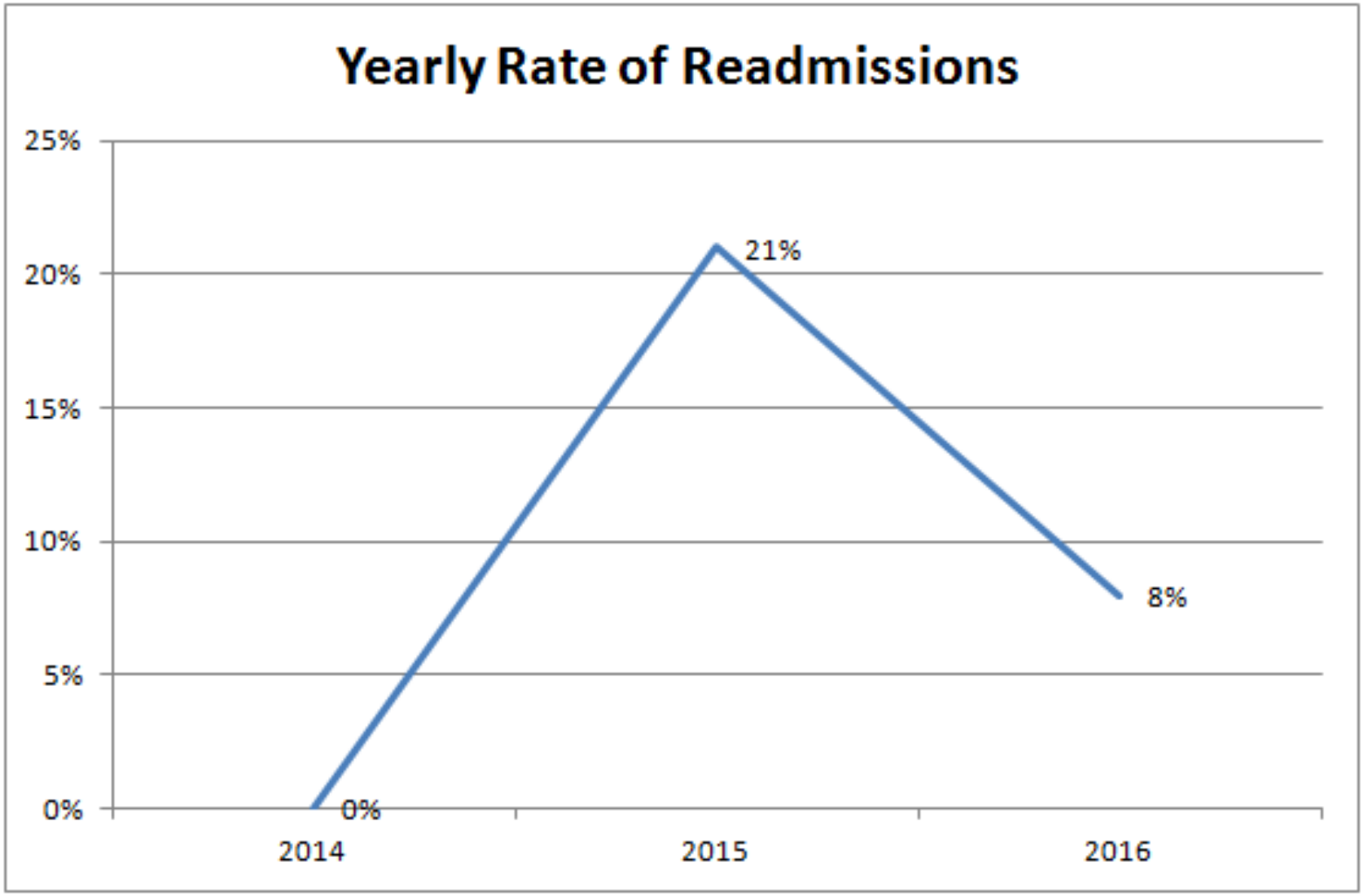
# 2016 Accomplishments: 30-Day All-Cause Readmissions (<16.8%)

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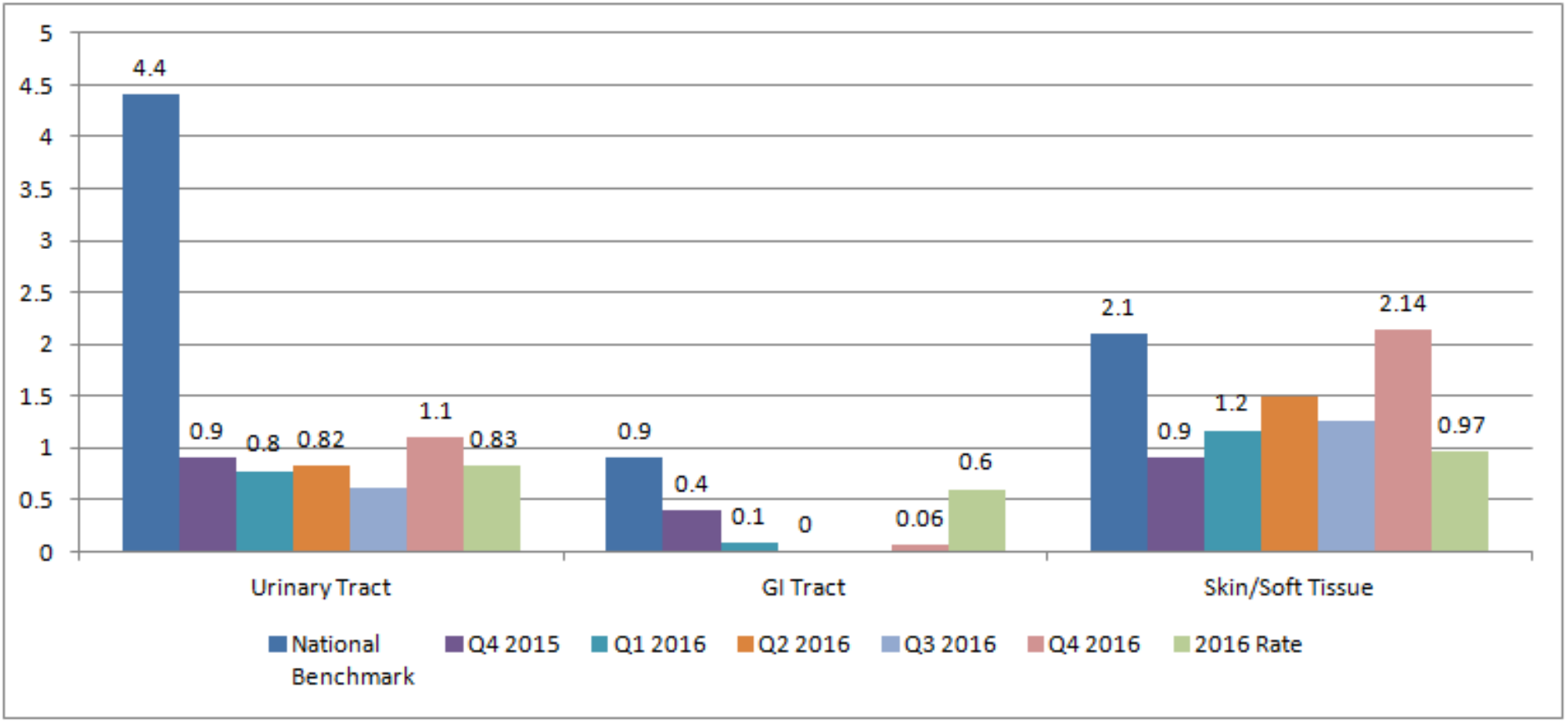
# 2016 Accomplishments: Infection Control (Episodes per 1000 Participant Days)

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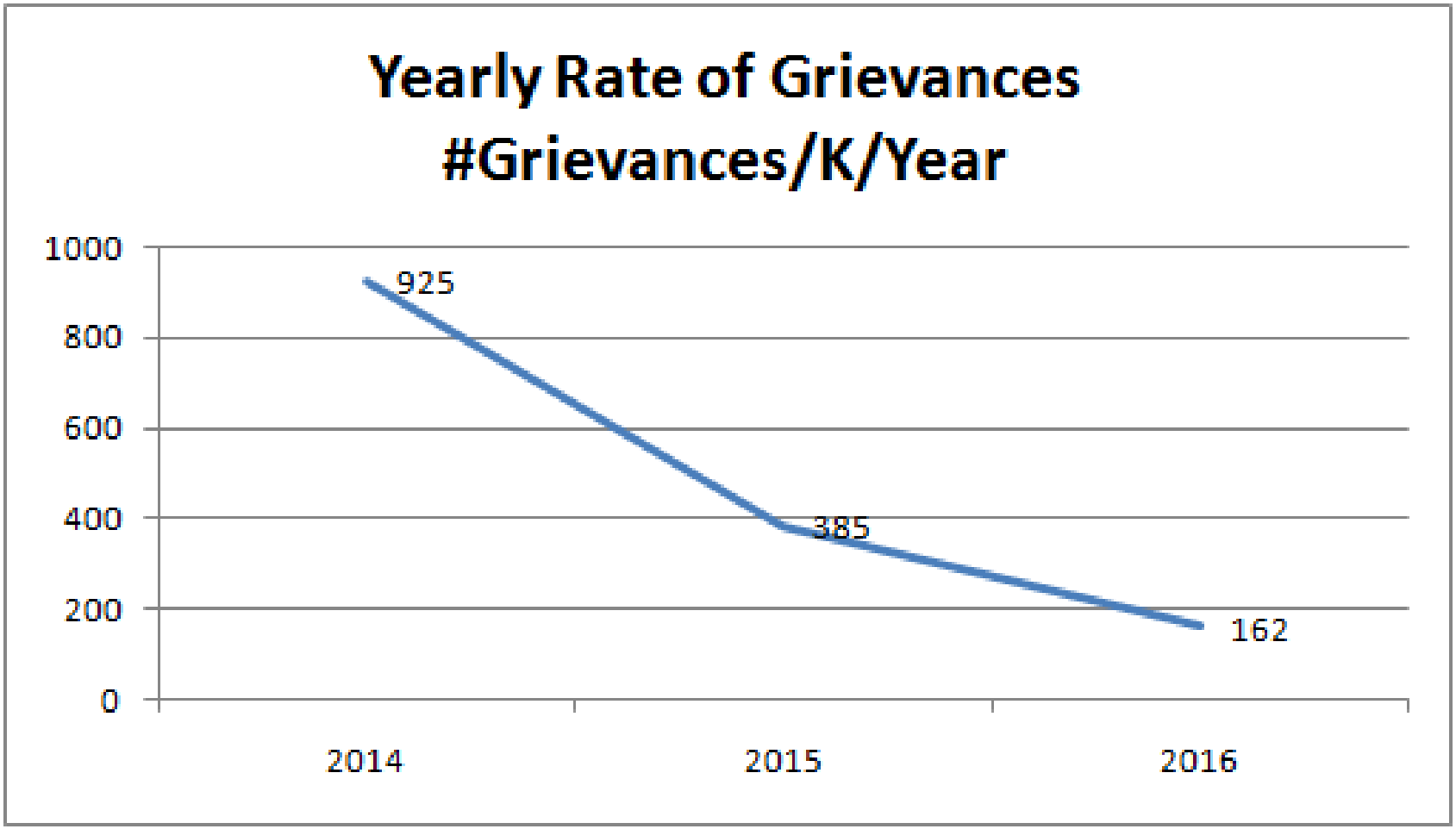
# Patient Satisfaction (Grievances)

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# Patient Satisfaction

| Domain | 2015 | 2016 |
|---|---|---|
| Transportation | 92% | 98% |
| Center Aids | 89% | 92% |
| Home Care | 88% | 92% |
| Medical Care | 83% | 86% |
| Health Care Specialist | 80% | 85% |
| Social Worker | 92% | 96% |
| Meal | 58% | 71% |
| Rehabilitation Therapy and Exercise | 94% | 98% |
| Recreational Therapy | **85%** | **82%** |
| Other Indicators | 91% | 92% |
| Overall Satisfaction | 84% | 89% |

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# 2016 QAPI Elements: Not Met

- Patient Satisfaction
- Specialty Care Access
- Disenrollment in the first 90 Days
- Annual Diabetic Eye Exams

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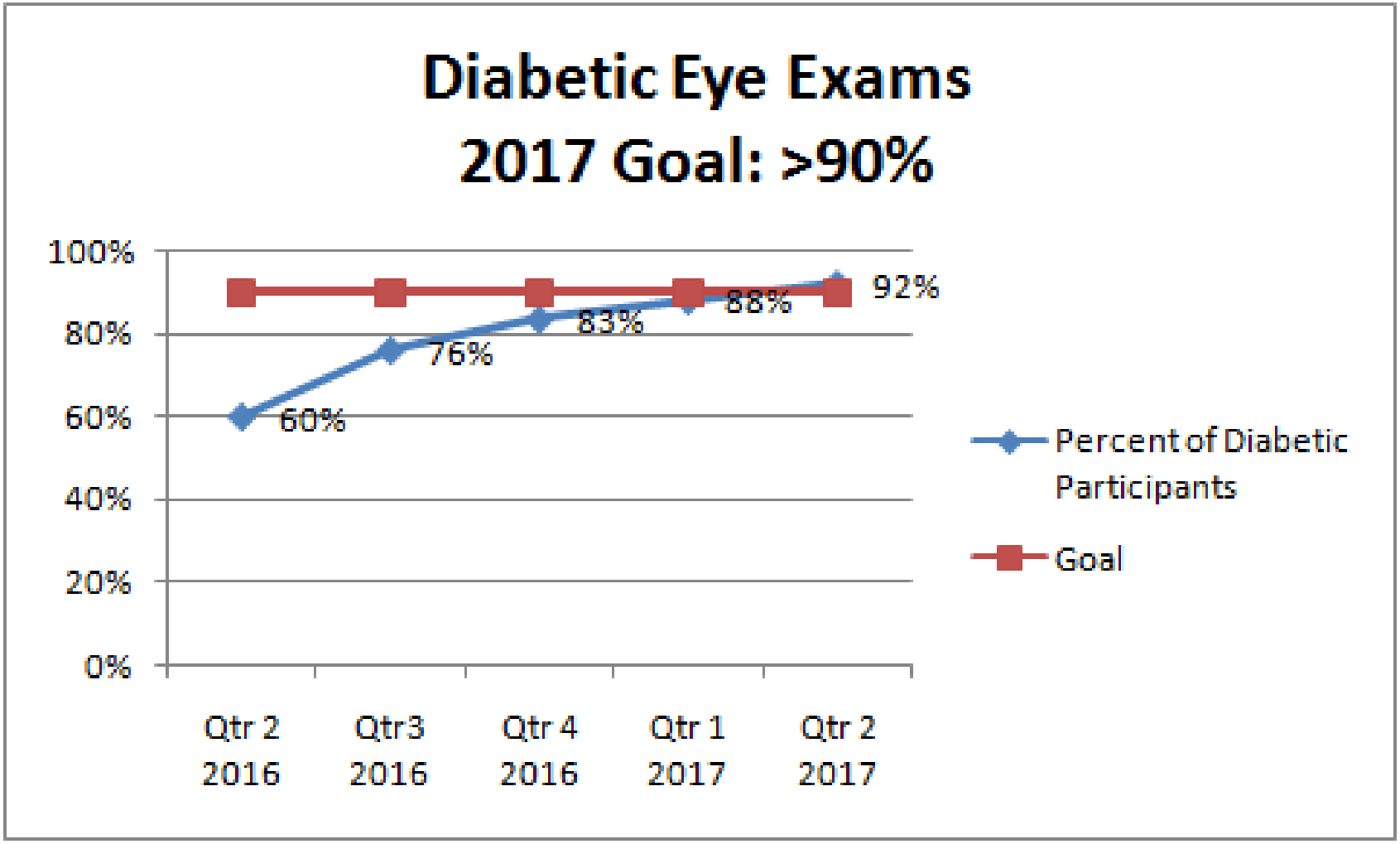
# Annual Diabetic Eye Exams

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# Opportunities for Improvement in 2017

- Patient Satisfaction
  - Coordination of Specialty Care
  - Transportation
- Membership Growth
  - Community Physician Waiver
  - Reduction in Voluntary Disenrollments
- Utilization Management
- Quality of Care Elements

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# Next Steps

- Patient Satisfaction
  - ✓ Develop and Implement a comprehensive Communication/Messaging Plan.
  - ✓ Started a new Customer Service Workgroup
  - ✓ Complete and Execute the Transportation RFP
  - ✓ Added staff resources to ensure tighter oversight of transportation and specialty care.
- Membership Growth
  - ✓ Split shifts to allow for increased flexibility for our members
  - ✓ Assessing Community Physician Waiver
  - ✓ Implement Communication/Messaging Plan
  - Evaluate Community Physician Waiver
  - Reduce voluntary disenrollments

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# Next Steps (Cont)

- Utilization Management
  - ✓ Leverage CalOptima's UM expertise
  - ✓ Utilize CalOptima's IS Population Health Solution for Inpatient Hospitalization Review
  - ✓ Improve relationship with Urgent Care Facilities through our service area
  - Added support for the PACE pharmacist's to allow additional time to be spent on pharmacy utilization.
  - Increase participation in the 340b drug program
- Quality of Care
  - ✓ Adding new HEDIS metrics focusing on reducing potential harmful drug-drug interactions in the elderly
  - ✓ Adding new metrics focused on care for the elderly
  - ✓ Increased the number of QI work plan elements from 14 to 21.

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# Recommended Action

Receive and file the 2016 PACE Quality Assessment Performance Improvement (QAPI) Plan Evaluation

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# CALOPTIMA PACE

## 2016 CALOPTIMA PACE QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) PLAN ANNUAL EVALUATION



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# SIGNATURE PAGE

*Quality Improvement Subcommittee Chairperson:*

_____ _____

Richard Helmer, MD
Chief Medical Officer

Date

*Board of Directors' Quality Assurance Committee Chairperson*

_____ _____

**Paul Yost, M.D.**
Chair, Board of Directors' Quality Assurance Committee

**Date**

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## I. EXECUTIVE SUMMARY

CalOptima PACE opened for operations on October 1st, 2013. We have seen steady growth over the last three years with 13 members at the end of 2013, 69 members at the end of 2014, 125 at the end of 2015, and 183 at the end of 2016. Our members represent 22 different ethnicities who speak 8 different languages. Sixty-two % of the PACE Participants utilize English as their second language. The purpose of the PACE Quality Assessment Improvement (QAPI) Plan is to improve the quality of health care for participants, improve on the patient experience, ensure appropriate use of resources, provide oversight to contracted services, communicate all quality and process improvement activities and outcomes and reduce the potential risk to safety and health of PACE participants through ongoing Risk Management. This is done via data-driven assessments of the program that drives continuous quality improvement for the entire PACE organization's services. It is designed and organized to support the mission, values, and goals of CalOptima PACE.

The goals of the CalOptima PACE QAPI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.

## II. PROGRAM STRUCTURE

The CalOptima's PACE QAPI Plan is developed by the PACE Quality Improvement Committee (PQIC) and is reviewed and approved by the CalOptima Board of Directors Quality Assurance Committee (QAC) and then approved by the CalOptima Board of Directors annually.

A written 2016 PACE QAPI Plan was reviewed and approved by the PQIC on Feb 3, 2016 and the CalOptima Board of Directors QAC on March 23, 2016. It was then approved by the full CalOptima Board of Directors on April 7, 2016.

The CalOptima PACE Medical Director has oversight and responsibility for implementation of the PACE QAPI Plan. The PACE QI Manager will ensure timely collection and completeness of data with the support of the PACE QI Coordinator. Overall oversight of the PACE QAPI Plan is provided by the Board of Directors.

The CalOptima PACE QAPI Plan incorporates continuous Quality Improvement (QI) methodology that focuses on the specific needs of Cal Optima's PACE members.

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It will foster the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to ensure that quality of care issues are identified and corrected.

## III. PACE QAPI PROGRAM: MAJOR ACCOMPLISHMENTS IN 2016

In 2016, overall CalOptima PACE accomplishments include:

1) Successful 3rd year CMS/DHCS audit
2) Successful DHCS Level of Care Audits (Spring and Fall 2016)
3) Met all utilization goals and showed improvement in acute hospital days, ER and 30-day all-cause readmission utilization.
    a) Inpatient Hospital Days
        i) 2015 Rate: 4,587 Hospital Days/K/Year
        ii) 2016 Goal: 3,462 Hospital Days/K/Year
        iii) 2016 Final Rate: 2,841 Hospital Days/K/Year
    b) ER Visits
        i) 2015 Rate: 449 Visits/K/Year
        ii) 2016 Goal: 458 Visits/K/Year
        iii) 2016 Final Rate: 283 Visits/K/Year
    c) 30-Day All-Cause Readmission
        i) 2015 Rate: 21%
        ii) 2016 Goal: 16.4%
        iii) 2016 Final Rate: 8%
4) Program Enrollment Growth
    a) Met goal for Q 1-3.
    b) We saw a drop in Q4 which left us just below the 2016 goal.
5) Exceeded the CMS Pneumococcal and Influenza immunization rates (CMS goal is >80%).
    a) 96% of members receiving their Influenza
    b) 93% of members receiving Pneumococcal immunizations
6) Participant Satisfaction: Improvement in 9 of the 10 Annual Participant Satisfaction Survey domains.
7) Implemented new Electronic Medical Record
        a. Migrated records to new application
        b. Trained clinical, on-call and administration staff
        c. Developed 37 individual process work flows for users
8) 100% of staff competency assessments were completed. Year-round staff trainings covered a broad area of topics including coding, infection control, case management, wound care, triage, appeals, grievances, customer service and participant's rights and responsibilities.
9) Hired and recruited staff to meet the needs of our Participants. As such, 72% of the PACE staff are bilingual or multilingual which account for 11 unique languages.
10) Rates of common infections in the elderly (respiratory tract, urinary tract, skin and gastrointestinal tract) all were lower than national benchmarks.
11) Increased utilization of Physician Orders for Life-Sustaining Treatment (POLST) to 81% of participants enrolled for at least 12 months.
12) Significant progress was made in developing the organizational structure of the program to support the census and programmatic growth, including:
        a. Orientating and training key manager positions, including a new Center Manager and Manager of Clinical Operations
        b. Establishing supervisor-level operations positions for frontline oversight of quality care and consistency of operations
        c. Addition of one to two positions per discipline, creating back-up support for

social work, home care, dietary, rehabilitation therapists and other interdisciplinary roles

d. The new PACE Quality Improvement (QI) Manager was added to have oversight of the QI Program Specialists and aided in expanding the breath of QI activities. In addition to GARS and HPMS reporting, QI now has oversight to the Medical Records Program Specialist and new the EMR Program Specialist.

13) Maintained a functional and viable PACE Quality Improvement Committee (PQIC) with increased membership, including representation from supervisory, clinical and transportation vendor staff.
    a. A new PACE QAPI Work Plan reporting format was developed and implemented in 2016. Quarterly status updates and evaluations were reported by management staff, while goals were documented, tracked and analyzed every quarter by the PACE QI team to find opportunities for quality improvement.
    b. Increased membership of PACE Member Advisory Committee (PMAC) which reported activities to the PQIC along with the CalOptima Board of Directors QAC.
    c. Completed Annual Participant Satisfaction Survey
14) All CalOptima PACE policies, procedures and desk references were reviewed and refined as recommended by the CMS/DHCS PACE Audit results and regulatory changes
15) Transportation RFP, with subsequent RFI while reducing transportation-related grievances by 20% from 2015.
16) Completed internal review of QI data reported to PQIC post CMS/DHCS audit transportation finding to evaluate weak sources of data, identify opportunities to reduce data reporting error and implement best practices for reliable tracking and trending.

## IV. Strategic Goals and Objectives of the 2016 PACE QAPI Program

1. It is organized to identify and analyze significant opportunities for improvement in clinical services, care and utilization.
    a. Accomplished as evidenced by the ongoing HPMS data collection, analysis and subsequent ongoing PACE QI activities.
    b. Accomplished as evidence by the population health techniques implemented in the area of preventative care.
2. The quality of clinical care and services and patient safety provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
    a. Accomplished as evidenced by monitoring of member grievances and complaints, and regular review of delegated entities.
    b. Collaboration with the Compliance Department for identification of potential quality issues that may involved fraud, waste, abuse, confidentiality, security, etc.
3. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners.
    a. Accomplished as evidenced by the daily interdisciplinary care team meetings at CalOptima PACE.
    b. Accomplished by developing workflows for the new electronic medical record for increased consistency of documentation and opportunities for care coordination.

    c. Accomplished as evidenced by the increasing number of specialty services being provided to the Participant at the PACE center. Currently, we a Podiatrist, Dentist, Audiologist and a Psychiatrist who deliver their care at our PACE center.
4. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population.
    a. Accomplished as evidenced by the number of grievances that have been tracked and trended.
    b. Accomplished by the access and availability metrics added to 2016 Work Plan and recommendation to revise metric for 2017.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service.
    a. Accomplished as evidenced by a solid credentialing and peer review process.
    b. Accomplished as evidenced by annual evaluations of all CalOptima PACE employees.
    c. Accomplished as evidenced by the annual approval of Up-to-date Clinical Practice Guidelines and the National PACE Association Preventative Guidelines.
6. Member and provider satisfaction, including the timely resolution of complaints and grievances.
    a. Accomplished as evidenced by PACE Member/Member's Caregiver Satisfaction Survey.
    b. Accomplished as evidenced by the summary of GARs activities.
7. Risk prevention and risk management processes.
    a. Accomplished as evidenced by the QI activities that occur around all Unusual Incidents.
    b. Accomplished as evidenced by Fall Huddles that occur with PACE staff after any reported fall.
    c. Accomplished as evidenced by Root Cause Analysis done on Level 2 incidences.
8. Compliance with regulatory agencies and accreditation standards.
    a. Accomplished as evidenced by CMS/DHCS audit.
9. Compliance with Clinical Practice Guidelines and evidence-based medicine.
    a. Accomplished as evidenced by the adoption of the National PACE Association Preventative Guidelines and the adoption of Uptodate.com clinical practice standards.
10. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently.
    a. Accomplished as evidenced by tracking, trending and analyzing UM data on a monthly basis.

## V. SUMMARY OF ACCOMPLISHMENTS, BARRIERS AND ACTIONS

2016 QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT WORK PLAN - ELEMENTS BY CATEGORY

***Quality of Care***

**QAPI14.01 PACE QAPI Plan and Work Plan will be reviewed and updated annually**
Received and filed by the CalOptima Board of Directors on April 7th, 2016.

**QAPI14.02 PACE QAPI Plan and Work Plan will be evaluated annually.**
Approved by the CalOptima Board of Directors on April 7th, 2016.

**QAPI14.03 Increase Influenza immunization rates for all eligible PACE participants**
**Goal:** > 90% of members will have influenza vaccination
**Data/Analysis:** 96% of members received the influenza vaccination.
**Summary:** Final metric determined at the end of the flu season.
**Key Findings/Opportunities for Improvement**

1. Barriers
    a. Staff responsible for influenza immunization was somewhat unclear. Each nurse assigned to a participant was tasked, which made overall oversight difficult.
    b. Data to track whether a participant received an immunization was not easily available during the EMR transition, as of September 19, 2016. Manual tracking was completed while the data migration was completed.
    c. All the Participants who did not receive the influenza immunization refused its administration.
2. Interventions
    a. One staff person in the clinic will be responsible for reviewing QI reports for missed opportunities for immunizations on a monthly basis during the months of October – March.
    b. Utilize EMR's quality analytics for tracking of missed opportunities for immunization.
    c. Participants who refused the immunization were offered it every month during the flu season.

**QAPI14.04 Improve compliance with pneumococcal immunizations recommendations**
**Goal:** > 90% of members will have pneumococcal vaccination
**Data/Analysis:** 93%
**Summary:** Continue metric in 2017 work plan for oversight of HPMS required monitoring. We had a slight dip in Q2 and Q3, but our rate increased to 93% by year end.
**Key Findings/Opportunities for Improvement**

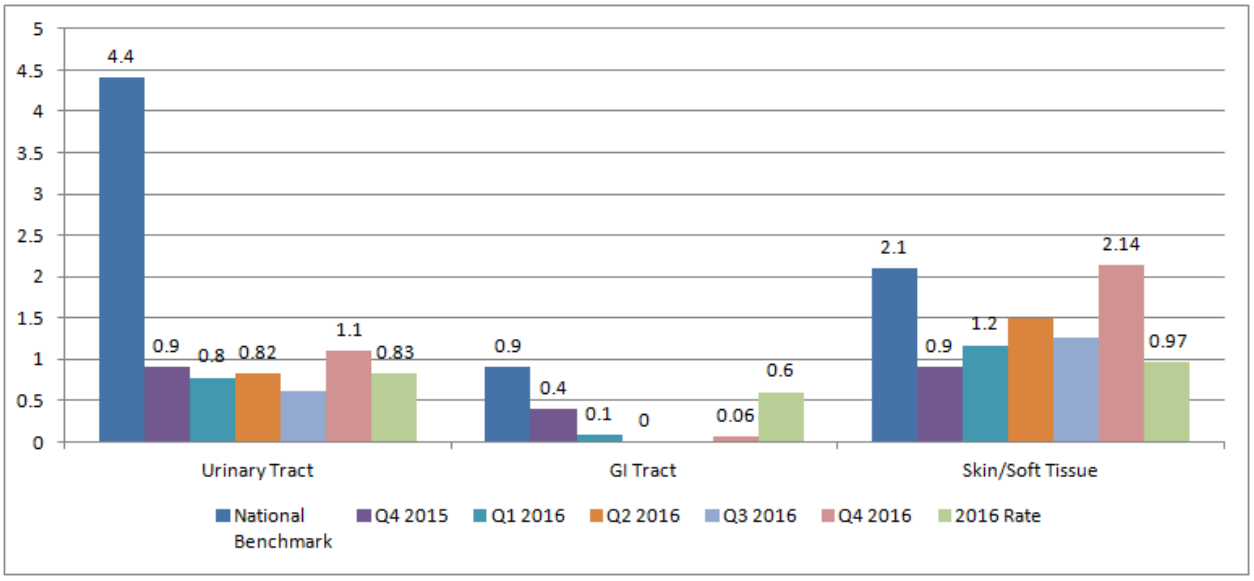
1. Barriers
    a. Inability to get previous medical records when participants reported prior immunization.
    b. Lack of consistently following immunization procedures for new participants.
    c. All but one of the Participants who did not receive the influenza immunization refused its administration.
2. Interventions
    a. Implemented new immunization procedure if medical records are unable to be obtained.

b. Clinic staff worked with QI staff to develop a new report detailing "missed opportunities" which will be distributed monthly.
c. Participants who refused the immunization are offered it every six months.

**QAPI14.05 Reduce common infections in PACE participants**
**Goal:** The table below shows the goal, based on national benchmarks compared to the actual rates for CalOptima PACE for 2016.

| | Goal Rate (episodes/1000 prt days) | Actual Rate (episodes/1000 prt days) |
|---|---|---|
| **Respiratory Tract** | 2.4 | 0.9 |
| **Urinary Tract** | 4.4 | 0.83 |
| **Skin and Soft Tissue** | 2.1 | 0.6 |
| **Gastrointestinal Tract** | 0.9 | 0.97 |

**Common Infections in PACE Participants by Quarter 2016**




**Summary:** Overall, rates were consistently below benchmarks. No outbreaks occurred.
**Key Findings/Opportunities for Improvement**

1. Barriers
    a. Previous EMR may have had some data integrity issues.
2. Interventions
    a. We will be developing a new infection identification model utilizing the quality analytics module that is built into the new EMR that was implemented September 19th, 2016.

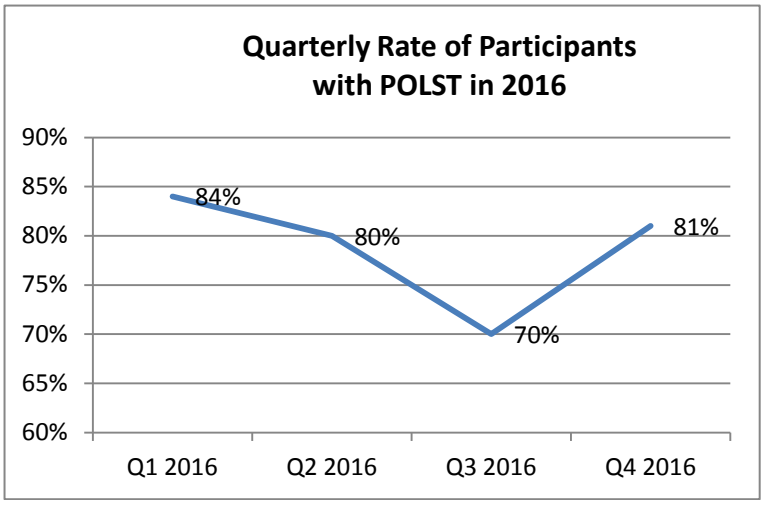
**QAPI14.06 Increase Physician Orders for Life Sustaining Treatment (POLST) utilization for PACE participants who have been enrolled in PACE for at least 12 months**
**Goal:** Improve POLST Utilization by 10% over the 2015 rate (65%)

**Data/Analysis:** 2016 final rate was 81%.
POLST for Participants who have been enrolled for >1 year:

- 101 Participants have been with PACE for over a year who are still currently enrolled with PACE.
- 82 of these Participants have a POLST filed in their electronic medical record.

POLST for Participants who have been enrolled for >6 Months:

- 144 participants enrolled for over 6 months
- 97 of these participants have a POLST filed in their electronic medical record.




**Summary:** 2016 element was modified to only include participants enrolled for more than 12 months, compared to all participants in 2015. An increase in Q4 2016 may be attributed to staff focusing on initiating POLST discussion during enrollment process. Increased POLST utilization is evident in findings. It is recommended that we continue measuring POLST utilization in 2017 with updated definition to include participants enrolled for more than 6 months.

**Key Findings/Opportunities for Improvement**

1. Barriers
    a. Disenrollment of members enrolled for more than 12 months increased in Q3, which skewed metric as majority had POLSTs in place.
    b. Lack of ownership/unclear assignment for staff responsible for POLST completion.
2. Interventions
    a. Customer Service Workgroup implementing interventions to retain membership.
    b. POLST assigned to Clinic, with one Provider responsible for coordinating effort.
    c. Providers and Social Work Supervisor are coordinating in-person meetings with participant, and family if necessary, upon enrollment and reassessment.

**QAPI14.11 Increase the percentage of PACE participants with diabetes who get their annual diabetic eye exam completed**

**Goal:** Greater than 90% of members with diabetes will have their annual eye exam completed

**Data/Analysis:**

| Quarter 2016 | Completion Rate |
|---|---|

| | |
|---|---|
| Q1 | 51% |
| Q2 | 60% |
| Q3 | 76% |
| Q4 | 83% |

**Summary:** Although, the goal was not reached, we had significant progress from the beginning of the year moving from 51% to 83%. This metric was a new addition to the 2016 work plan. Tracking this metric revealed an opportunity for improvement. It is recommended that this metric continue to be tracked.

**Key Findings/Opportunities for Improvement**

1. Barriers
    a. Data integrity issues with the previous EMR
    b. Challenges with coordination of specialty visits as PACE is coordinating the specialist appointment along with transportation, the family, the participant, a translator (if needed) and an escort (if needed).
2. Interventions
    a. Transitioned to new EMR on September 19th, 2016
    b. New reports have been developed utilizing the new EMR's quality analytics module which will be shared with the clinic monthly.

***Access and Availability***

**QAPI16.07 PACE Access and Availability**

**Goal:** Greater than 90% of specialty practitioners will have appointments available within 14 business days

**Data/Analysis:** Survey respondents revealed that 85.8% of OneCare Connect providers (overlapping network to CalOptima PACE) had availability within 15 business days.

**Summary:** Quality element was included to better understand access to specialty practitioners. The goal was that greater than 90% of specialty practitioners will have appointments available within 14 business days. CalOptima Quality Improvement conducts an annual survey for community providers to self report availability. PACE used this survey as the indicator for this element. The survey differed from the PACE QAPI element in that the survey measured appointments available within 15 business days.

The QAPI element was not met and will be replaced in 2017 for a more targeted metric that addresses turnaround time for PACE specialty care orders. The metric will make use of utilization data and ordering/authorization/scheduling milestones to ascertain access and availability specific to PACE members.

**Key Findings/Opportunities for Improvement**

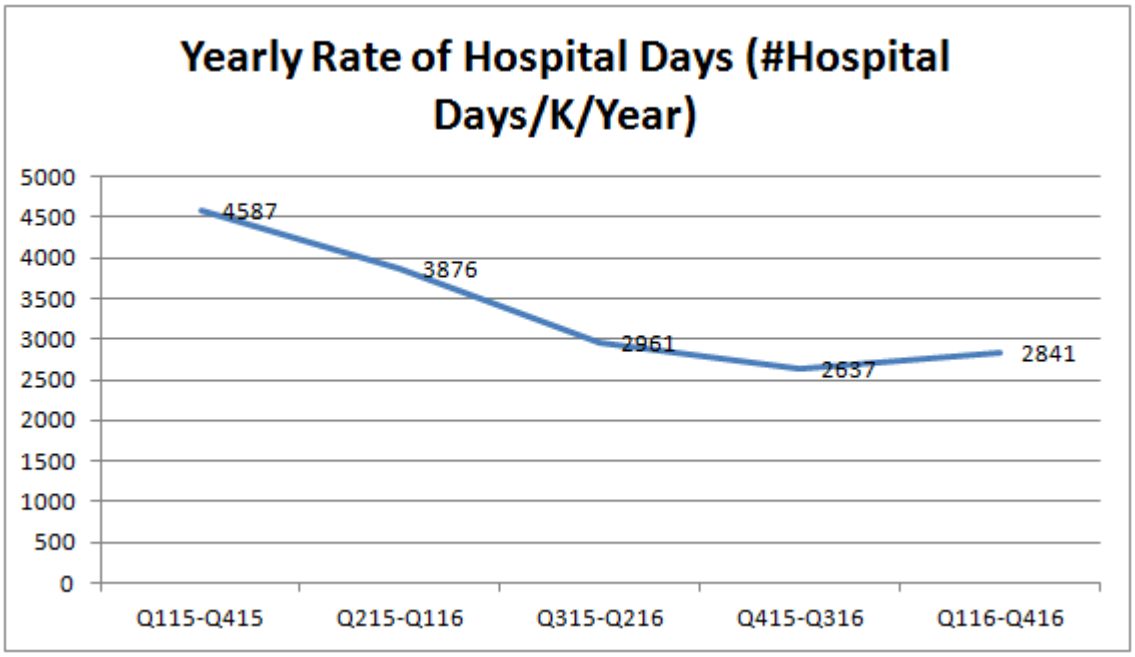
1. Barriers
    a. Specialist availability limited or providers responding with little or no knowledge of the PACE model of care or contractual agreement.

b. Limited reporting functionality in previous EHR. New EHR has improved reporting; however, training and implementation have been a challenge for scheduling.
c. Inconsistent process for scheduling appointments confounded by staff changes.
d. Scheduling appointments is a PACE-wide effort involving the participants, clinic staff, transportation, escort services, medical records, social work and day center staff at times.

2. Interventions
    a. We initiated a PACE clinic corrective action plan to address specialty appointment scheduling in January 2017, including:
        i. Engaging CalOptima's Process Excellent team to help review, revised and implement a new specialty appointment workflow.
        ii. Addition of staff to total 1.5 FTE resourced to scheduling with addition 1.0 temporary staff person to process orders to resolve current issues related to turnaround time.
        iii. Implementation of Specialty Care Calendar in new EHR.
    b. We will coordinate provider outreach with Provider Relations team to educate providers on PACE model and contractual agreements.

***Utilization Management***

**QAPI14.08 Reduce the rate of acute hospital days by PACE participants**
**Goal:** Less than 3,462 hospital days per 1000 per year (20% reduction from the CalOptima PACE utilization in 2015)
**Data/Analysis:** The 2016 final rate was 2,841 Hospital Days per 1000 per year (38% reduction). This was a significant decrease in the rate from 2015 (4,587 hospital days/K/Y to 2,841 hospital days/K/Y). Most recent CalPACE average (1st 6 months of 2016) was 2,112 Hospital Days per 1000 per year.

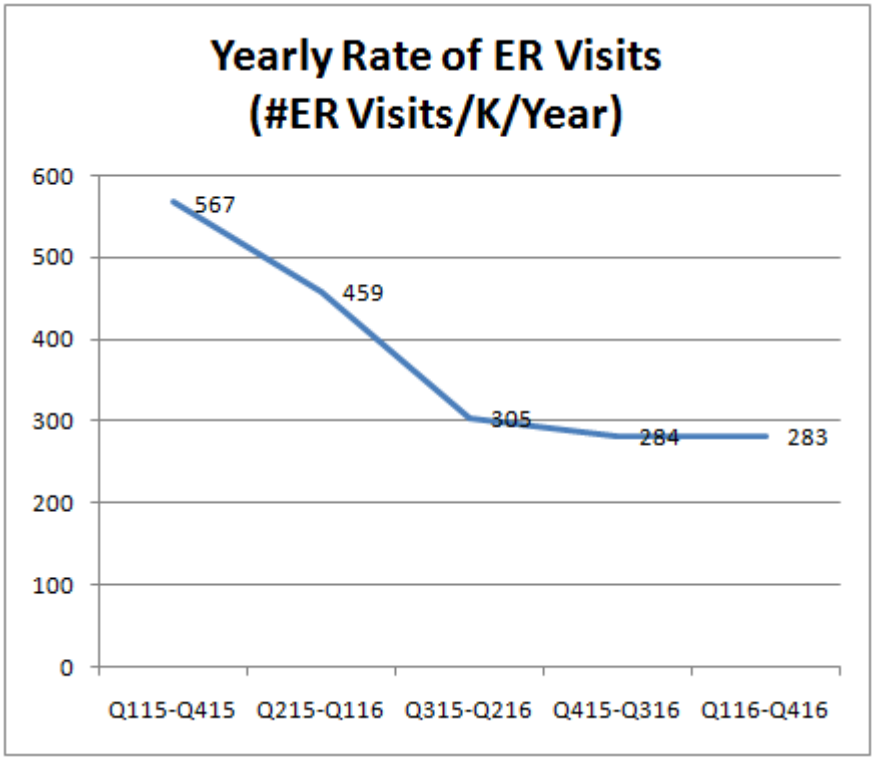



**Summary**: Decreased utilization may be correlated to an increase in access to skilled nursing facilities, as PACE increased the number of contracts with facilities in 2016 and were able to move Participants more rapidly to the appropriate level of care. Additionally, 2016 was the first year having a fully integrated PACE RN Case Manager. Activities now being completed by this new role include increased frequency of skilled nursing facility rounds, hospital rounds and participation in the transition of care process to ensure the participants are receiving the right level/intensity of care. Although there was significant improvement year over year, the rate is still higher than the CalPACE average.

**Key Findings/Opportunities for Improvement**

1. Barriers
    a. Building an appropriately trained and staffed PACE concurrent review department.
    b. Admission notifications from hospitals
    c. Transition to new Electronic Medical Record system on September 19th, 2016
    d. Difficulty getting real time utilization management reports
    e. Several members contributed to a significant percentage of the utilization.
2. Interventions
    a. Integrating the CalOptima Concurrent Review team for PACE hospital utilization management.
    b. Leveraging the new EMR quality analytics module in order to get real-time front end hospital authorization data to get real time utilization reports.
    c. Expanding the PACE Case Manager's role to provide enhanced case management to high utilizing members.
    d. Implemented daily clinical rounds which focus on those participants who are in the hospital, receiving skilled care in nursing facilities or who had been to the ER the day previously.

**QAPI14.09 Reduce the rate of ER utilization by PACE participants**
**Goal:** Less than 428 Emergency Room only visits per 1000 per year
**Data/Analysis:** The 2016 final rate was 283 emergency room only visits per 1000 per year. The graphs below illustrate the trends.

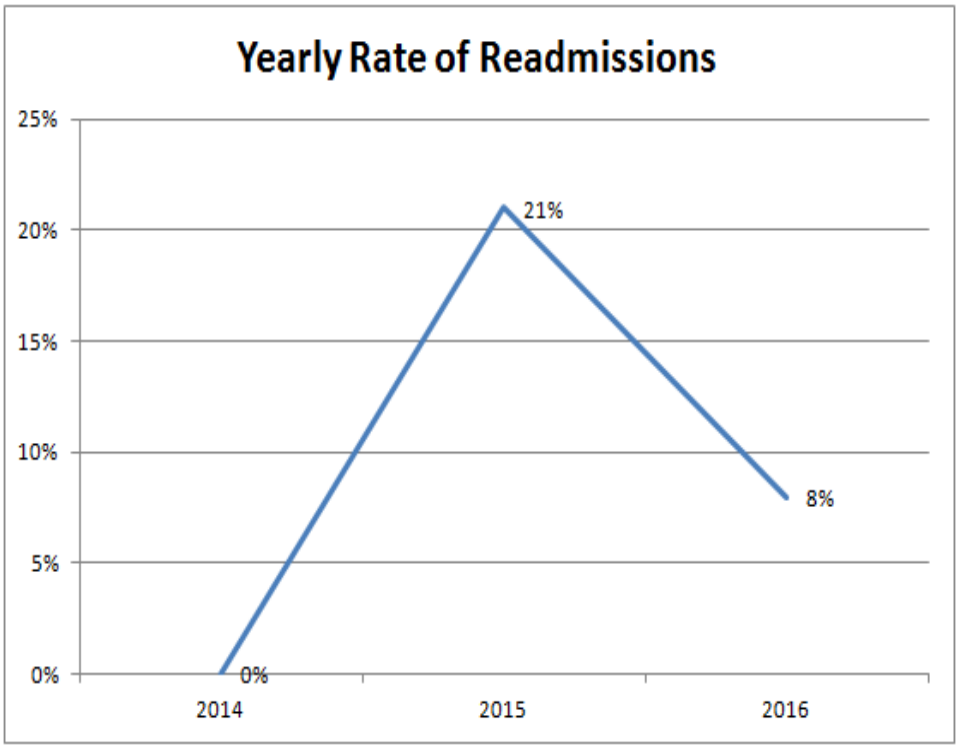



**Summary:** There was a significant decrease from 2015 rates. Most recent CalPACE average for 2015 was 485 ER only visits per 1000 per year. Interventions related to this decrease is in part due to the increased the scope of the services provided at the PACE clinic, including the ability to give intravenous fluids as well as the fully integrated PACE RN Case Manager who investigates all ER visits and reports her findings to IDT every day.
**Key Findings/Opportunities for Improvement**

1. Barriers
    a. Lack of close relationships with local urgent care centers.
    b. Difficulty getting real time utilization management reports.
    c. Several members contributed to a significant percentage of the utilization.
2. Interventions
    a. Developing close relationships with local urgent cares who are open evenings and weekend and have the ability to perform X-Rays, Ultrasounds, Splinting and minor procedures.
    b. Leveraging the new EMR quality analytics module in order to get real-time front end hospital authorization data.

c. Expanding the PACE Case Manager's role to provide enhanced case management to high utilizing members.
d. Implemented daily clinical rounds, which focuses on those participants who are in the hospital, receiving skilled care in nursing facilities or who had been to the ER the day previously.

**QAPI14.10 Reduce the 30-day all cause readmission rates by PACE participants**
**Goal:** Less than 16.8% (20% reduction from the CalOptima PACE utilization in 2015)
**Data/Analysis:** The 2016 Final Rate was 8%.




**Summary**: This was a significant decrease from 2015. The most recent CalPACE average for 2015 was 11%. Decrease was partly due to having a fully integrated the PACE RN Case Manager who started at the end of 2015. Activities completed by this new role include increased frequency of rounds to skilled nursing facilities, hospitals and increased participation in the transition of care process to ensure the participants are receiving the right level/intensity of care.
**Key Findings/Opportunities for Improvement**

1. Barriers
    a. Building an appropriately trained and staffed PACE concurrent review department.
    b. Admission notifications from hospitals.
    c. Difficulty getting real time utilization management reports.
2. Interventions
    a. Integrating the CalOptima Concurrent Review team for PACE hospital utilization management.

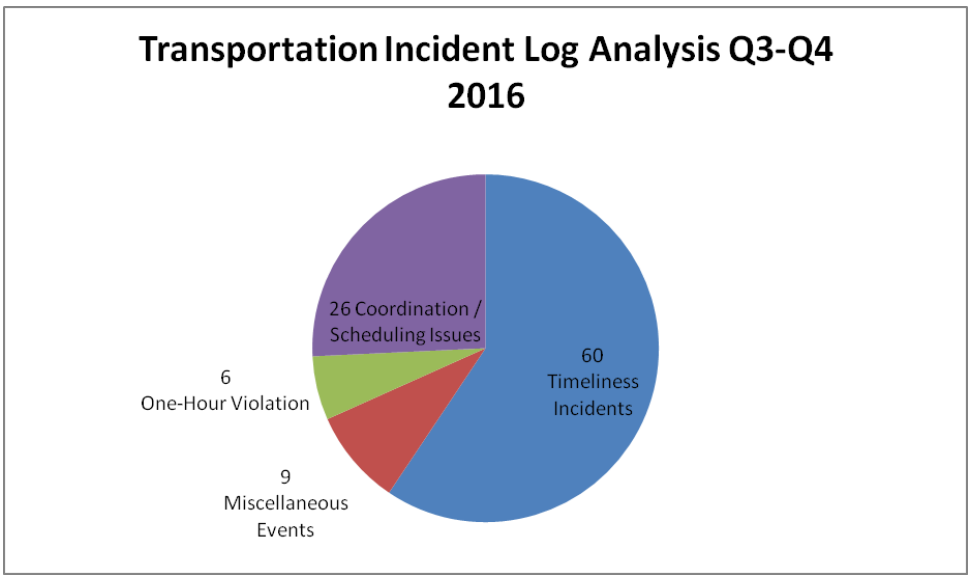
b. Leveraging the new EMR quality analytics module in order to get real-time front end hospital authorization data to get real time utilization reports.
c. Expanding the PACE Case Manager's role to provide enhanced case management to high utilizing members.
d. Implemented daily clinical rounds, which focuses on those participants who are in the hospital, receiving skilled care in nursing facilities or who had been to the ER the day previously.

***Participant Satisfaction***

**QAPI14.12 Improve the satisfaction of participants and their families with the CalOptima PACE transportation department**
**Goal:** Reduce transportation grievances by 20% from 2015 (Goal = <10 grievances)
**Data/Analysis**: The QAPI goal for this element was to reduce transportation grievances to less than 10. This QAPI element was met, as there were a total of 9 transportation grievances reported in 2016.

**Grievances Related to Transportation Analysis Q2 2015 – Q4 2016**

| Quarter | Timeliness | Prt-Driver Interaction | Escort | Total |
|---|---|---|---|---|
| Q2 2015 | 1 | 0 | 0 | 1 |
| Q3 2015 | 4 | 1 | 2 | 7 |
| Q4 2015 | 1 | 1 | 1 | 3 |
| Q1 2016 | 0 | 0 | 0 | 0 |
| Q2 2016 | 4 | 0 | 0 | 4 |
| Q3 2016 | 2 | 1 | 0 | 3 |
| Q4 2016 | 0 | 2 | 0 | 2 |




**Summary:** June 2016 marked an increase in the number of transportation concerns communicated to PACE operations and quality improvement, however, this increase was not evident in the number of formal grievances filed. Upon assessment of the grievance policy and confirming that staff continues to educate participants on their right to file a grievance, a Transportation Incident Log was initiated to capture and resolve transportation issues. From 7/1/16 – 12/31/16, the Transportation Incident log contained 101 incidents.

The increase in transportation concerns coincided with CalOptima PACE disclosing to DHCS the existence of multiple unreported one-hour trip violations, as high as 90 occurrences within a month dating back to October 2015. Prior to this time, Secure Transportation had reported to the PACE operations that there were no 1-hour violations in the FY 2015. However, at the end of June, 2016, Secure Transportation reported that there had actually been a significant number of 1-hour violations starting as far back at October, 2015. Secure Transportation identified the cause of the one-hour rides as the CalOptima PACE fleet not being optimized, local mismanagement of transportation resources and a software error that failed to identify the one-hour violations. During this time period, there were no grievances filed due to a long ride time (i.e., such as greater than 60 minutes).

The Transportation Incident Log has been a powerful tool to identify trends in transportation service, such as one-hour violations, scheduling issues, timeliness, and other miscellaneous events. In Q3 and Q4 2016, 199 one-hour violations were reported. Of the 199 violations, six were reported by a participant, with the remainder reported by Secure Transportation.

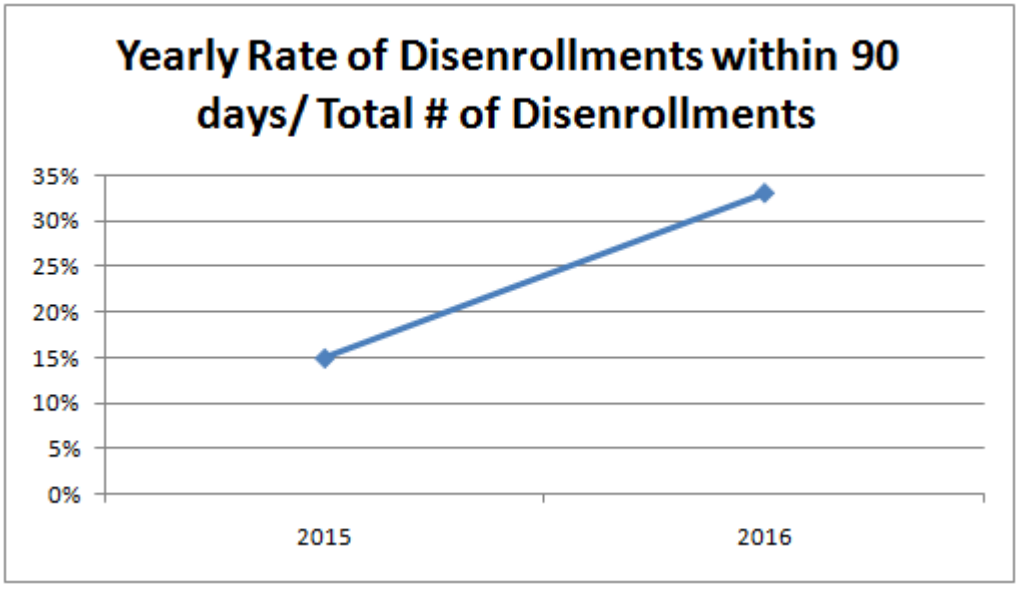
**Key Findings/Opportunities for Improvement**

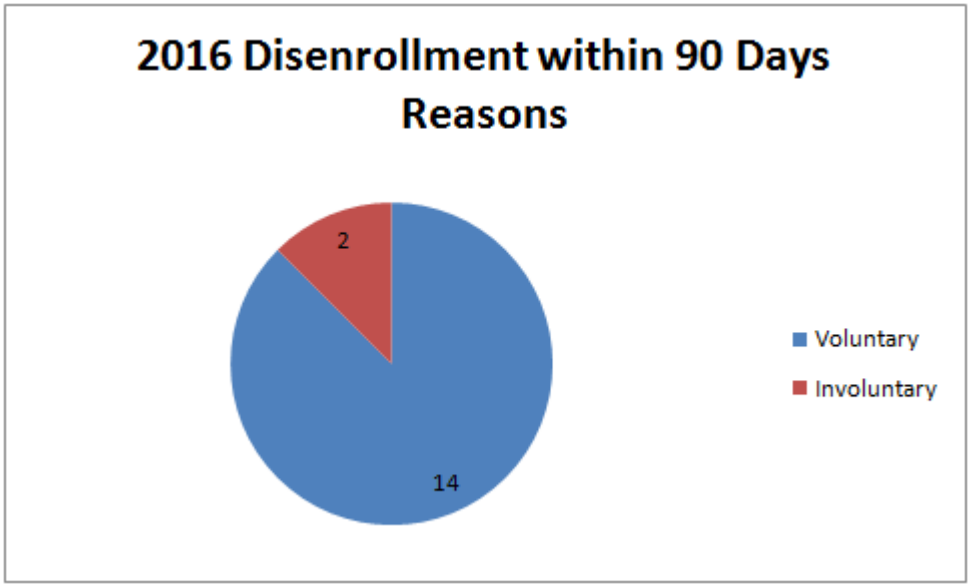
1. Barriers
    d. Transportation grievances did not reflect the long ride times that were occurring
    e. Lack of validation of the data in the vendor's monthly reports.

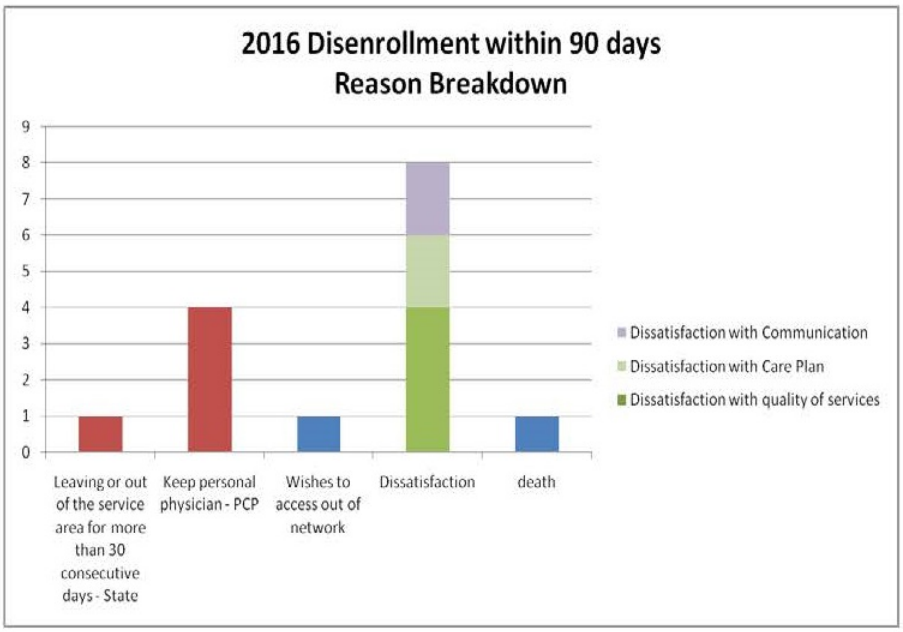
2. Interventions
    a. Recommend including different transportation quality metric in future work plans.
    b. Consider use of the transportation log for trending and tracking ride times over one hour.
    c. Monetary sanctions have been placed on current transportation vendors for any future 1-hour violations.
    d. Unannounced monthly ride-along to ensure accuracy of transportation vendor reports.
    e. Transportation vendor will report any violations or issues daily to IDT.
    f. Transportation vendor will present weekly and monthly reports to PACE Director for review, analysis and discussion.
    g. Submitted a Request for Proposal to see if there are other vendors who can meet our needs with a consideration of multiple vendors.

**QAPI14.13 Reduce the percentage of participants who have withdrawn or have disenrolled from the PACE program within the first 90 days of enrollment**
**Goal:** Reduce the percentage below 10% of the 2015 rate of 15%
**Data/Analysis:** The total yearly rate was calculated for 2015 and 2016 by taking the amount of disenrollments within 90 days for the year divided by the total number of disenrollments. The result is 15% in 2015 compared to 33% in 2016.

Of the 16 total disenrollments within 90 days in 2016, 14 were voluntary and 2 were involuntary. Notably, 8 of the 14 participants who voluntarily disenrollment (53%) reported dissatisfaction with the PACE program






**Key Findings/Opportunities for Improvement**

1. Barriers:
    a. Difficult to manage expectations of participants enrolling in program. A high potential exists for conflicting messages prior to enrollment.
    b. Transportation grievances do not appear to be an accurate indicator of overall transportation satisfaction.
    c. Local mismanagement of transportation services by Secure Transportation.
    d. Issues with specialty care appointments.

e. Participant's dissatisfaction in not being able to see all their previous specialists.
f. Limited resources allocated to overall satisfaction due to decentralized structure of operations team

2. Interventions:
   a. Developing an overall PACE communication/messaging strategy to improve understanding of the program as well as to improve participant expectations.
   b. We will utilize the Transportation Incident Log in 2017 to track and trend incidents and resolutions.
   c. We will complete a RFI to consider other transportation options and revision to the transportation scope of work.
   d. We will revise the transportation scope of work and issue a new RFP in 2017.
   e. We will monitor performance of Secure Transportation via monthly Transportation monitoring with new Secure Transportation staff (replaced regional director responsible for oversight of contract and transportation coordinator in 2016).
   f. We will leverage the CalOptima Process Excellence Team to help review, revise and implement a new specialty appointment workflow.
   g. Additional staff dedicated to scheduling specialty appointments has been added.
   h. We will leverage CalOptima's Provider Relations department to improve contracted physician's knowledge of PACE as well as to help recruit specialists when needed.
   i. We will initiate a Customer Service Workgroup to will focus efforts to increase participant satisfaction, including:
      i. Increased enrollment retention
      ii. Decreased cancellations for the day health center
      iii. Increased communication from participants to the appropriate discipline
      iv. Increased participant feelings of connection to the program.
      v. The workgroup will focus on refreshing current strategies as well as new initiatives in 2017 to include:
      vi. We will refresh the 'First month buddy' program. The current format has been reviewed and opportunities for improvement identified. Implementation of 'Peer Buddy' as part of this strategy.
      vii. We will facilitate a program orientation 3x/mo (English, Spanish, and Vietnamese). Orientation will be an activity scheduled monthly to capture new and enrolled participants.
      viii. We will provide new participants with a listing of their Care Circle (i.e., interdisciplinary team members assigned to the participant).
      ix. We will initiate new enrollee check-in surveys that addressed multiple program domains and overall satisfaction with program.

**QAPI14.14 Improve the overall satisfaction of participants and their families with the CalOptima PACE program**
**Goal:** Greater than 90% will answer 3/4 (satisfied), very satisfied (4/4) on this question.
**Data/Analysis:** CalOptima PACE participates in an annual satisfaction survey conducted each

fall to determine the level of participant satisfaction with the program. The 90% overall satisfaction goal for this element was not met. The Participant Satisfaction Survey score for this element in 2016 was 89%. The table below* provides additional information for comparison.

| Quality Indicator | CalOptima PACE 2016 | CalOptima PACE 2015 | CalPACE 2016 |
|---|---|---|---|
| **Overall, would you rate the care you receive from CalOptima PACE as: (% Excellent, Very Good, Good)** | **89%** | **82%** | **95%** |

**Source: 2016 CalPACE Participant Satisfaction Survey conducted by Vital Research*

**Summary**: Aside from overall satisfaction, the transportation domain had a notable increase from 92% in 2015 to 98% in 2016. Considerable staff time was spent on addressing transportation issues with increased communication to participants informing them of the challenges and actions planned. This increased communication may have contributed to the increase in satisfaction, as actual service metrics did not improve significantly. This will be considered by management for opportunities to increase the overall rating in the future. All but one domain improved from 2015 to 2016. The exception was Recreational Therapy, which decreased from 85% to 82%, with the CalPACE average score of 87%.

**2016 Annual Participant Satisfaction Survey**

| Domain | 2015 | 2016 |
|---|---|---|
| Transportation | 92% | 98% |
| Center Aids | 89% | 92% |
| Home Care | 88% | 92% |
| Medical Care | 83% | 86% |
| Health Care Specialist | 80% | 85% |
| Social Worker | 92% | 96% |
| Meals | 58% | 71% |
| Rehabilitation Therapy and Exercise | 94% | 98% |
| Recreational Therapy | **85%** | **82%** |
| Other Indicators | 91% | 92% |
| Overall Satisfaction | 84% | 89% |

**Key Findings/Opportunities for Improvement:** Barriers and interventions identified in QAPI14.13 (above) are directly related to this element. Interventions will be adopted to address both elements, as they are interrelated.

**2016 HEALTH PLAN MANAGEMENT SYSTEM (HPMS) – NOT COVERED IN THE QAPI WORK PLAN**

**2016 HPMS Updates:** CMS implemented changes to the level I event reporting structure. On a quarterly basis, the following events are reports to CMS via the Health Plan Management System (HPMS):

1. Grievances
2. Appeals
3. Level II events, formerly known as sentinel events, are reported as they occur.
4. Burns
5. Medication Errors
6. Immunizations (evaluated in the Quality of Care section of this report)
7. Enrollment/Disenrollment (evaluated previously in this report)
8. Falls without Injury
9. ER Visits (evaluated in the Utilization Management section of this report)
10. Kennedy Terminal Ulcer (not implemented)

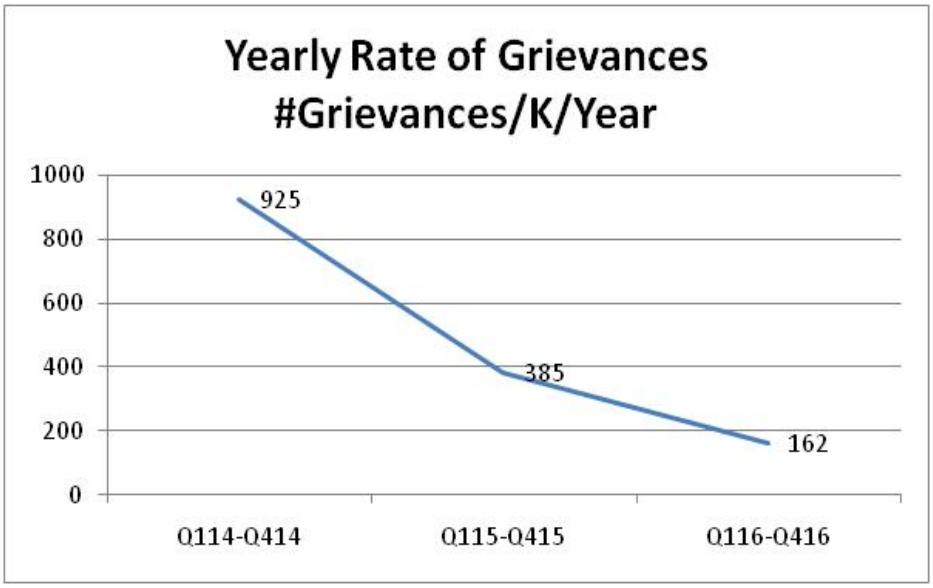
## Grievances

**Summary:** While overall grievance rates were lower in 2016 than 2015, PQIC tracking revealed clear trends. 50% of grievances were related to transportation (timeliness and prt-driver interaction) and the other 50% were related to clinical services (dissatisfaction with services, timeliness and scheduling). A detailed breakdown is below. Recommendations for the 2017 QAPI work plan are to focus efforts on utilization management, participant satisfaction and delegation oversight to improve the areas with the highest grievance rates – transportation and clinic services.

### Grievance Trends Q4 2014 – Q4 2016

| | CENTER | | | | | | CLINIC | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Transportation | | | Clinical Care/ Service/ Treatment | | | |
| | # Grievances | Food | Home Care | Timeliness | Prt-Driver I | Escort | Dissatisfaction | Timeliness | Comm-unication about care | Scheduling/ Communication |
| Q4 2014 | 2 | | | | | | | | | |
| Q1 2015 | 0 | | | | | | | | | |
| Q2 2015 | 7 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 |
| Q3 2015 | 17 | 0 | 0 | 4 | 1 | 2 | 3 | 4 | 1 | 1 |
| Q4 2015 | 13 | 0 | 0 | 1 | 1 | 1 | 8 | 1 | 0 | 1 |
| Q1 2016 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Q2 2016 | 7 | 0 | 0 | 4 | 0 | 0 | 2 | 0 | 0 | 1 |
| Q3 2016 | 6 | 0 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 2 |
| Q4 2016 | 4 | 0 | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 0 |

### Annualized Rate of Grievances 2014 - 2016




**Appeals**

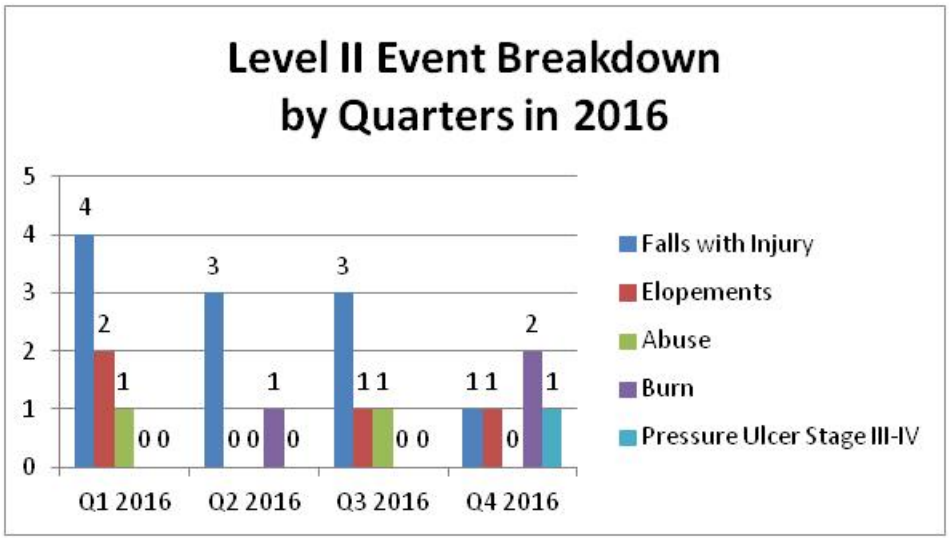
Appeals by participants continue to be minimal in 2016. A total of 4 appeals were submitted, the majority concerning requests for increased attendance. Explanations for this could be contributed to effective/over-utilization and/or effective communication from interdisciplinary team members when explaining care plans. We are working with CMS/DCHS to help us understand the difference between provider recommendations verses a provider request on behalf of a participant. This issue will become more prevalent as we implement a concurrent review program. Currently, CMS/DHCS are unable to give us guidance.

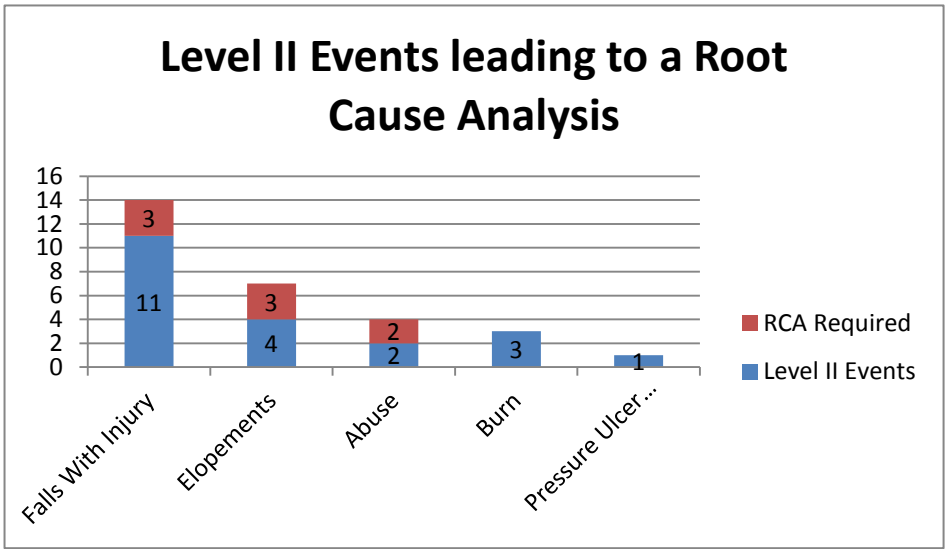
**Level II Events**

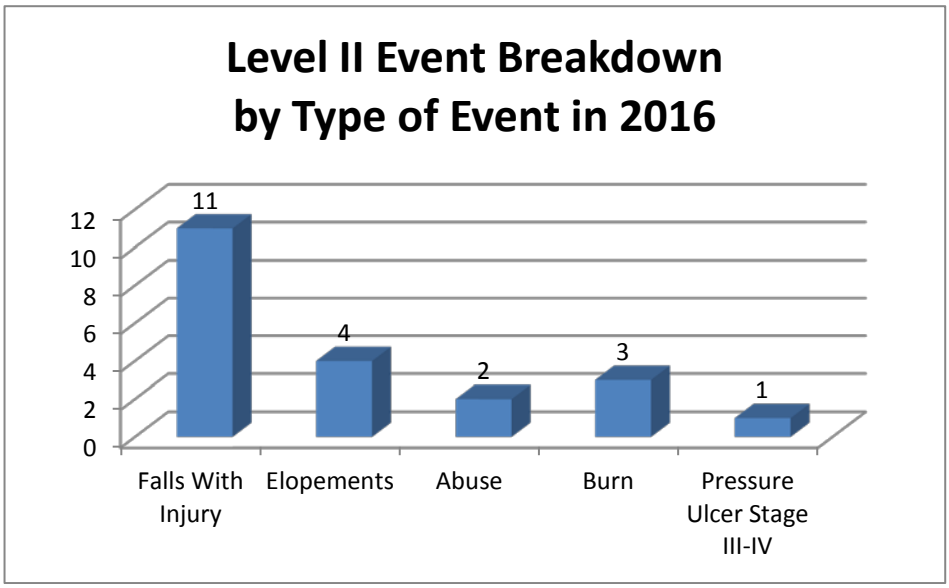
**Summary:** In 2016, CalOptima PACE reported 21 level II events, an increase from 17 in 2015 (24% increase). Most frequently reported were (1) Fall with fracture or requiring hospitalization and (2) Elopement. Notable system changes implemented in 2016 due to level II incidents and their associated root cause analyses:

1. Developed and implemented a 'Do Not Leave Alone' protocol for participants requiring 24/7 supervision
2. Developed and implemented a policy to restrict cell phone use in participant care areas

The charts below provide additional trends in 2016 Level II reporting.


Level II Event Breakdown by Quarters in 2016
5
4
3
2
1
0
4
2
1
0 0
3
0 0
1
0
3
1 1
0 0
1 1
0
2
1
Q1 2016
Q2 2016
Q3 2016
Q4 2016
Falls with Injury
Elopements
Abuse
Burn
Pressure Ulcer Stage III-IV


Level II Events leading to a Root Cause Analysis
16
14
12
10
8
6
4
2
0
3
11
3
4
2
2
3
1
Falls With Injury
Elopements
Abuse
Burn
Pressure Ulcer ...
RCA Required
Level II Events




**Burns**

A total of 2 burns (first degree or less) were reported in 2016. Both burns occurred in the home environmental. It is expected that this element is under-reported, as participants may not consider burns of first degree or less reportable to their primary care provider or day health center staff.

**Medication Errors**

A total of 8 medication errors were reported in 2016. All were attributed to pharmacy error. In each incident, medication was not administered due to either an omitted or incorrect dose. In Q3 2016, CalOptima PACE transitioned to a new pharmacy. Since this transition, no medication errors have been reported.

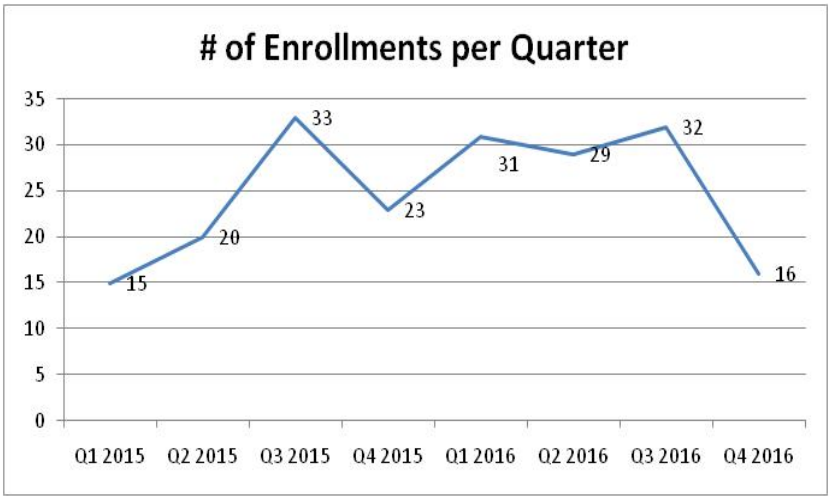
**Enrollment & Disenrollment**

**Summary:**

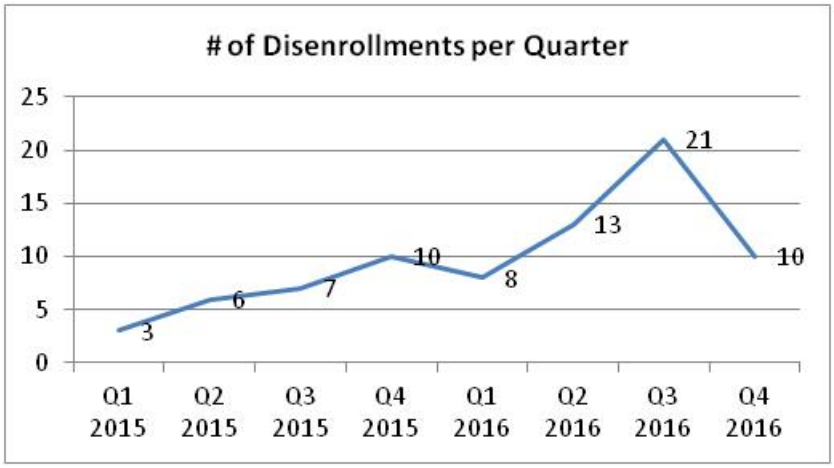
1. CalOptima PACE's enrollment has remained close to budgeted goal. Enrollment for Q1, Q2 and Q3 2016 surpassed projections, and then declined in Q4. While simultaneously disenrollments increased from 2015.
2. The make-up of the Enrollment Team consisted of an additional Outreach Specialist (1.0 FTE) and a transitioned Home Care Coordinator RN (1.0 FTE) to Level of Care Nurse in 2016 compared to 2015. The loss of the only Vietnamese-speaking Enrollment Coordinator in August 2016 may have affected enrollments in Q3 and Q4.
3. Increase from 91 members in 2015 to 183 members in 2016 (101% increase).
4. Increase in disenrollments from 26 members in 2015 to 52 in 2016 (100% increase). More detailed discussion of disenrollment trends can be found in the QAPI16.13 (Disenrollment within 90-days).
5. Improved tracking of disenrollment trends related to the implementation of Disenrollment Reason sub-codes. Opportunity exists to further explore reasons for disenrollment.
6. Most common reasons for disenrollment:
    - Dissatisfaction with services

- Keep personal physician
- Death

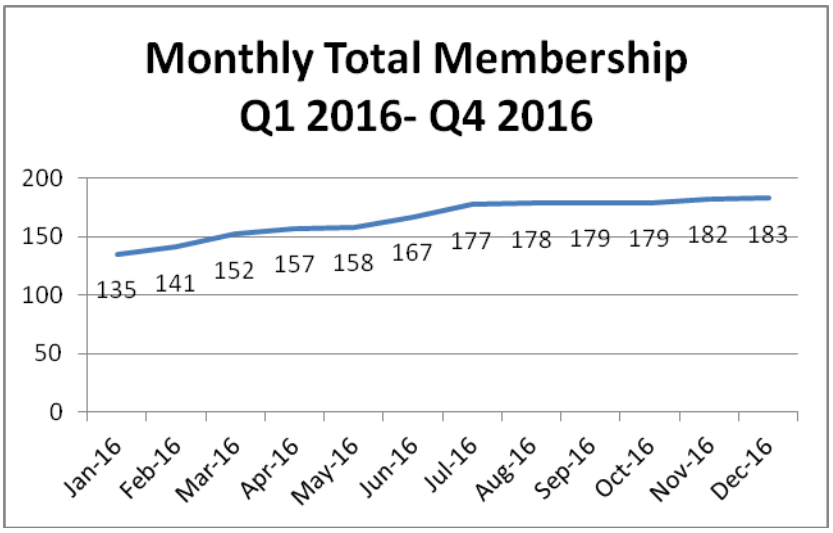
**2015-2016 Enrollment Trends**




**2015-2016 Disenrollment Trends**



**2016 Monthly Membership Trends**



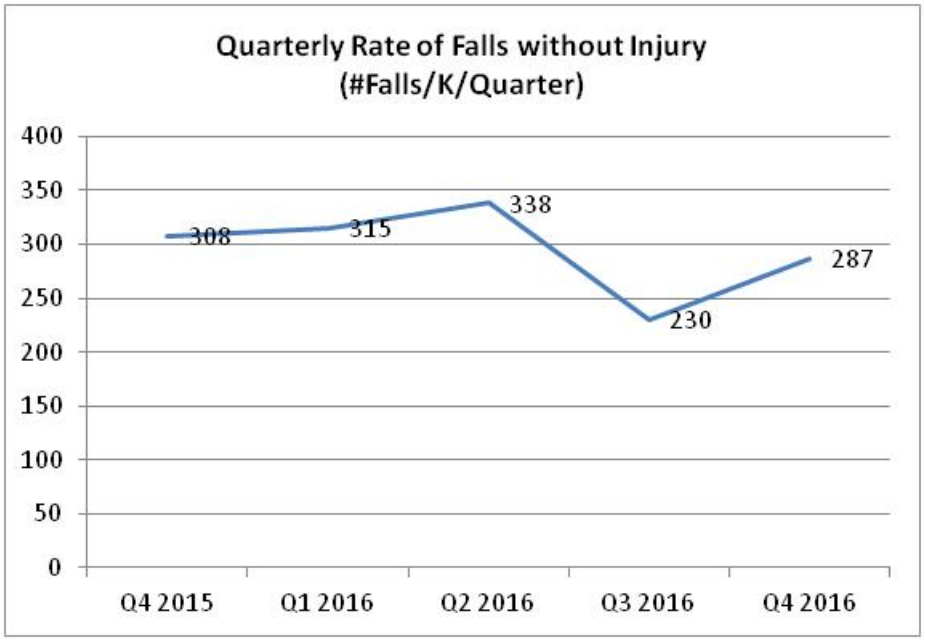

**Key Findings/Opportunities for Improvement**

1. Barriers
    a. Enrollment team operated with two enrollment coordinators for 60% of the year. Replacing enrollment coordinators is a lengthy process due to the DHCS marketing exam requirement.
    b. Limited enrollment detail reports related to limitations in previous electronic health record (EHR) and transition to new EHR in September 2016.
    c. Source of dissatisfaction with services difficult to identify due to inconsistent findings from Annual Participant Satisfaction Survey results and grievance trends.
    d. Members want to return to previous primary care physicians or specialists once enrolled in PACE.
2. Interventions
    a. We will consider having all enrollment staff complete the marketing exam, enabling the enrollment process to continue in times of staff transition.
    b. We will develop improved methods to track referral sources and prospective participant milestones via the new EHR and will utilize the reports to focus enrollment resources.
    c. Marketing and Enrollment Manager has initiated a Customer Services work group to identify quality improvement activities related to member satisfaction. Interventions of this workgroup are discussed in detail in QAPI16.14.
    d. We will develop an overall PACE communication/messaging strategy to improve understanding of the program as well as to improve participant expectations.

**Falls Without Injury**

**Summary:** Calculated as a rate against member months, there have not been significant changes of reported falls without injury. The majority of falls are occurring in the community,

specifically in the participant's home environment. CalOptima PACE is preparing a study of falls without injury for Q1 2017 to better understand events and trends. The 2016 fall trends are below.




## VI. OPPORTUNITIES FOR IMPROVEMENT IN 2017

1. Utilization Management
    a. Inpatient Utilization
        i. Although we saw an improvement in all our utilization rates, the hospital bed days per 1000 per year was still higher than the CalPACE average. This year we shall adopt the CalPACE average as the benchmark/program goals for all our utilization program goals.
        ii. PACE will leverage CalOptima's expertise in concurrent review by utilizing CalOptima's Concurrent Review (CCR) team to help manage and make recommendations to the IDT on authorizations related to inpatient care.
        iii. The PACE RN Case Manager will be trained on how to use Milliman Care Guidelines (MCG) and Guiding Care (GC) in order to ensure Participants are getting the appropriate level of care and to ensure smooth transitions in care.
    b. ER Utilization
        i. PACE will work to improve partnerships with local Urgent Care facilities and to coordinate with the on-call Providers to help prevent unnecessary ER visits.
        ii. The PACE QI team will utilize claims data to identify those participants who would benefit from a higher level of care coordination/case management.
    c. 30-Day All-Cause Readmissions.
        i. PACE RN Case Manager and the IDT will work closely with the

CalOptima CCR team to improve coordination of care, most importantly during any transitions in care.

ii. PACE will leverage Guiding Care (GC) to improve the information that is available to the IDT to improve the coordination of care and supervision required to reduce readmissions.

d. PACE Center.
   i. The PACE QI team will utilize the new EMR's reporting capabilities to track and manage the services rendered at the PACE center which will be reviewed by IDT as well as the PACE management team. This would include, but will not be limited to Center Days, Meals and Rehab therapies.

e. Specialty Care
   i. The PACE RN Case Manager will be trained to utilize MCG to improve the information that is available to IDT to improve their ability to make service/utilization decisions.
   ii. PACE will leverage CalOptima's Provider Relations department to ensure that the specialist network meets the needs of PACE.
   iii. A CalOptima PACE wide communication/messaging strategy will be developed in order to ensure participant's understanding of the PACE model of care in which the majority of services are provided by the PACE PCP at the PACE center.
   iv. PACE has identified one staff member who will take ownership over supervision of both transportation and specialty care.

f. Develop and utilize a UM dashboard which will include:
   i. Hospital, ER and 30-day all-cause readmission
   ii. Skilled Nursing Facility
   iii. Day center services (e.g., days, meals, rehab therapies)
   iv. Medically complex participants
   v. Specialty care
   vi. Pharmacy UM metrics

g. Pharmacy
   i. Continue to expand the 340b drug pricing program.
   ii. The roles and responsibilities of the pharmacists, RN's, LVN,'s and pharmacy technicians will be adjusted to allow the pharmacists to focus more time on reviewing high cost specialty medications along with other UM projects.
   iii. Adding a pharmacy technician to free up some of the pharmacists' time to work on the projects discussed above.

h. Develop and utilize a UM dashboard which will include:
   i. Hospital, ER and 30-day all-cause readmission
   ii. Skilled Nursing Facility
   iii. Day center services (e.g., days, meals, rehab therapies)
   iv. Medically complex participants
   v. Specialty care
   vi. Pharmacy UM metrics

2. Participant Satisfaction
    a. The PACE Management Team will work on developing an overall PACE communication strategy which will help to:
        i. Reinforce the mission, vision and values of the CalOptima PACE program which is help our Participant's to continue to live safety at home in the community.
        ii. Improve communication between the Participants and staff to ensure appropriate levels of Participant expectations.
        iii. Improve the community's understanding of the PACE program.
        iv. Improve our health delivery partners understanding of PACE.
    b. Customer service training has been planned.
    c. PACE has identified one staff member who will take ownership over supervision of both transportation and specialty care.
    d. Participants will be updated on the Satisfaction Survey process.
    e. The PACE QI team will track, trend and identify opportunities for quality improvement related to grievances with a focus on transportation, specialty care and clinic services.
    f. A Customer Service workgroup will be started and will focus on efforts to:
        i. Increase Participant satisfaction
        ii. Decreased cancellations for the day health center
        iii. Increased communication from participants to the appropriate discipline
        iv. Increased participant feelings of connection to the program.
        v. Refreshing current strategies as well as new initiatives in 2017, such as orientation of new participants and clarity on who are members of the participant's care circles.

3. Enrollment and Marketing
    a. Improve communication and participant satisfaction to decrease voluntary disenrollments.
    b. Review and refine current marketing strategy to reach all of CalOptima's currently PACE eligible population.
    c. Full implementation of our NP's additional duties allowed under the recently approved NP waiver.
    d. Assess community physician waiver which would allow increased access to potential participants who don't want to change PCP's and may have very specific needs related to their language or ethnicity.
    e. QOC improvement project around decreasing voluntary disenrollments in the first 90 days after enrollment.
4. Quality of Care (QOC) Metrics
    a. New QOC HEDIS metrics will be added as new QI work plan elements to allow the QI and clinical teams to start comparing the care delivered and received at PACE against other like populations.

b. New HEDIS metrics tailed to the population that is served by the PACE program will be added.

5. Delegation Oversight
    a. The QI team shall evaluate CalOptima credentialing activities and their efficacy related to CalOptima PACE operations.
    b. The QI team will focus on strengthening oversight activities of external providers and vendors specifically related to home care, skilled nursing facilities, board and care facilities and transportation.
    c. PACE has identified one staff member who will take ownership over supervision of the vendors associated with both transportation and specialty care.

PACE CalOptima Better. Together.

# 2016 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan

| QAPI Item# | Scope | Objective | Activity | Goal | Responsible Person | Reporting Frequency | Target completion | Q1 2016 Results | Q1 Action Items | Q2 2016 Results | Q2 Action Items | Q3 2016 Results | Q3 Action Items | Q4 2016 Results | Q4 Action Items | 2016 Result (Total of Qtrs, if applicable) | Completed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| QAPI14.01 | **PACE Quality of Care- 2016 PACE QAPI Plan and Work Plan Annual Oversight** | PACE QAPI Plan and Work Plan will be reviewed and updated annually | QAPI and QAPI Work Plan will be approved and adopted on an annual basis | Annual Adoption | PACE Medical Director | Annually | March, 2016 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | Completed |
| QAPI14.02 | **PACE Quality of Care- 2015 PACE QAPI Plan and Work Plan Annual Evaluation** | PACE QAPI Plan and Work Plan will be evaluated annually. | PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis | Annual Evaluation | PACE Medical Director | Annually | March, 2016 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | Completed |
| QAPI14.03 | **PACE Preventative Care- Influenza Immunization Rates** | Increase Influenza immunization rates for all eligible PACE participants | Improve comp iance with influnza immunizations recommendations | > 90% of members will have influenza vaccination | PACE QA Manager | Quarterly | 12/31/2016 | 92% | No tracking until qtr 3. | Not tracked for Q2. | N/A | Not tracked for Q3. | N/A | 96% | Continue metric in 2017 work plan | N/A | Completed |
| QAPI14.04 | **PACE Preventative Care- Pneumococcal Immunization Rates** | Increase Pneumococcal immunization rates for all eligible PACE participants | Improve comp iance with pneumococcal immunizations recommendations | > 90% of members will have pneumococcal vaccination | PACE QA Manager | Quarterly | 12/31/2016 | 93% | New enrollees need to be addressed | 88% | New practice: if immunizatio n records are not | 83% | Increased reports from QI to inform clinic of | 93% | Continue metric in 2017 work plan | N/A | Completed |
| QAPI14.05 | **PACE Quality of Care- Infection Control** | Reduce common infections in PACE participants | Monitor and analyze the incidence of common infections in the elderly at PACE and compare against national benchmarks to find opportunities for quality improvement | Maintain common infection rates less than the following national benchmarks: Respiratory Tract 0.1-2.4 episodes/1000 participant days Urinary Tract 0.46-4.4 | PACE QA Manager | Quarterly | 12/31/2016 | Respiratory Tract 1.9; Urinary Tract 0.8; GI Tract 0.1; Skin/Soft Tissue 1.2 | Continue current practices. | Respiratory tract 0.55; Urinary tract 0.82; GI tract 0.1; Skin/Soft tissue 1.5 | Continue current practices. | Respiratory Tract .56; Urinary Tract .62; GI Tract 0; Skin/Soft Tissue 1.25 | Continue current practices. | Respiratory Tract .8; Urinary Tract 1.1; GI Tract 0.1; Skin/Soft Tissue 2.14 | 2 years of metric met. Focus on Skin/Soft Tissue in 2017 work plan with updated | Respiratory Tract = 0.9; UTI Tract = 0.83; GI Tract = 0.6; Skin/Soft Tissue = 0.97 | Completed |
| QAPI114.06 | **PACE Quality of Care- Physician Orders for Life-Sustaining Treatment (POLST) Utilization** | Increase POLST utilization for PACE participants who have been enrolled in PACE for at least 12 months | Ensure all PACE members are offered a POLST every six months until they have one completed in order to improve utilization of POLST | Improve POLST utilization by 10% over 2015 rate (65%) | PACE Center Manager | Quarterly | 12/31/2016 | 84% | Continue current practices. | 80% | Redefine process to have Nurse Practitioner as owner of POLST completion. | 70% | Increased reports from QI to inform clinic of 'missed opportuniti es' | 81% | Continue metric in 2017 work plan with decreased enrollment time from 12 months to 6 months. | N/A | Completed |
| QAPI14.07 | **PACE Access and Availability** | Improve access to specialty practitioners | Access to high impact specialty practitioners will be measured, analyzed and adjusted as necessary such that appointments occur within 14 business days | > 90% of specialty practitioners will have appointments available within 14 business days | PACE QA Manager | Quarterly | 12/31/2016 | N/A | N/A | N/A | N/A | N/A | N/A | 85.8% based on OneCare's 15 business day | Replace metric with updated measure of turn-around | 85.80% | Incomplete |
| QAPI14.08 | **PACE Utilization of Services- Acute Hospital Days** | Reduce the rate of acute hospital days by PACE participants | PACE participants hospital days will be monitored and analyzed by the PACE QA department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education | < 3,462 hospital days per 1000 per year (20% reduction from the CalOptima PACE utilization in 2015) | PACE Medical Director | Quarterly | 12/31/2016 | 3876hospita l days/1000 | Case Mgr to review utilization with Medical Director. | 2961 hospital days/1000 | Case Mgr to review utilization with Medical Director. | 2637 hospital days/1000 | Case Mgr to review utilization with Medical Director. | 2841 hospital days / 1000 | Continue metric in 2017 work plan | 2,841 | Completed |
| QAPI14.09 | **PACE Utilization of Services- Emergency Room Utilization** | Reduce the rate of ER utilization by PACE participants | ER utilization by PACE participants will be monitored and analyzed by the PACE QA department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education | < 428 emergency room vists per 1000 per year (CalPACE Average for 2015) | PACE Medical Director | Quarterly | 12/31/2016 | 459 ER visits/1000 | Educate prts on after hours service. Complete after hours study. | 305 ER visits/1000 | Continue current practices. | 284 ER Visits/1000 | Medical team to review ER utilization to identify possibly preventabl e visits and frequent fliers. | 283 ER visits / 1000 | Continue metric in 2017 work plan | 283 | Completed |
| QAPI14.10 | **PACE Utilization of Services- 30-Day All Cause Readmission Rates** | Reduce the 30-day all cause readmission rates by PACE participants | 30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QA department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement | <16.8% (20% reduction from the CalOptima PACE utilization in 2015) | PACE Medical Director | Quarterly | 12/31/2016 | 14% readmission rate | Case Mgr to review utilization with Medical Director. | 16% readmission rate | Case Mgr to review utilization with Medical Director. | 3% Readmissi on rate | Case Mgr to review utilization with Medical Director. | 7% Readmissio n rate | Continue metric in 2017 work plan | 8% | Completed |
| QAPI14.11 | **PACE Quality of Care- Diabetic Eye Exams** | Increase the percentage of PACE participants with diabetes who get their annual diabetic eye exam completed | PACE participants with diabetes will be monitored by the PACE QA department who will work with the interdisciplinary and clinical teams to develop strategies for improvement | > 90% of members with diabetes will have their annual eye exam completed | PACE Medical Director | Quarterly | 12/31/2016 | 51% | QI to provide more detail on barriers to completing diabetic eye | 60% | QI to provide more detail on barriers to | 76% | Increased reports from QI to inform clinic of | 83% | Continue metric in 2017 work plan | N/A | Incomplete |
| QAPI14.12 | **PACE Participant Satisfaction- Transportation** | Improve the satisfaction of participants and their families with the CalOptima PACE transportation department | Review and analyze the grievances related to transportation, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE transportation department | Reduce transportation grievances by 20% from 2015 (Goal =<10) | PACE Director | Quarterly | 12/31/2016 | 0 grievances | Continue current practices. | 4 grievances | Secure Transportati on initiated a CAP to address | 3 grievance | Small quantity of grievances overall, QI to graph # | 2 grievance | Replace metric with new focus on tracking of | 9 transportation grievances (20% reduction) | Completed |

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| QAPI Item# | Scope | Objective | Activity | Goal | Responsible Person | Reporting Frequency | Target completion | Q1 2016 Results | Q1 Action Items | Q2 2016 Results | Q2 Action Items | Q3 2016 Results | Q3 Action Items | Q4 2016 Results | Q4 Action Items | 2016 Result (Total of Qtrs, if applicable) | Completed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| QAPI14.13 | PACE Participant Satisfaction- Withdrawals and Disenrollment's | Reduce the percentage of participants who have withdrawn or have disenrolled from the PACE program within the first 90 days of enrollment. | Review and analyze the participants who have either withdrawn or disenrolled from PACE within 90 days of enrollment to developed strategies for improvement | Reduce the percentage below 10% | PACE Marketing and Enrollment Manager | Quarterly | 12/31/2016 | 25% | QI to conduct a disenrollment study. | 27% | Center Mgr to review disenrollment log reason categories and QI to determine validity of reason codes. | 38% | QI to develop an exit survey for social workers to utilize when processing voluntary disnerollments for consideration in Q1 2017. | 22% | Continue metric in 2017 work plan | 33% | Incomplete |
| QAPI14.14 | PACE Participant Satisfaction- Overall Satisfaction | Improve the overall satisfaction of participants and their families with the CalOptima PACE program | Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program | > 90% will answer 3/4 (satisfied), very satisfied (4/4) on this question. | PACE Director | Annually | 12/31/2016 | N/A | Continue Participant Satisfaction Work Plan initiated by management | N/A | Continue Participant Satisfaction Work Plan initiated by management | N/A | Continue Participant Satisfaction Work Plan initiated by management | 89% | Continue metric in 2017 work plan | 89% | Incomplete |

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# Board of Director's Quality Assurance Committee Meeting
# September 20, 2017

## PACE Member Advisory Committee (PMAC) Update

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**PMAC Meeting June 12, 2017**

- Updates from the Director
  - Staffing Update: New team members at PACE include a new physician, marketing and enrollment manager, receptionist, two (2) Personal Care Attendants and a medical records specialist. The departure of a physician, previous manager of marketing and enrollment, clinic nurse and therapy services supervisor.

- New Items Discussed
  - Splits Shifts: Staff shared the process of implementing split shifts, effective June 19. A morning and afternoon shift, with 2 lunch services per day, will be initiated to increase the capacity of the center to serve more PACE participants.
  - Mission & Values Re-Imagined: Staff are currently in the process of updating the CalOptima PACE mission and values. Members provided feedback on the top two options and were given an opportunity to explain their reasoning. Feedback was shared with staff prior to finalizing the mission.

- The following suggestions and comments were provided by PACE Participants:
  - Feedback was provided on improving the efficiency of meal service with the goal of everyone at one table being served at one time.
  - Appreciation was expressed for the 'team' model of PACE.
  - Request for field trips for participants who are unable to drive or isolated at home.
  - One participant was concerned about her access to the PCP.
  - Suggestion for PACE to have lockers for participant items.

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# HEDIS® 2017 Results

**Board of Directors' Quality Assurance Committee Meeting**
**September 20, 2017**

**Caryn Ireland**
**Executive Director, Quality and Analytics**

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# Results Compared to CalOptima Goals*

- Medi-Cal
  - **All DHCS MPLs have been met !!**
  - 25 out of 57 measures met goal (44%)
  - 41 out of 57 measures are better than last year (72%)
  - Opportunities for Behavioral Health Rates Improvement
- OneCare
  - 13 out of 21 measures met goal (62%)
  - 14 out of 21 measures are better than last year (67%)
- OneCare Connect
  - 9 out of 13 measures met goal (69%)
  - Baseline Reporting—first year of plan level HEDIS results for OCC

* Some Goals were “stretch goals” designed to move to the next highest NCQA percentile

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# HEDIS and Regulatory Reporting

- Department of Health Care Services (DHCS)
  - External Accountability Set (EAS)
  - Select Measures must achieve minimum performance level (MPL)
- Centers for Medicare & Medicaid Services (CMS)
  - Medicare/SNP Rates and Patient Level Data
  - CMS 2018 Star Rating
  - Medicare/MMP Rates and Patient Level Data (first year for OCC submission)
- National Committee for Quality Assurance (NCQA)
  - Accreditation score (HEDIS 37 points, CAHPS 13 points)
  - National Health Plan Ratings
  - Quality Compass

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# HEDIS Regulatory Reporting

- 6 reports (IDSS) submitted to NCQA
- Patient Level Detail (PLD) files for Medicare and Medicaid submitted to CMS and NCQA respectively

  49 measures (nearly half of required measures) required medical record review

  ➢12,084 chart reviews
    - Medi-Cal – 21 measures with 6,876 chart reviews
    - OneCare – 14 measures with 1,726 chart reviews
    - OneCare Connect – 14 measures with 3,482 chart reviews

- **Medical record retrieval rate of 98.12%--this is excellent!**

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# Medi-Cal Measure Results

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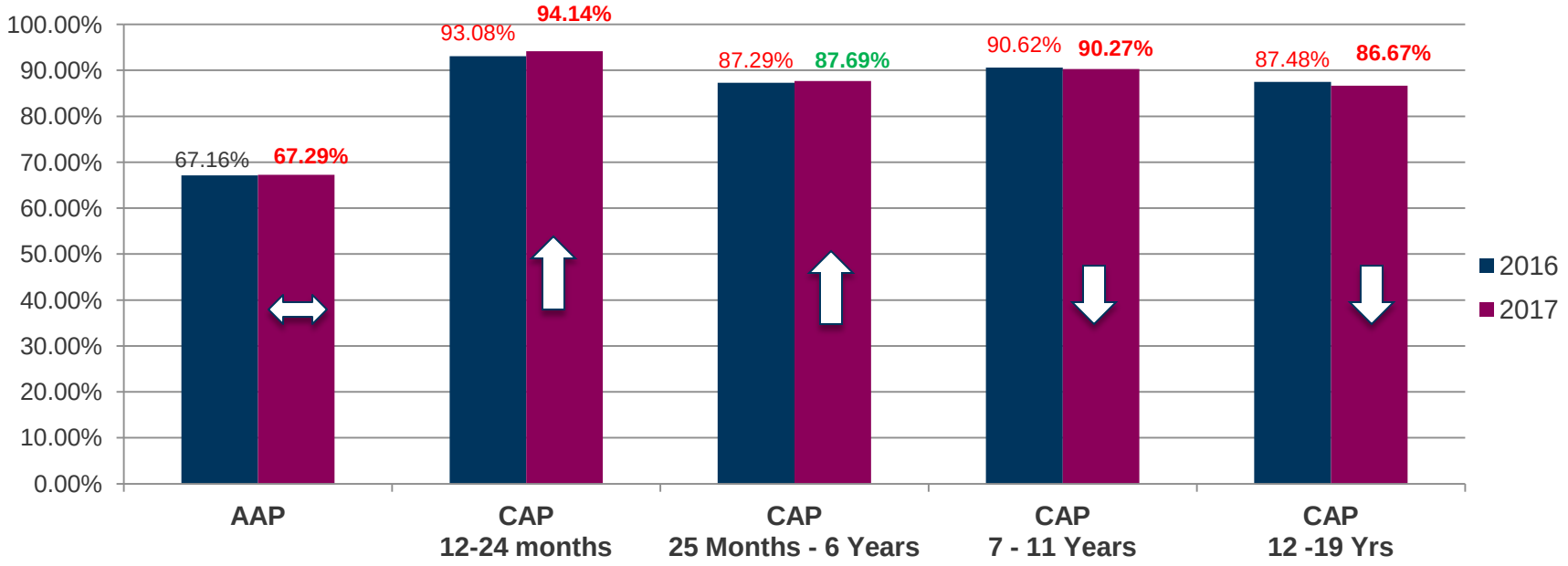
# HEDIS 2017 Results: Medi-Cal
# Annual Visits to PCP's (Under Performing)




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| **Adult's Access to Preventive/Ambulatory Health Services (AAP)** | 82.15% | 85.50% | 87.58% | 82.15% | P4V |
| **Children's Access to Primary Care Practitioners (CAP)** | | | | | |
| 12 - 24 Months | 95.74% | 97.28% | 97.85% | 95.74% | P4V |
| 25 Months - 6 Years | 87.69% | 90.98% | 93.34% | **87.69%** | P4V |
| 7 - 11 Years | 91.00% | 93.25% | 96.10% | 91.00% | P4V |
| 12 -19 Years | 89.37% | 92.67% | 94.69% | 89.37% | P4V |

***Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference**

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

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# Children and Women's Health

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# HEDIS 2017 Results: Medi-Cal Well Child Visits


| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements** |
|---|---|---|---|---|---|
| Well-Child Visits in the First 15 Months of Life - Six Well Child Visits (W15) | 59.57% | 67.76% | 73.88% | 59.57% | RS |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) | 71.42% | 77.57% | 82.97% | 80.27% | MPL, P4V, RS |
| Adolescent Well-Care Visits (AWC) | 48.41% | 57.66% | 66.04% | 55.47% | P4V, RS |

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

↑ ↓ statistically higher or lower ↔ statistically no difference

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

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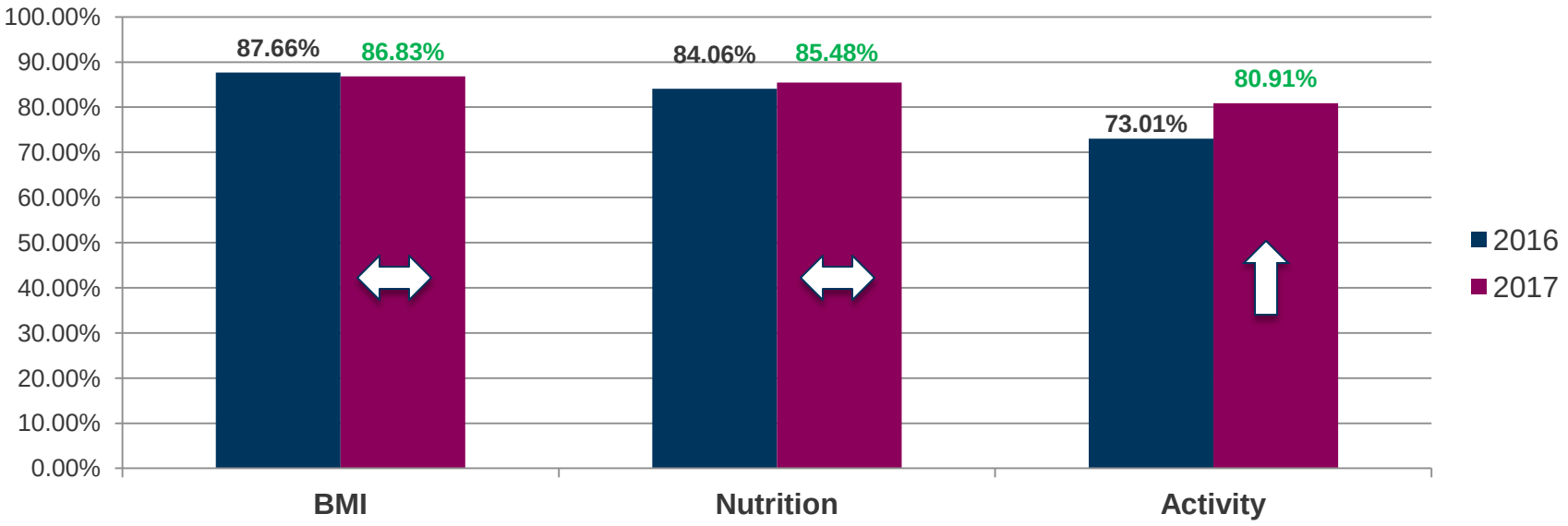
# HEDIS 2017 Results: Medi-Cal Weight Assessment and Counseling




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements* * |
|---|---|---|---|---|---|
| BMI Percentile (WCC) | 67.54% | 77.78% | 86.37% | 86.37% | ACC, MPL, RS |
| Counseling for Nutrition (WCC) | 62.65% | 70.88% | 79.52% | 79.52% | ACC, MPL, RS |
| Counseling for Physical Activity (WCC) | 55.38% | 63.47% | 71.58% | 71.58% | ACC, MPL, RS |

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

↑ ↓ statistically higher or lower ↔ statistically no difference

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

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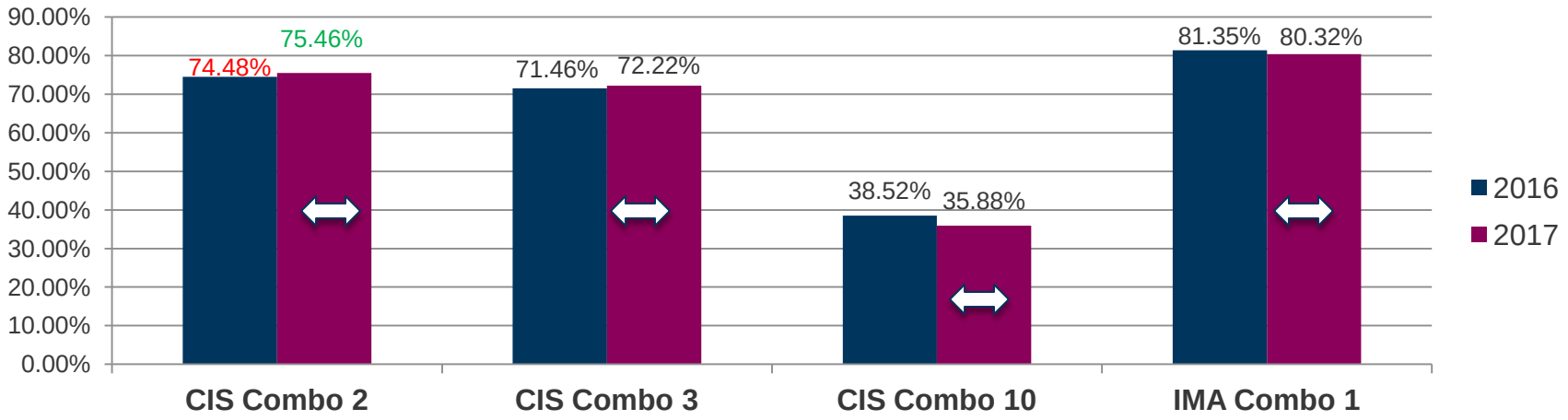
# HEDIS 2017 Results: Medi-Cal Immunizations




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements** |
|---|---|---|---|---|---|
| **Childhood Immunization Status (CIS)** | | | | | |
| CIS - combo 2 | 75.18% | 78.59% | 82.88% | 75.18% | ACC |
| CIS - combo 3 | 71.06% | 75.60% | 79.81% | 73.72% | MPL |
| CIS - combo10 ++ | 32.64% | 40.91% | 46.47% | 40.91% | ACC, P4V, RS |
| **Immunizations for Adolescents (IMA)** | | | | | |
| IMA - Combo 1 ++ | 74.52% | 82.09% | 86.57% | 82.09% | ACC, MPL, RS |

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

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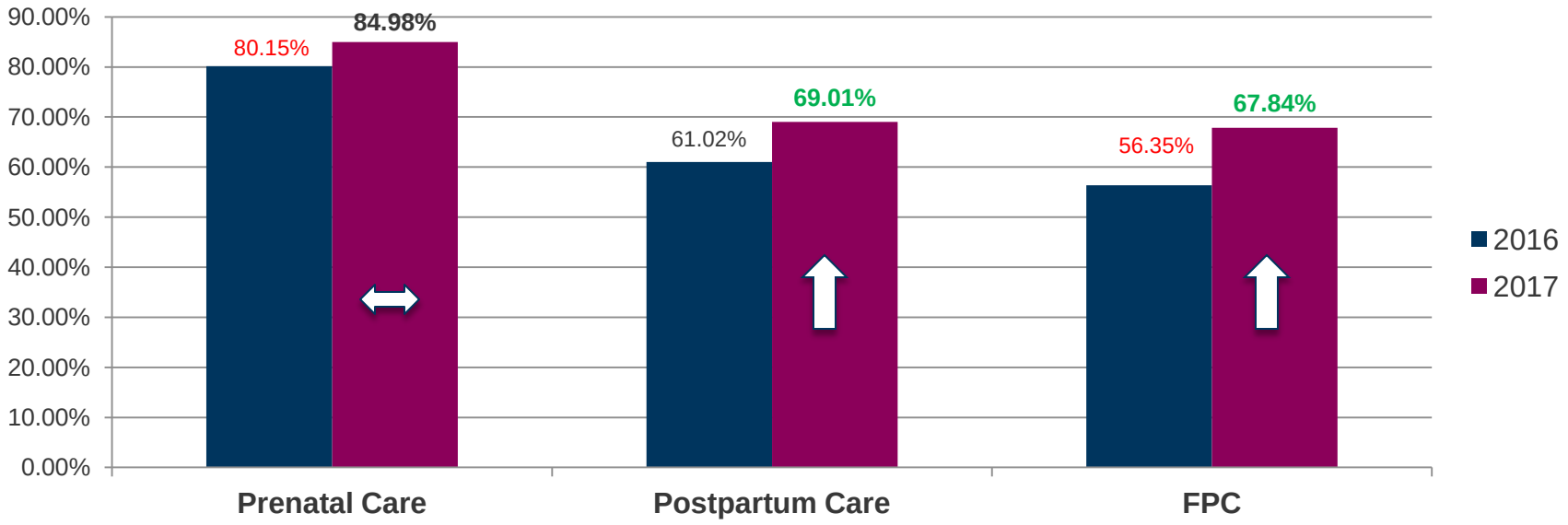
# HEDIS 2017 Results: Medi-Cal Prenatal and Postpartum Care




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements** |
|---|---|---|---|---|---|
| **Prenatal Care and Postpartum Care (PPC)** | | | | | |
| Prenatal Care | 82.25% | 87.56% | 91.00% | **85.57%** | ACC, **MPL**, RS |
| Postpartum Care | 60.98% | 67.53% | 73.61% | **65.96%** | ACC, **MPL**, RS |
| **Frequency of Prenatal Care (FPC) >=81%** | 59.26% | 69.54% | 75.77% | **59.26%** | ACC, RS |

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

**↑ ↓ statistically higher or lower ↔ statistically no difference**

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

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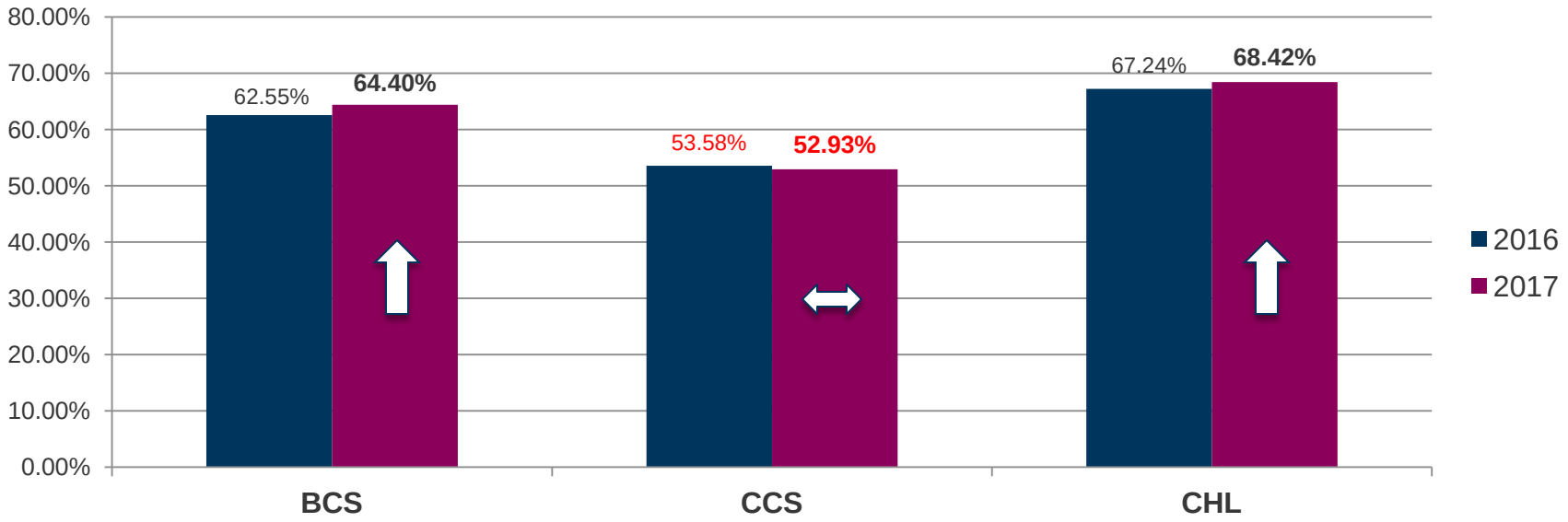
# HEDIS 2017 Results: Medi-Cal Women's Health




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| Breast Cancer Screening (BCS) | 58.08% | 65.30% | 71.52% | 65.30% | ACC, P4V, RS |
| Cervical Cancer Screening (CCS) | 55.94% | 63.88% | 69.95% | 55.94% | ACC, MPL, P4V, RS |
| Chlamydia Screening (CHL) | 55.16% | 61.63% | 68.92% | 68.92% | ACC, RS |

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

**↑ ↓ statistically higher or lower ↔ statistically no difference**

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

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# Care for Chronic Conditions

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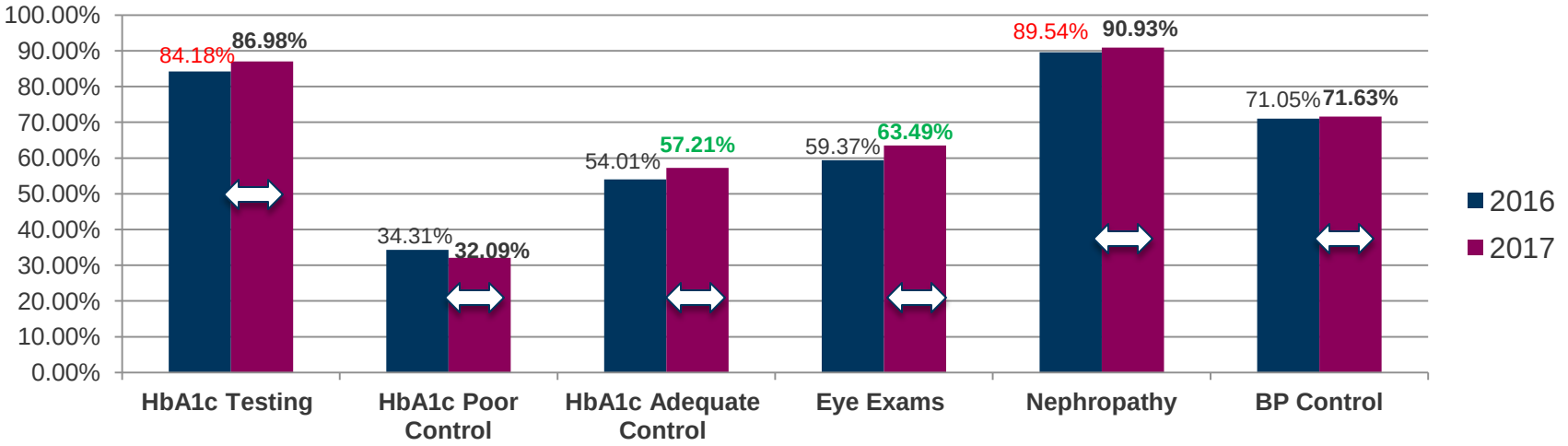
# HEDIS 2017 Results: Medi-Cal Comprehensive Diabetes Care




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| HbA1c Testing | 85.95% | 89.42% | 92.88% | 88.08% | ACC, , MPL, P4V |
| HbA1c Poor Control (>9.0%) (Lower is better) | 43.80% | 36.87% | 29.23% | 29.23% | ACC, , MPL |
| HbA1c Adequate Control (<8.0%) ++ | 46.76% | 52.55% | 58.39% | 55.47% | ACC, , MPL, RS |
| Eye Exams | 53.28% | 61.50% | 68.11% | 61.50% | ACC, , MPL, P4V, RS |
| Nephropathy Monitoring | 90.51% | 91.97% | 93.56% | 91.20% | ACC, , MPL, RS |
| BP Control (<140/90) ++ | 59.73% | 68.61% | 75.73% | 72.17% | ACC, , MPL, RS |

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

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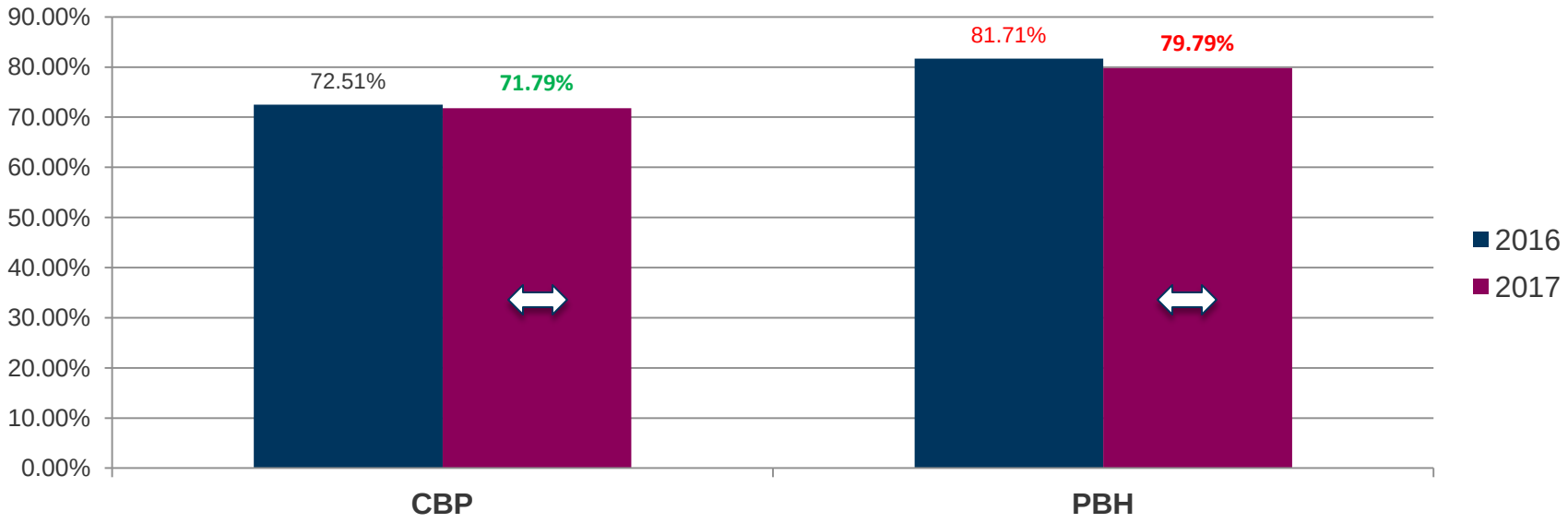
# HEDIS 2017 Results: Medi-Cal Cardiovascular Conditions




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| Controlling High-Blood Pressure (CBP) ++ | 54.78% | 63.99% | 70.69% | 70.69% | ACC, MPL, RS |
| Persistence of Beta Blocker Treatment after a Heart Attack (PBH) | 83.06% | 88.30% | 91.67% | 83.06% | RS |

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

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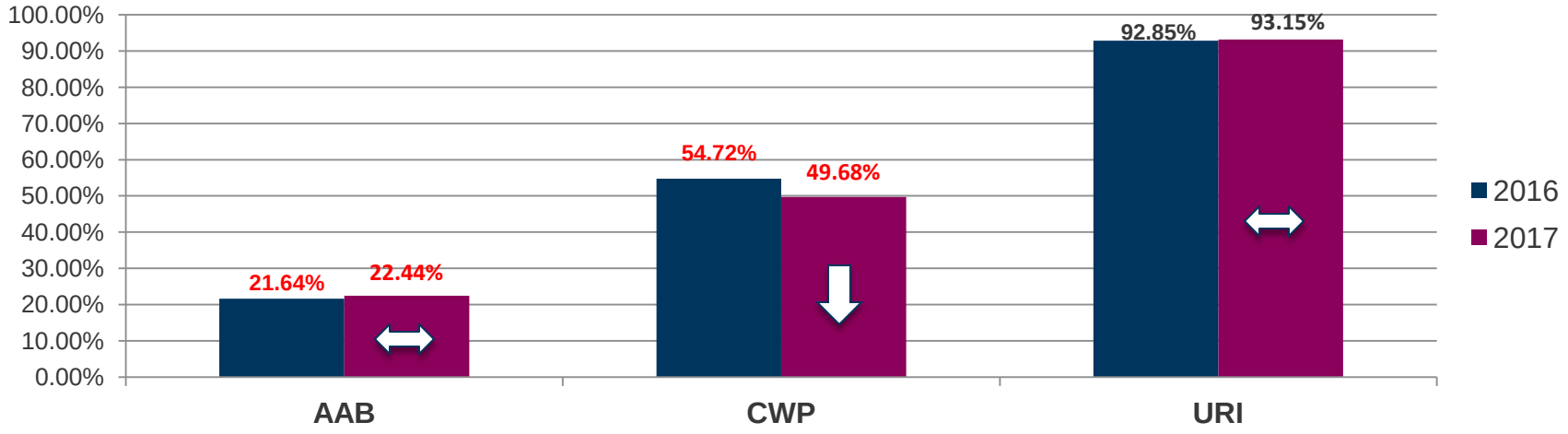
# HEDIS 2017 Results: Medi-Cal Respiratory Conditions




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) | 26.17% | 32.51% | 38.91% | 22.12% | ACC, MPL, RS |
| Appropriate Testing for Children with Pharyngitis (CWP) | 71.62% | 81.01% | 86.59% | 63.24% | ACC, P4V, RS |
| Appropriate Treatment for Children with Upper Respiratory Infection (URI) | 89.39% | 93.38% | 96.08% | 93.38% | ACC, P4V, RS |

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

↑ ↓ statistically higher or lower ↔ statistically no difference

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

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# Behavioral Health

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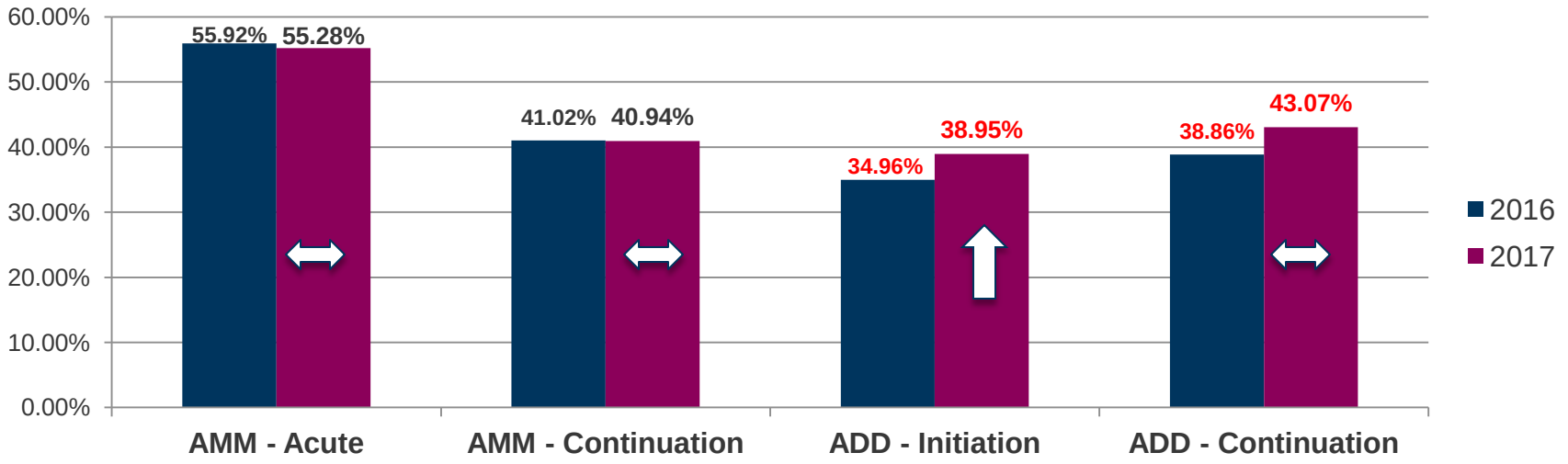
# HEDIS 2017 Results: Medi-Cal Behavioral Health




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| Antidepressant Medications Management (AMM) - Acute Phase Treatment | 53.38% | 59.52% | 67.57% | 59.52% | ACC, RS |
| Antidepressant Medications Management (AMM) - Continuation Phase Treatment | 38.06% | 43.39% | 54.30% | 43.39% | ACC |
| Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase | 42.19% | 49.55% | 55.48% | 49.55% | ACC, RS |
| Follow-up Care for Children Prescribed ADHD Medication (ADD) - Continuation Phase | 52.47% | 62.50% | 67.23% | 62.50% | ACC |

*Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference

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

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# OneCare Results

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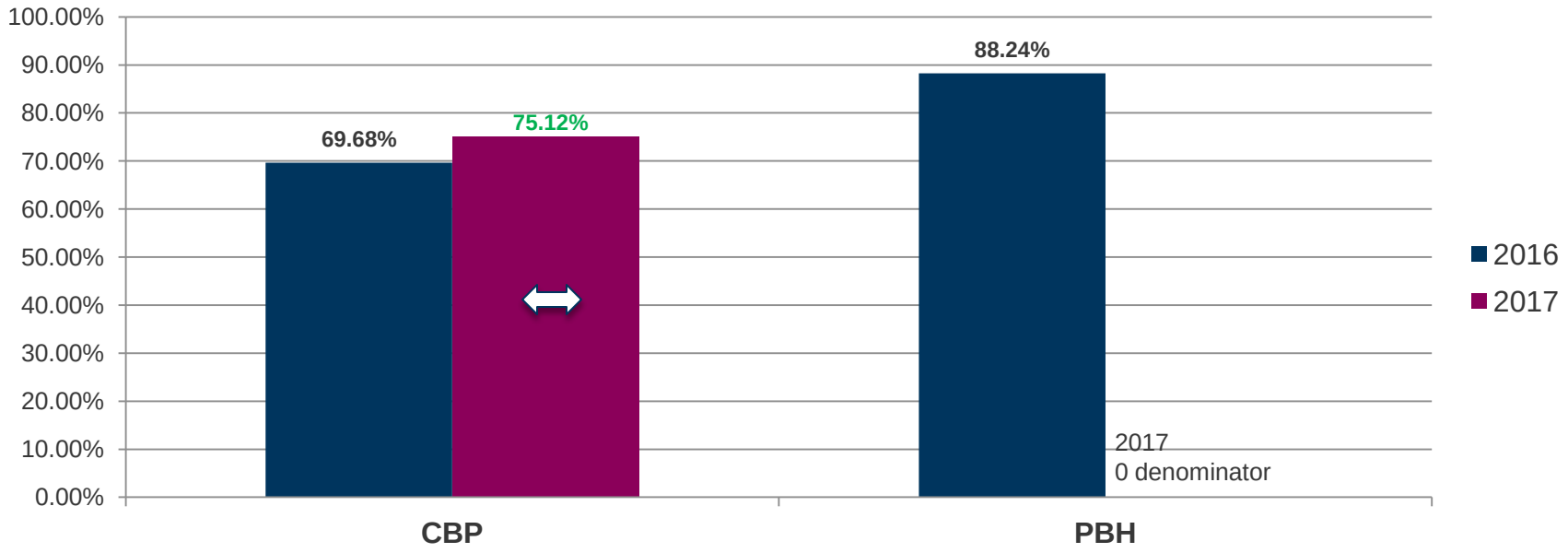
# HEDIS 2017 Results: OneCare Cardiovascular Conditions




| HEDIS Measure | 3-Star/ 50th percentile | 4-Star/ 75th percentile | 5-Star/ 90th percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| Controlling High-Blood Pressure** | 56% | 64% | 75% | 75.00% | Star |
| Persistence of Beta Blocker Treatment after a Heart Attack | 91.45% | 94.50% | 97.26% | 88.24% | CMS |

*Red = less than 3-Star or 50th percentile, Green= met goal

↑ ↓ statistically higher or lower ↔ statistically no difference ** Triple weighted for STARS

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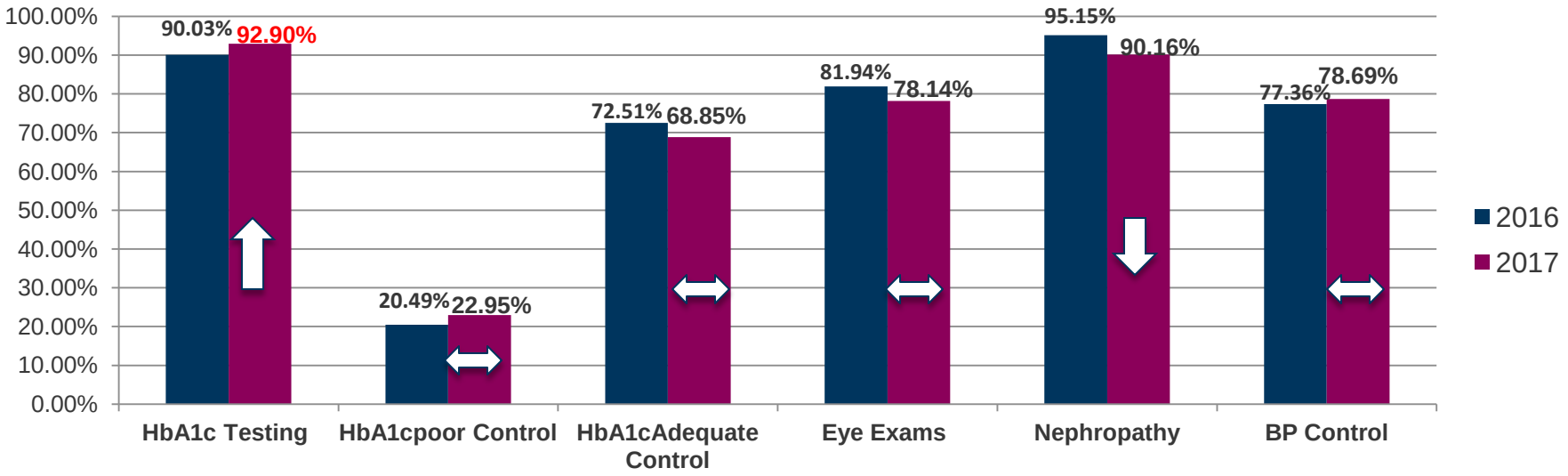
# HEDIS 2017 Results: OneCare Comprehensive Diabetes Care




| HEDIS Measure | 3-Star/ 50th percentile | 4-Star/ 75th percentile | 5-Star/ 90th percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| **Comprehensive Diabetes Care (CDC)** | | | | | |
| **1. HbA1c Testing** | 93.90% | 95.62% | 97.08% | **91.39%** | CMS |
| **2. HbA1c Poor Control (>9.0%) **** | 38% | 24% | 16% | 16% | **Star** |
| **3. HbA1c Adequate Control (<8.0%)** | 66.07% | 72.75% | 76.72% | 72.75% | CMS |
| **4. Eye Exams** | 57% | 75% | 87% | 81% | **Star** |
| **5. Nephropathy Monitoring** | 56% | 74% | 86% | 96% | **Star** |
| **6. B/P <140/90** | 59% | 75% | 88% | 79.32% | **Star** |

***Red = less than 3-Star or 50th percentile, Green= met goal**

**↑ ↓ statistically higher or lower ↔ statistically no difference  **Triple weighted for STARS**

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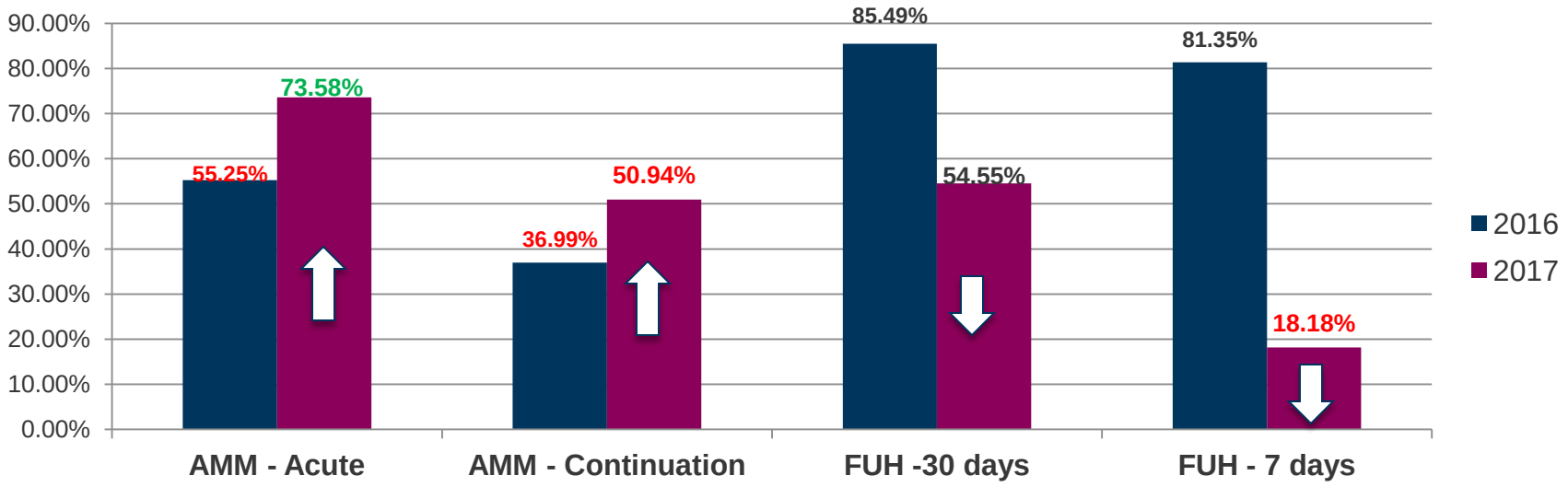
# HEDIS 2017 Results: OneCare Behavioral Health




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| **Antidepressant Medications Management (AMM) - Acute Phase Treatment** | 69.47% | 75.15% | 82.77% | **64.09%** | CMS |
| **Antidepressant Medications Management (AMM) - Continuation Phase Treatment** | 55.26% | 61.02% | 72.25% | **48.36%** | CMS |
| **Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days** | 49.81% | 65.70% | 76.19% | 76.19% | CMS |
| **Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days** | 30.80% | 42.86% | 57.95% | 57.95% | CMS |

***Red =less than 3-Star or 50th percentile, Green= met goal**

**↑ ↓ statistically higher or lower ↔ statistically no difference**

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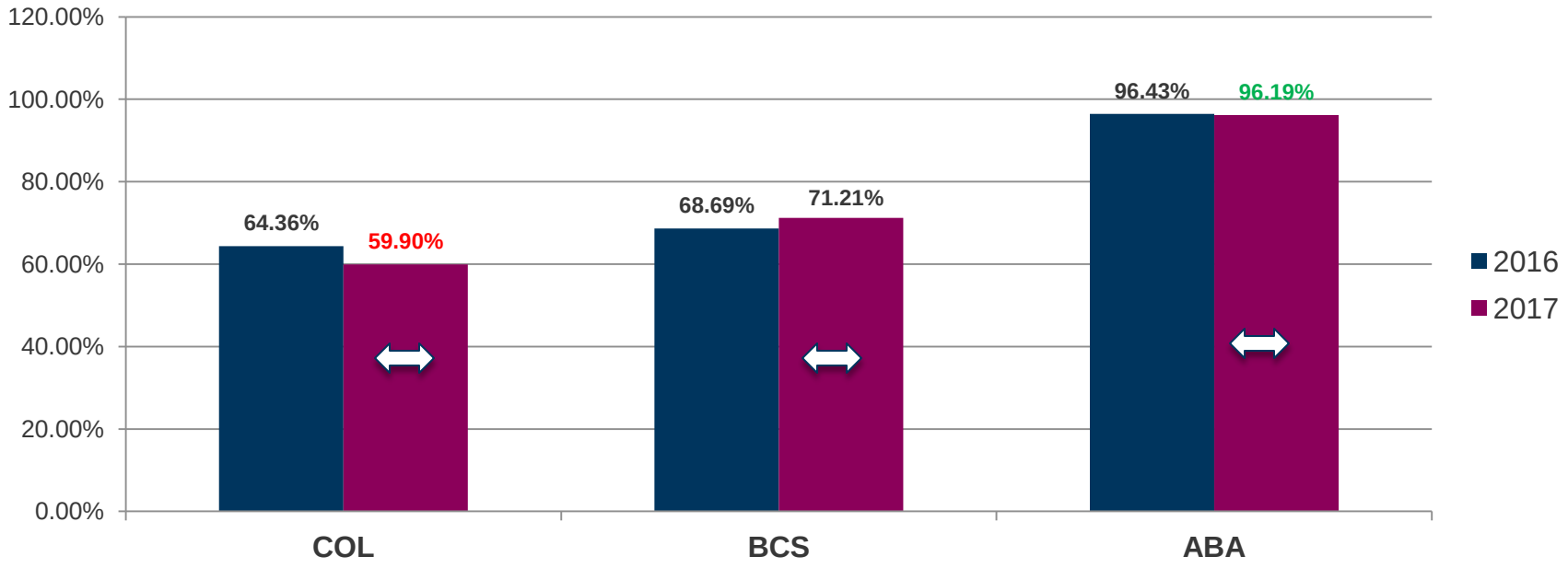
# HEDIS 2017 Results: OneCare Prevention and Screening




| HEDIS Measure | 3-Star | 4-Star | 5-Star | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| Colorectal Cancer Screening (COL) | 62% | 71% | 81% | 71% | Star |
| Breast Cancer Screening (BCS) | 63% | 69% | 76% | 69% | Star |
| Adult BMI Assessment (ABA) | 63% | 87% | 96% | 96% | Star |

***Red = less than 3-Star or 50th percentile, Green= met the goal**

**↑ ↓ statistically higher or lower ↔ statistically no difference**

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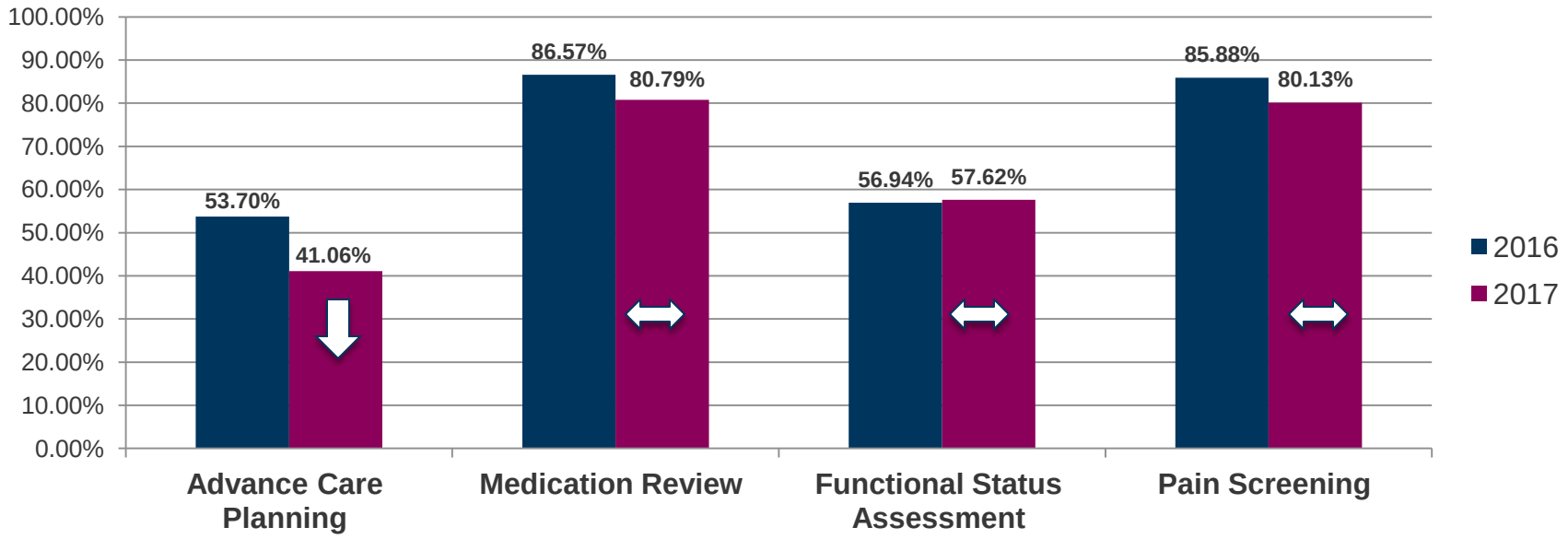
# HEDIS 2017 Results: OneCare
# Care for Older Adults




| HEDIS Measure | 3-Star | 4-Star | 5-Star | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| Care for Older Adults (COA) | | | | | |
| 1. Advance Care Planning | | | | | CMS |
| 2. Medication Review | 57% | 75% | 87% | 87% | Star |
| 3. Functional Status Assessment | 56% | 74% | 86% | 74% | Star |
| 4. Pain Screening | 59% | 75% | 88% | 88% | Star |

***Red = less than 3-Star or 50th percentile ↑ ↓ statistically higher or lower ↔ statistically no difference**

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# OneCare Connect Results
# 1st Year Baseline

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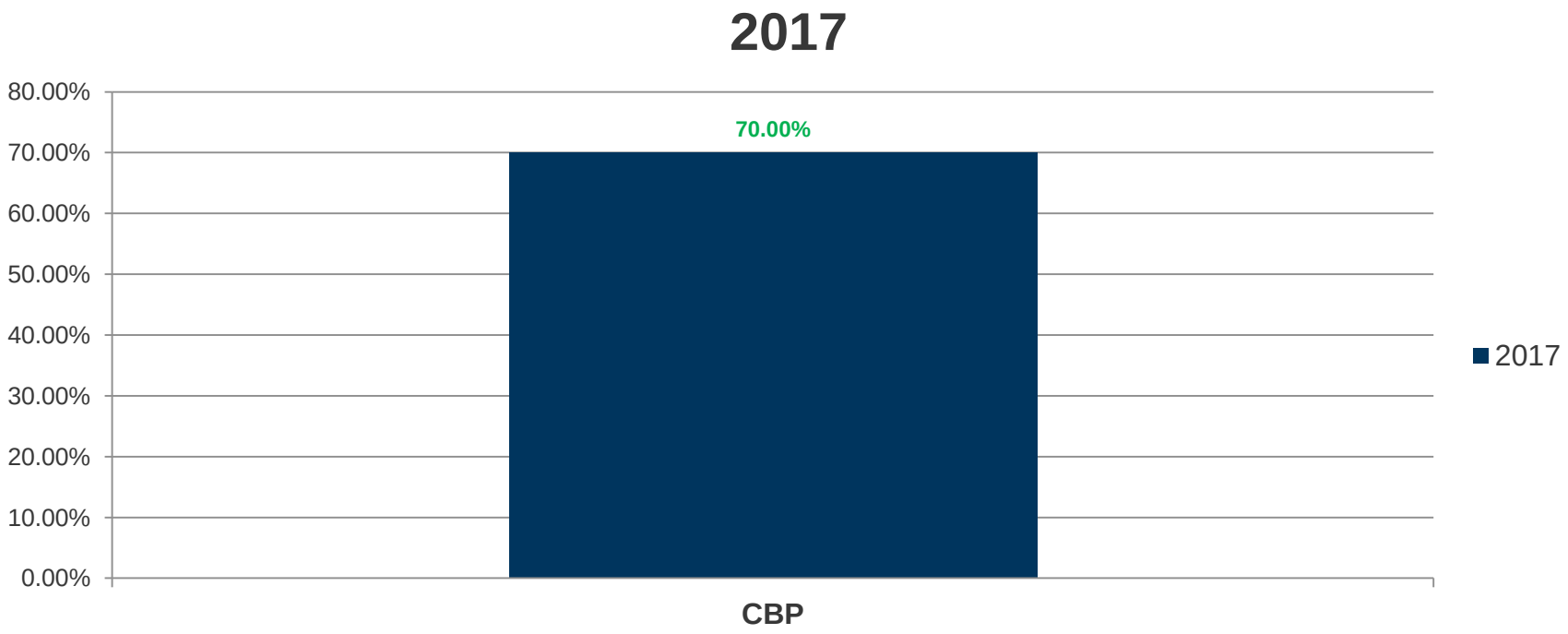
# HEDIS 2017 Results: OneCare Connect Controlling Blood Pressure




| HEDIS Measure | 3-Star/ 50th percentile | 4-Star/ 75th percentile | 5-Star/ 90th percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| Controlling High-Blood Pressure** | 56% | 64% | 75% | 56% | Star, P4V, Withhold |

*Red = less than 3-Star or 50th percentile, Green= met goal

** Triple weighted for STARS

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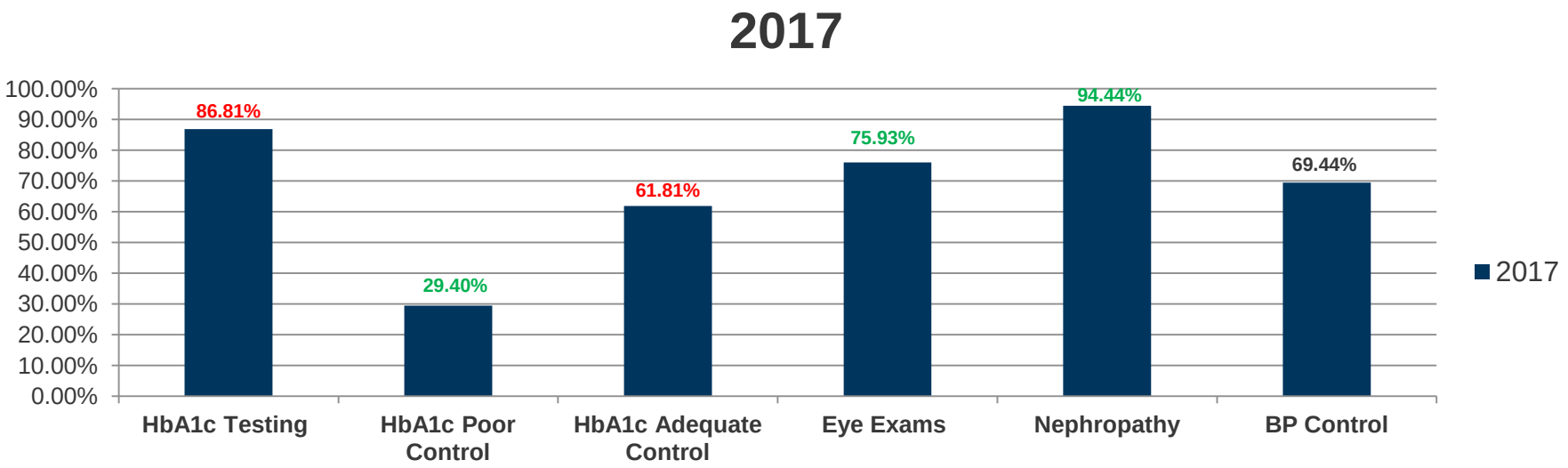
# HEDIS 2017 Results: OneCare Connect Comprehensive Diabetes Care




| HEDIS Measure | 3-Star/ 50th percentile | 4-Star/ 75th percentile | 5-Star/ 90th percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| **Comprehensive Diabetes Care (CDC)** | | | | | |
| **1. HbA1c Testing** | 93.90% | 95.62% | 97.08% | 93.90% | CMS |
| **2. HbA1c Poor Control (>9.0%) **** | 38% | 24% | 16% | **38%** | **Star** |
| **3. HbA1c Adequate Control (<8.0%)** | 66.07% | 72.75% | 76.72% | 66.07% | CMS |
| **4. Eye Exams** | 57% | 75% | 87% | **57%** | **Star** |
| **5. Nephropathy Monitoring** | 56% | 74% | 86% | **56%** | **Star** |
| **6. BP Control** | 59% | 75% | 88% | **59%** | **Star** |

***Red = less than 3-Star or 50th percentile, Green= met goal**

****Triple weighted for STARS**

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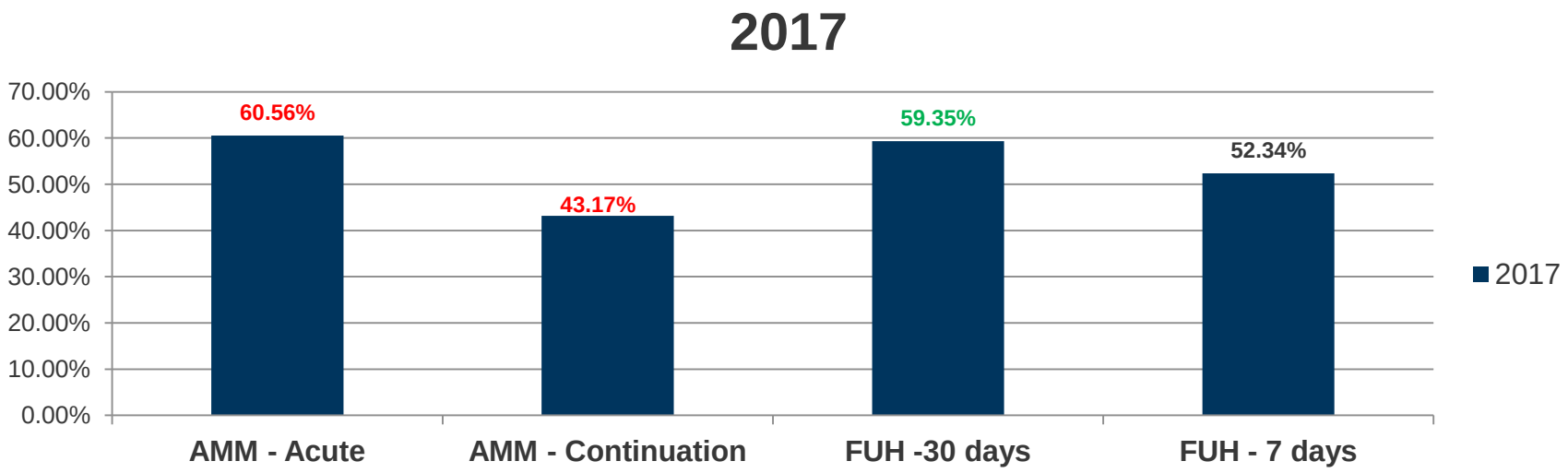
# HEDIS 2017 Results: OneCare Connect Behavioral Health




| HEDIS Measure | NCQA 50th Percentile | NCQA 75th Percentile | NCQA 90th Percentile | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| **Antidepressant Medications Management (AMM) - Acute Phase Treatment** | 69.47% | 75.15% | 82.77% | | **P4V** |
| **Antidepressant Medications Management (AMM) - Continuation Phase Treatment** | 55.26% | 61.02% | 72.25% | | **P4V** |
| **Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days ++** | 49.81% | 65.70% | 76.19% | **56%** | CMS, Withhold |
| **Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days ++** | 30.80% | 42.86% | 57.95% | 56% | CMS, Withhold |

***Red =less than 3-Star or 50th percentile, Green= met goal ++ Quality Withhold measure**

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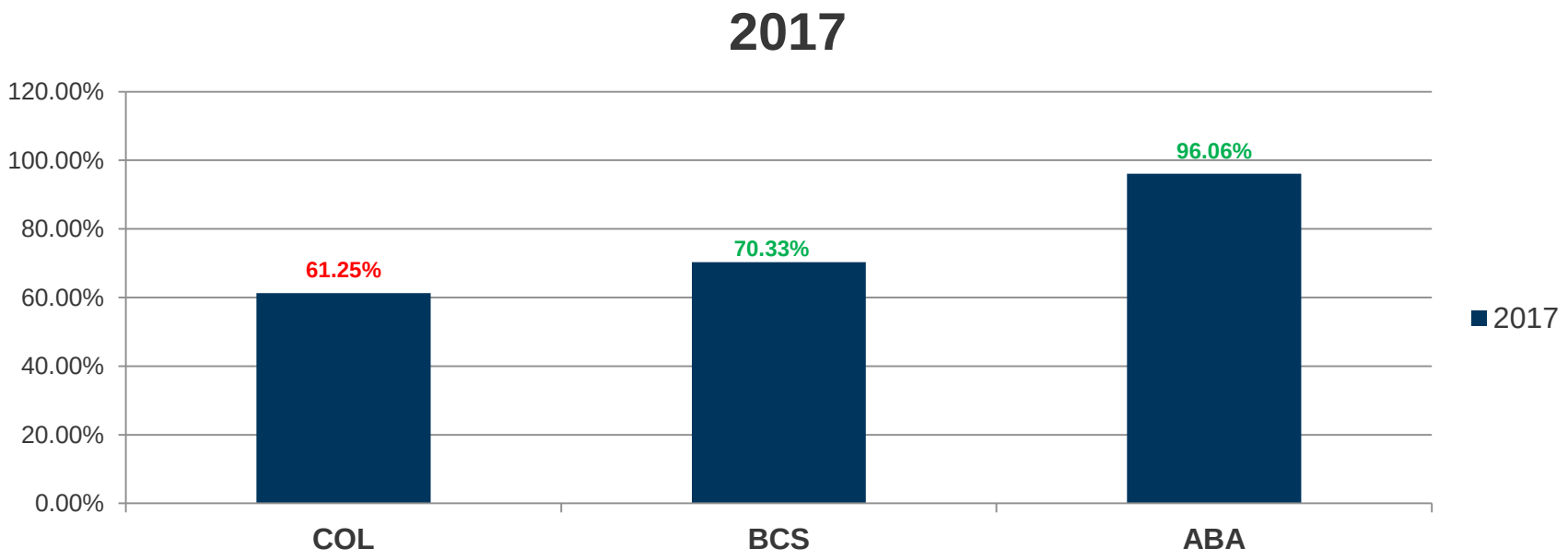
# HEDIS 2017 Results: OneCare Connect Prevention and Screening




| HEDIS Measure | 3-Star | 4-Star | 5-Star | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| Colorectal Cancer Screening (COL) | 62% | 71% | 81% | 62% | Star |
| Breast Cancer Screening (BCS) | 63% | 69% | 76% | 63% | Star |
| Adult BMI Assessment (ABA) | 63% | 87% | 96% | 63% | Star |

*Red = less than 3-Star or 50th percentile, Green= met goal

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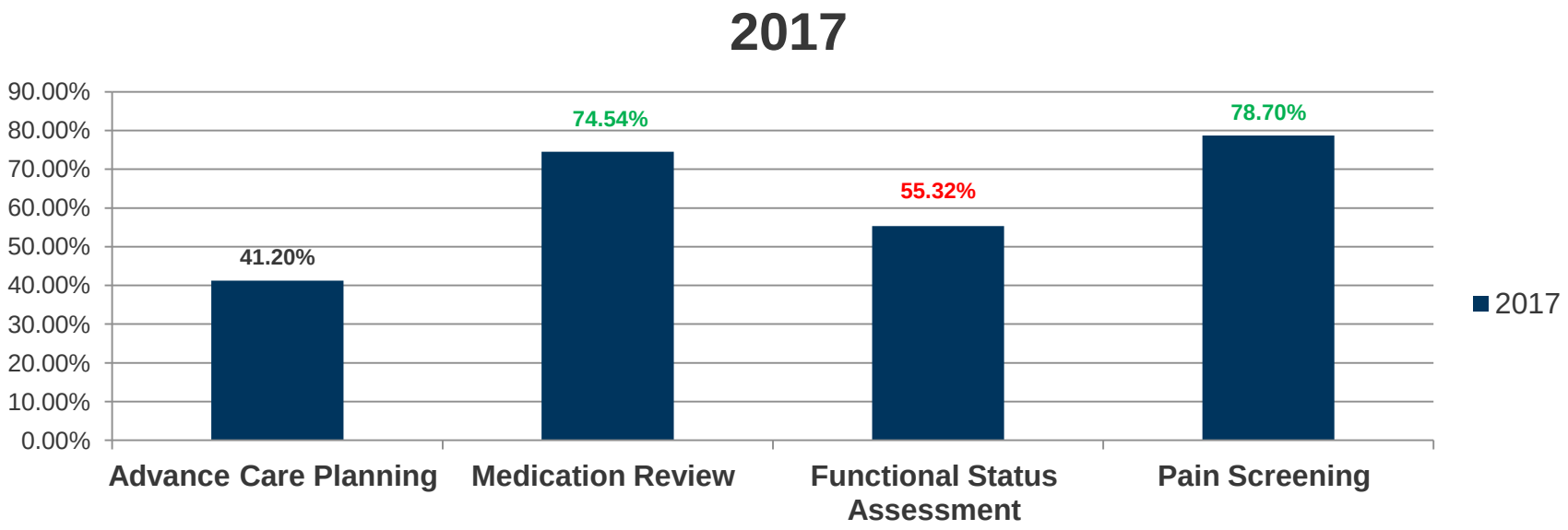
# HEDIS 2017 Results: OneCare Connect Care for Older Adults




| HEDIS Measure | 3-Star | 4-Star | 5-Star | Goal | Reporting Requirements* |
|---|---|---|---|---|---|
| Care for Older Adults (COA) | | | | | |
| 1. Advance Care Planning | | | | | CMS |
| 2. Medication Review | 57% | 75% | 87% | 57% | Star |
| 3. Functional Status Assessment | 56% | 74% | 86% | 56% | Star |
| 4. Pain Screening | 59% | 75% | 88% | 59% | Star |

*Red = less than 3-Star or 50th percentile, Green = met goal

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# Member Experience (CAHPS)

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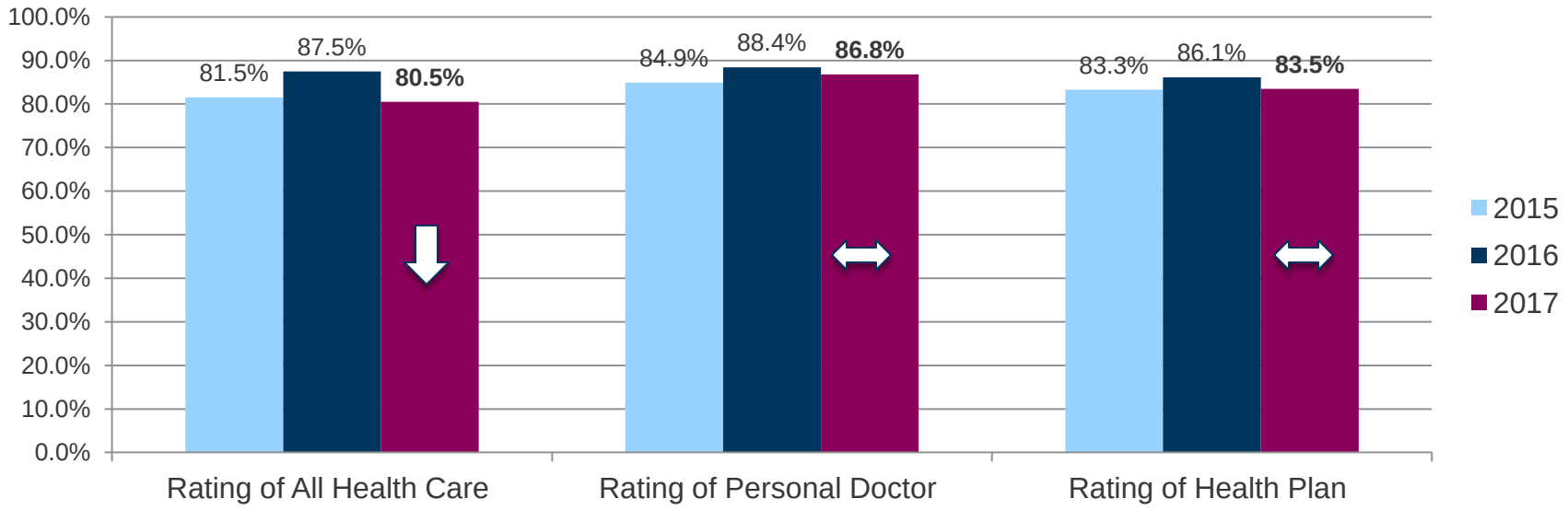
# CAHPS Child Member Survey Results

## (Parents Satisfaction with Their Child's Care)




| NCQA Accreditation 3-point score | CalOptima 2016 | CalOptima 2017 | 25th Percentile | 50th Percentile | 75th Percentile | 90th Percentile |
|---|---|---|---|---|---|---|
| Rating of All Health Care | 2.61 | 2.49 | 2.49 | 2.52 | 2.57 | 2.59 |
| Rating of Personal Doctor | 2.69 | 2.62 | 2.58 | 2.62 | 2.65 | 2.67 |
| Rating of Health Plan | 2.64 | 2.54 | 2.51 | 2.57 | 2.62 | 2.67 |

*Red = less than 25th percentile, Yellow = 25th percentile, Pink = 50th percentile,
Blue = 75th percentile, Green = 90th percentile ↑ ↓ statistically higher or lower ↔ statistically no difference

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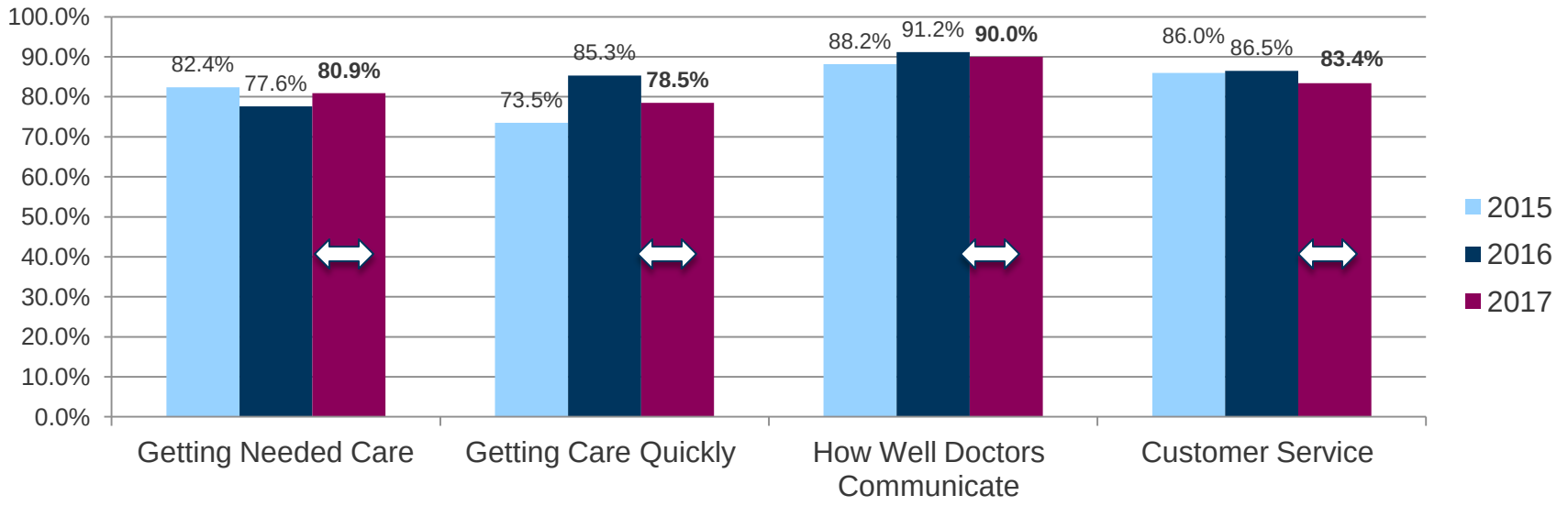
# CAHPS Child Member Survey Results

## (Parents Satisfaction with Their Child's Care)




| NCQA Accreditation 3-point score | CalOptima 2016 | CalOptima 2017 | 25th Percentile | 50th Percentile | 75th Percentile | 90th Percentile |
|---|---|---|---|---|---|---|
| **Getting Care Needed** | **2.25** | **2.24** | 2.37 | 2.46 | 2.51 | 2.56 |
| **Getting Care Quickly** | **2.45** | **2.33** | 2.54 | 2.61 | 2.66 | 2.69 |
| **How Well Doctors Communicate** | **2.61** | **2.58** | 2.63 | 2.68 | 2.72 | 2.75 |
| **Customer Service** | **2.48** | **2.41** | 2.50 | 2.53 | 2.58 | 2.63 |

***Red = less than 25th percentile, Yellow = 25th percentile, Pink = 50th percentile,**
**Blue = 75th percentile, Green = 90th percentile ↑ ↓ statistically higher or lower ↔ statistically no difference**

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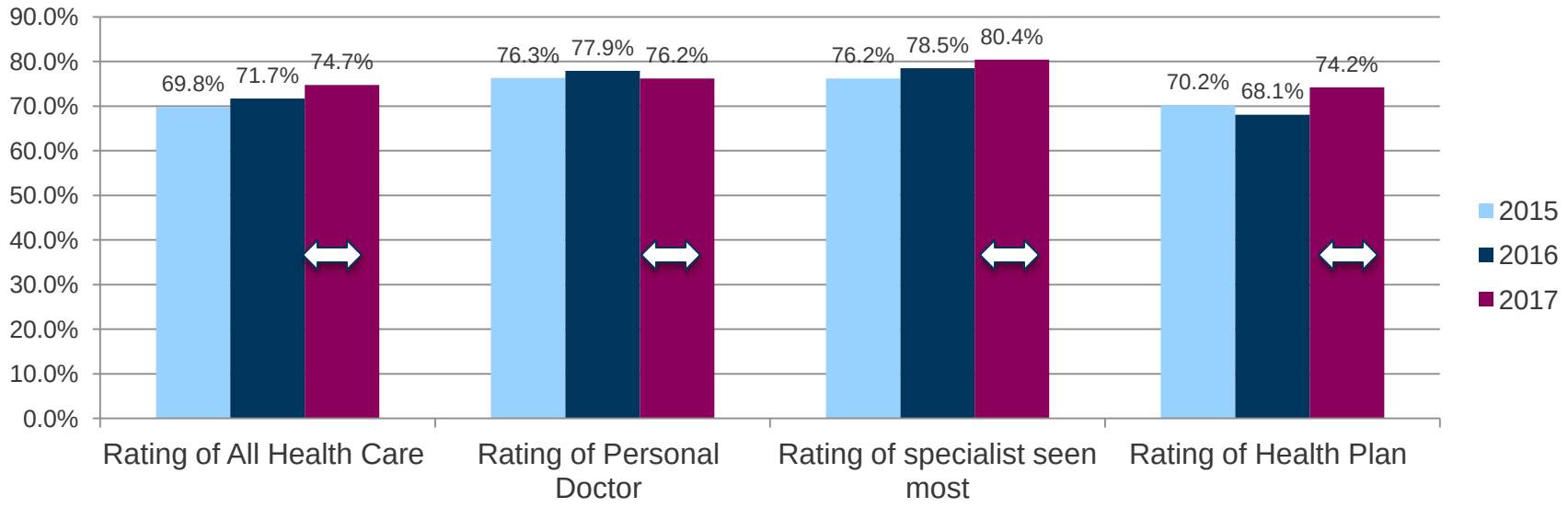
# CAHPS Adult Member Survey Results




| NCQA Accreditation 3-point score | CalOptima 2017 | 25th Percentile | 50th Percentile | 75th Percentile | 90th Percentile |
|---|---|---|---|---|---|
| Rating of All Health Care | 2.38 | 2.32 | 2.38 | 2.43 | 2.46 |
| Rating of Personal Doctor | 2.43 | 2.43 | 2.50 | 2.53 | 2.57 |
| Rating of Specialist Seen Most | 2.44 | 2.48 | 2.51 | 2.56 | 2.59 |
| Rating of Health Plan | 2.40 | 2.35 | 2.43 | 2.48 | 2.53 |

*Red = less than 25th percentile, Yellow = 25th percentile, Pink = 50th percentile,
Blue = 75th percentile, Green = 90th percentile ↑ ↓ statistically higher or lower ↔ statistically no difference

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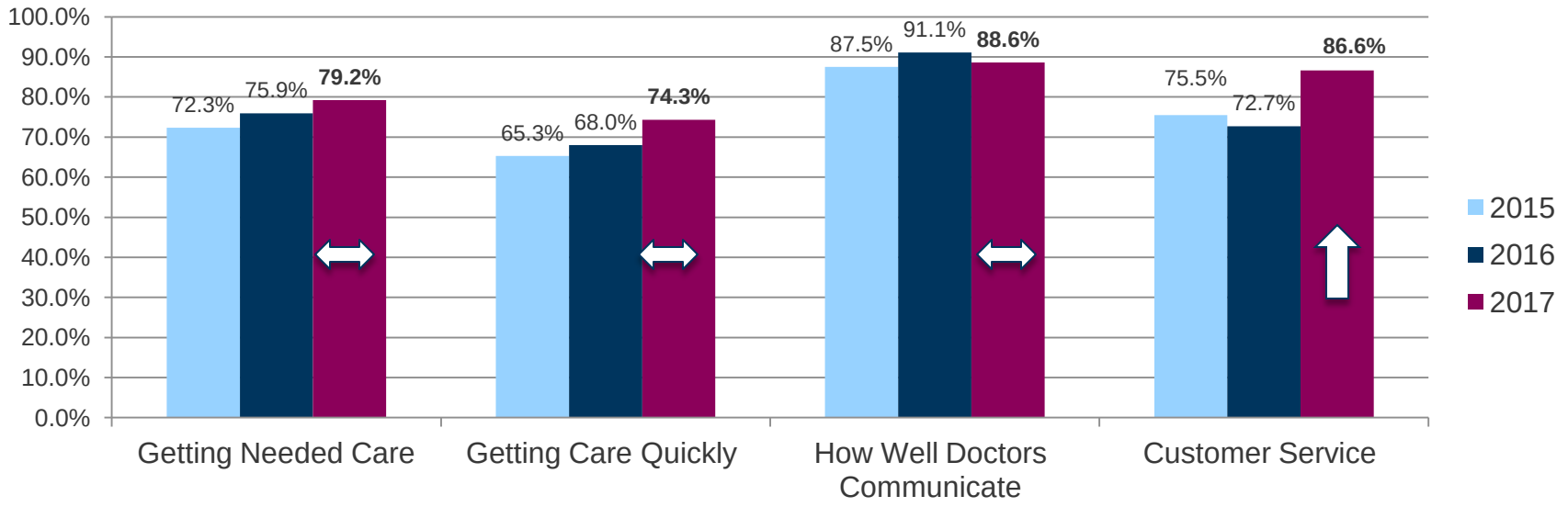
# CAHPS Adult Member Survey Results




| NCQA Accreditation 3-point score | CalOptima 2017 | 25th Percentile | 50th Percentile | 75th Percentile | 90th Percentile |
|---|---|---|---|---|---|
| **Getting Care Needed** | **2.13** | 2.28 | 2.35 | 2.41 | 2.45 |
| **Getting Care Quickly** | **2.30** | 2.33 | 2.40 | 2.45 | 2.49 |
| **How Well Doctors Communicate** | **2.55** | 2.48 | 2.54 | 2.58 | 2.64 |
| **Customer Service** | **2.48** | 2.48 | 2.54 | 2.58 | 2.61 |

***Red = less than 25th percentile, Yellow = 25th percentile, Pink = 50th percentile, Blue = 75th percentile, Green = 90th percentile ↑ ↓ statistically higher or lower ↔ statistically no difference**

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# Next Steps

- Implement strategies on low performing areas
  - Priority areas will include low areas of performance and areas related to strategic initiatives (DHCS MPL, NCQA Accreditation, NCQA Health Plan Ratings, OneCare Star Rating)
- Results presented to QIC, PAC, OCC MAC
- NCQA  Accreditation Status
- NCQA  Health Plan Ratings
- Calculate 2016 P4V payments
- Prepare for HEDIS 2018!

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# Mission Statement

The mission of CalOptima is to provide members with access to **quality health care** services delivered in a cost-effective and compassionate manner.

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# Behavioral Health Integration Update

**Board of Directors' Quality Assurance Committee Meeting**
**September 20, 2017**

**Richard Helmer, M.D., Chief Medical Officer**
**Donald Sharps, M.D., Behavioral Health Integration**

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# Topics of Discussion

- Customer Service
  - Call Center Metrics
  - CalOptima  Audit of Call Center update
- Utilization Management Trends
- Drug Medi-Cal (DMC) update
- Interdisciplinary Care Teams
- Performance Guarantees
- NCQA status

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# Call Center Metrics (Medi-Cal)

| | Goal | 2016 Monthly Avg* | Q1 | Q2 |
|---|---|---|---|---|
| **Incoming Calls monthly average** | | 3,956 | 3,054 | 4,567 |
| **Average speed To Answer** | **<30 sec** | 28 | 21 | 14 |
| **Percentage of calls Abandoned** | **<5%** | 2% | 2.5% | 1.60% |
| **Percent answered within 30 sec** | **≥ 80%** | 85% | 86.6% | 91.80% |

After 5:30pm calls – 173 / mo (avg 1st 8 months)

*data source DOC 12/2016 Beacon

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# Call Center Metrics (OC/OCC)

| | Goal | 2016 Monthly Avg* | Q1 | Q2 |
|---|---|---|---|---|
| **Incoming Calls monthly average** | | 307 | 756 | 328 |
| **Average speed To Answer** | **<30 sec** | 17 | 18 | 9 |
| **Percentage of calls Abandoned** | **<5%** | 2% | 2.8% | 1.0% |
| **Percent answered within 30 sec** | **≥ 80%** | 88% | 88% | 94.3% |

After 8:00pm calls – 49 / mo (avg 1st 8 months)

*data source DOC 12/2016 Windstone

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# CalOptima Audit of Magellan Customer Service

- CalOptima Customer Service department mystery calls

| Test Dates | Topic | Total # of Calls | # of Test Calls Passed | # of Test Calls Failed |
|---|---|---|---|---|
| 3/20–3/24 | Provider assistance | 10 | 5 | 5 |
| 4/3–4/7 | Provider assistance | 10 | 6 | 4 |
| 4/3–4/7 | Safety / welfare check | 10 | 3 | 7 |

- CalOptima Customer Service follow up
  - Planned follow up mystery caller audit in May with increased calls
  - Discussed at weekly Operations meeting with action plans
- Magellan follow up
  - Three live-call audits per customer service agent per month
  - 50 item Audit tool including safety and welfare

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# CalOptima Audit of Magellan Customer Service (follow up)

- CalOptima Customer Service mystery calls in early May

| LOB | Topic | Total # of Calls | Total # of Calls Passed | Total # of Calls Failed |
|---|---|---|---|---|
| M-C | Provider Assistance | 43 | 29 (67%) | 14 (33%) |
| M-C | Anxiety/Safety Check | 36 | 27 (75%) | 9 (25%) |
| OC | Benefit Questions | 60 | 50 (83%) | 10 (17%) |
| OCC | Benefit Questions | 110 | 86 (78%) | 24 (22%) |

- CalOptima provided feedback & training after these calls
- Magellan - 151 CSA live call audits in 2nd quarter
  - ➢ One call failed to inquire about Safety/Crisis*

*Are you in danger of harming yourself or anyone else?"

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# Utilization

1) Medi-Cal non-ABA outpatient

2) Medi-Cal ABA

3) OC/OCC outpatient

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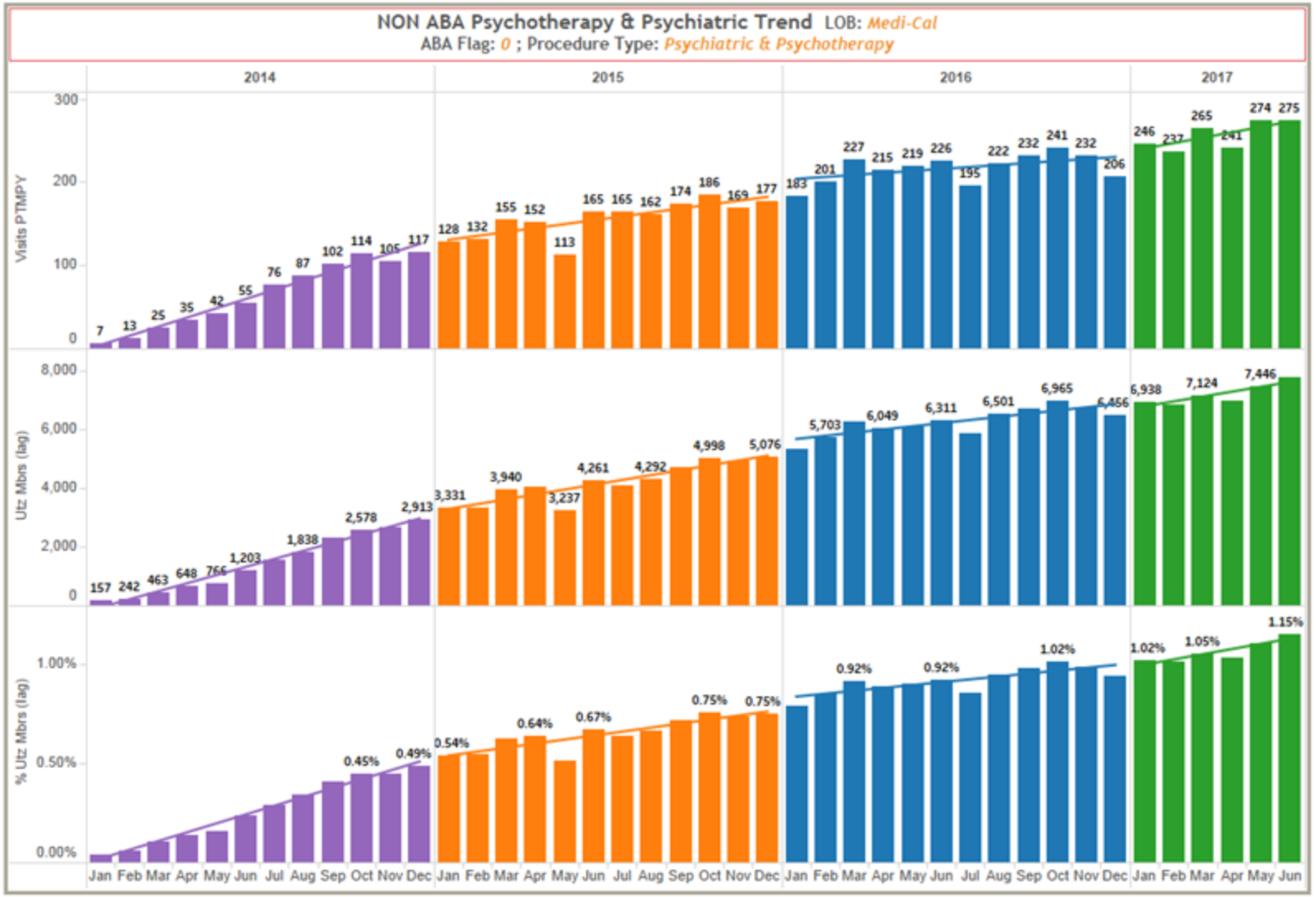
# Utilization Medi-Cal non-ABA

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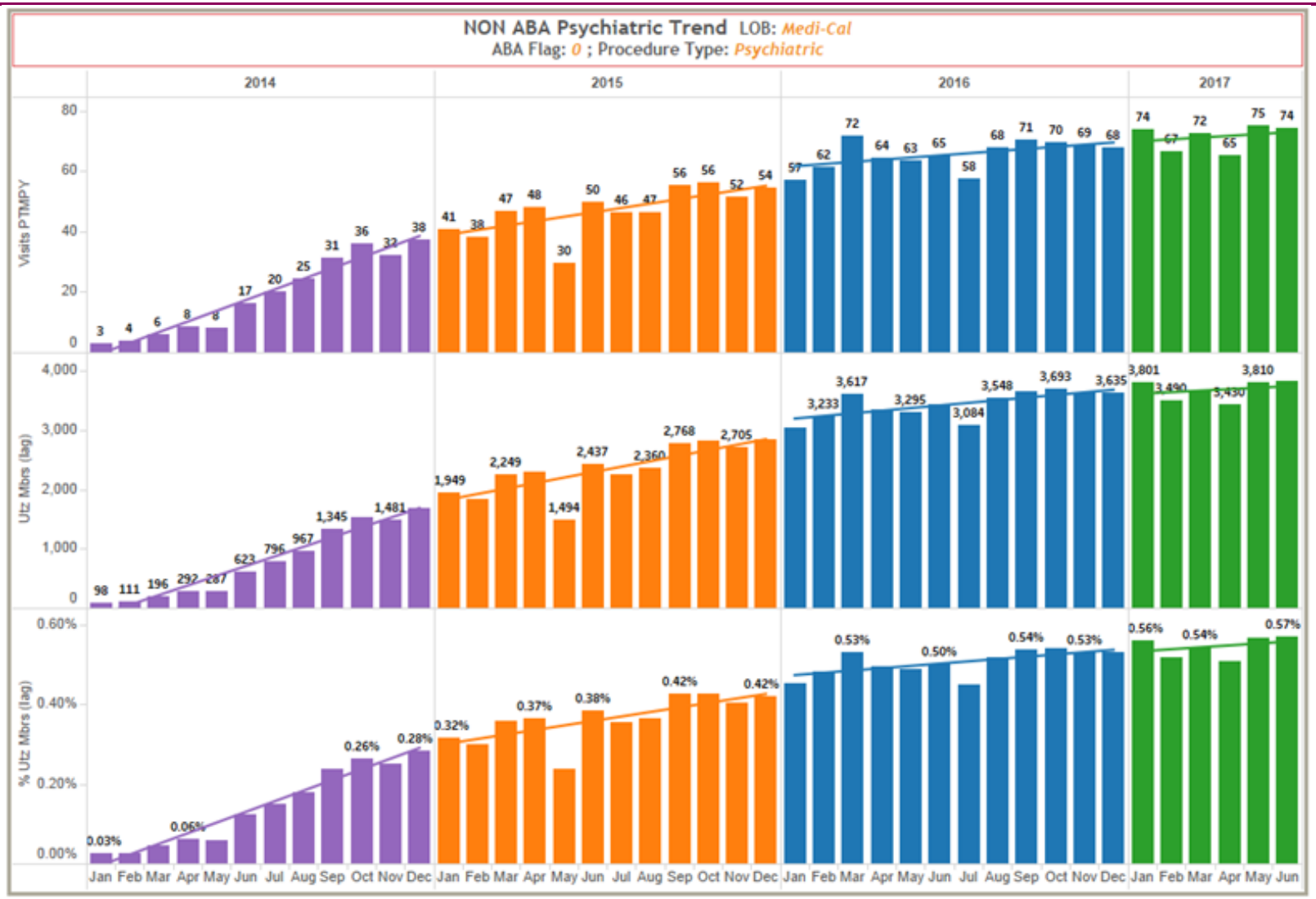
# Utilization Medi-Cal just psychiatrist visits

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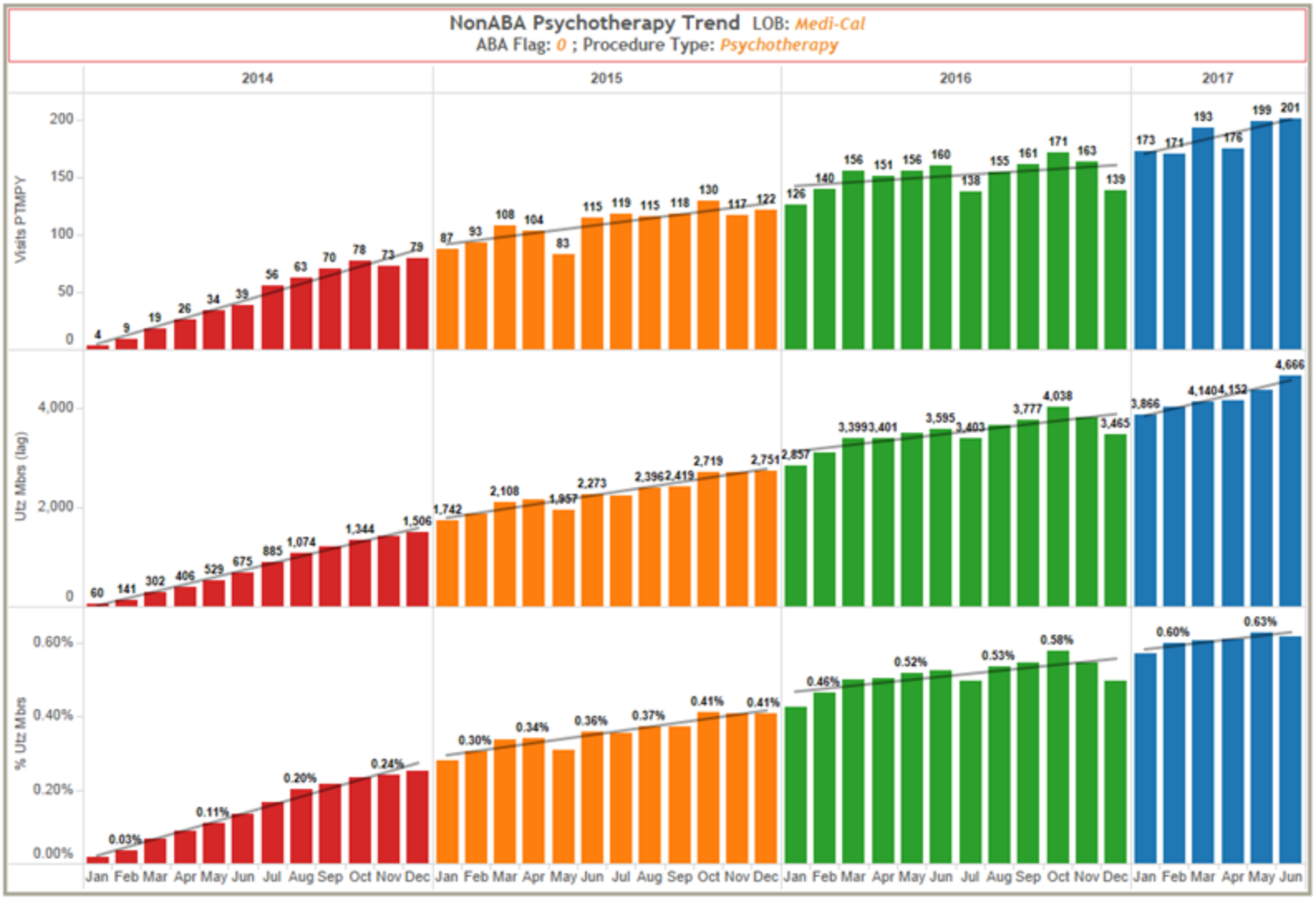
# Utilization Medi-Cal just psychotherapy

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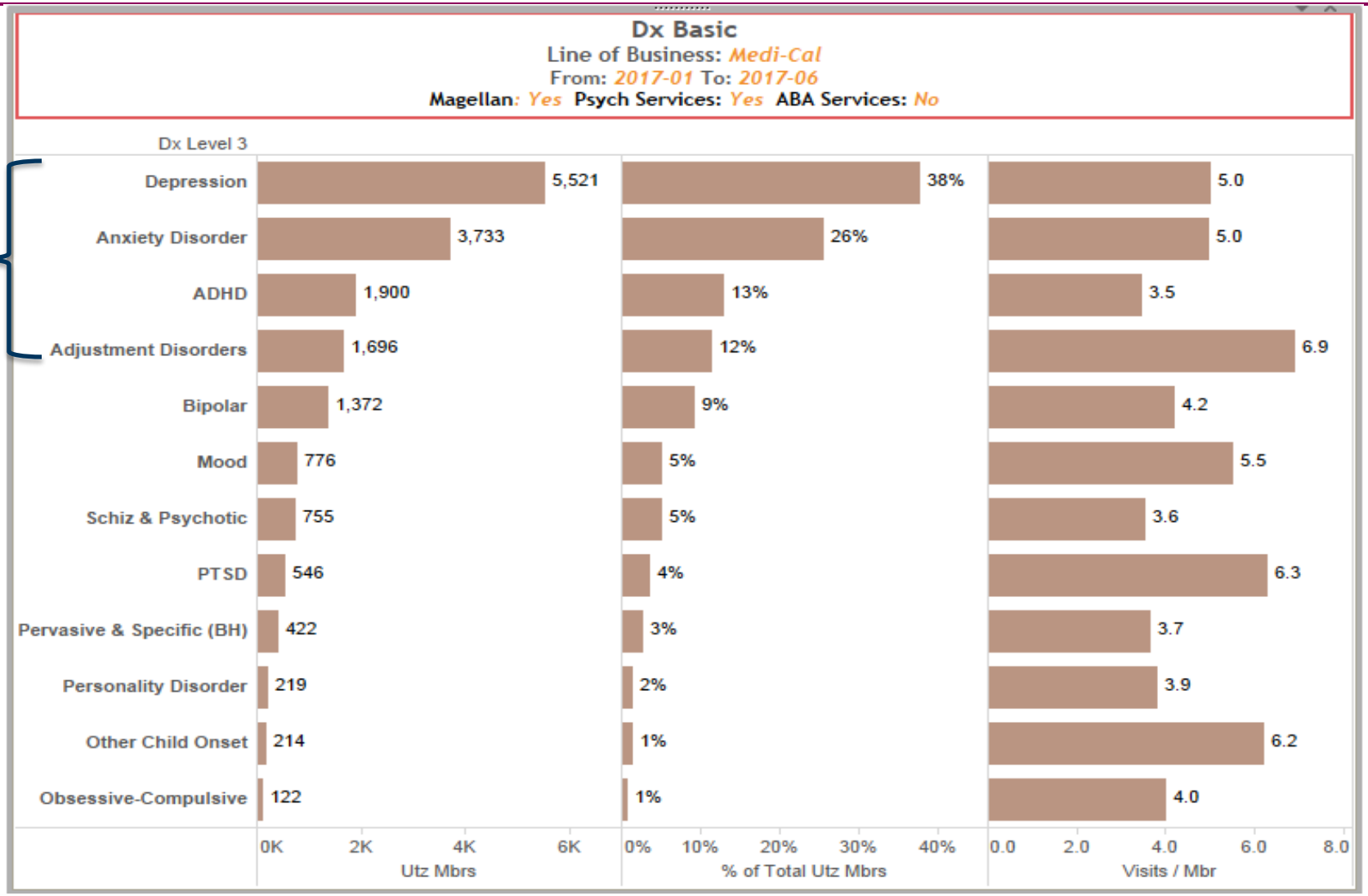
# Utilization Diagnoses Medi-Cal non-ABA

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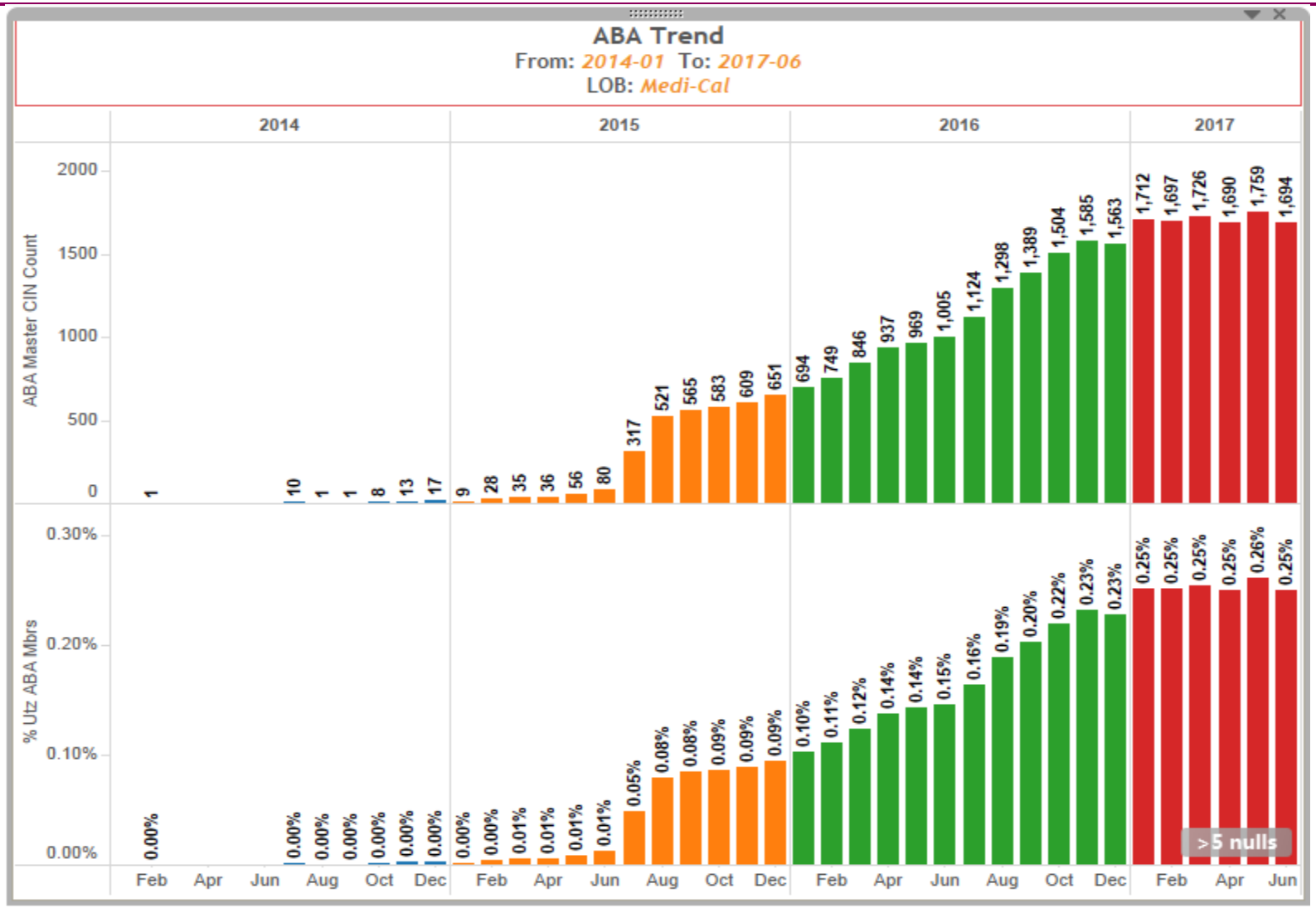
# Utilization Medi-Cal ABA

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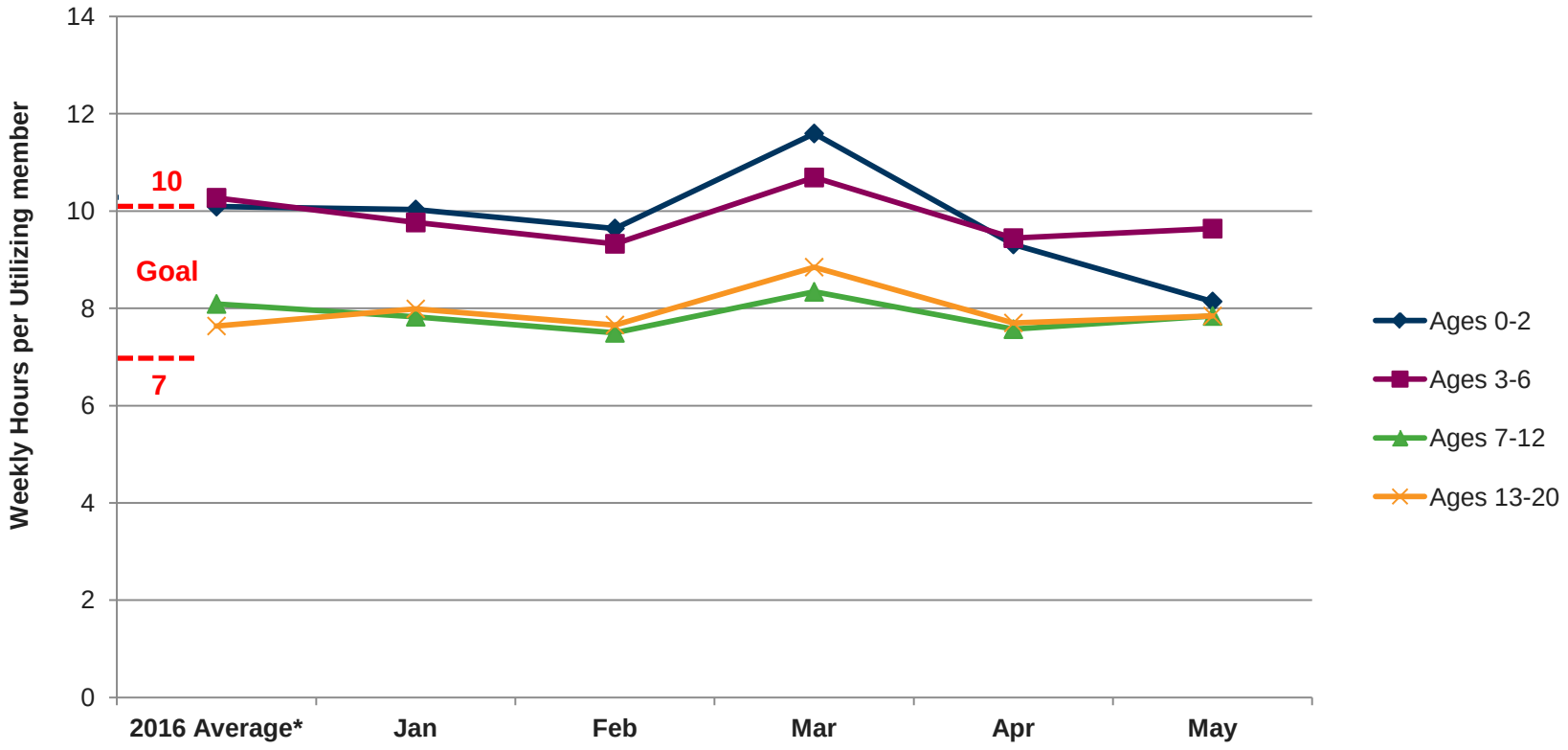
# Utilization Medi-Cal ABA Hrs / wk / UM




**Data from Magellan Encounter Data: 06/30/2017 Load Date**
**Formula: Weekly Hours per utilizing member = hours/utilizing member/4.33**
**Data includes all ABA Services (professional & paraprofessional)**
***2016 Average : Jan- Nov 2016 ; no M13 received from Beacon after Jan 2017 submission**

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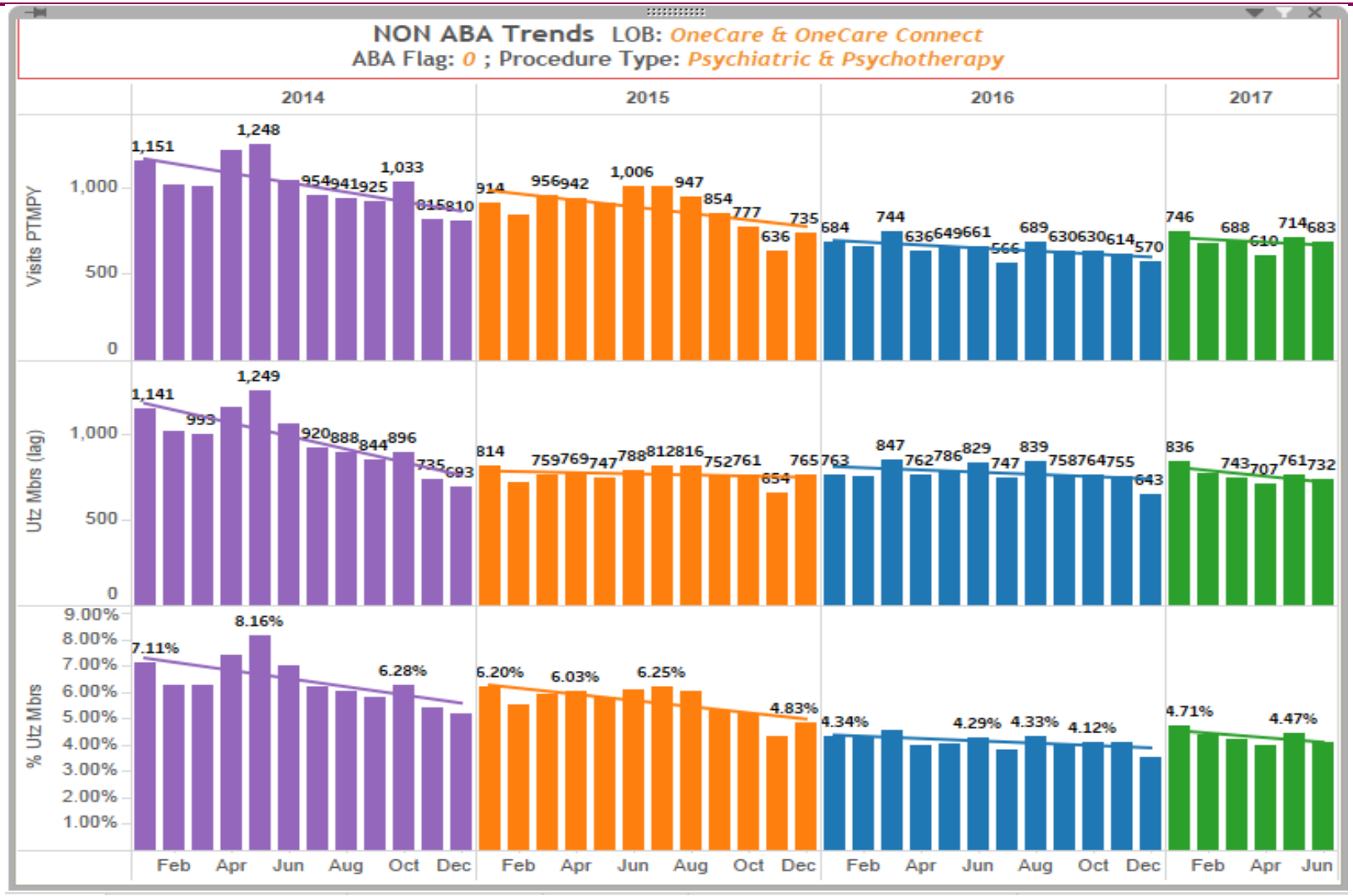
# Utilization OC / OCC

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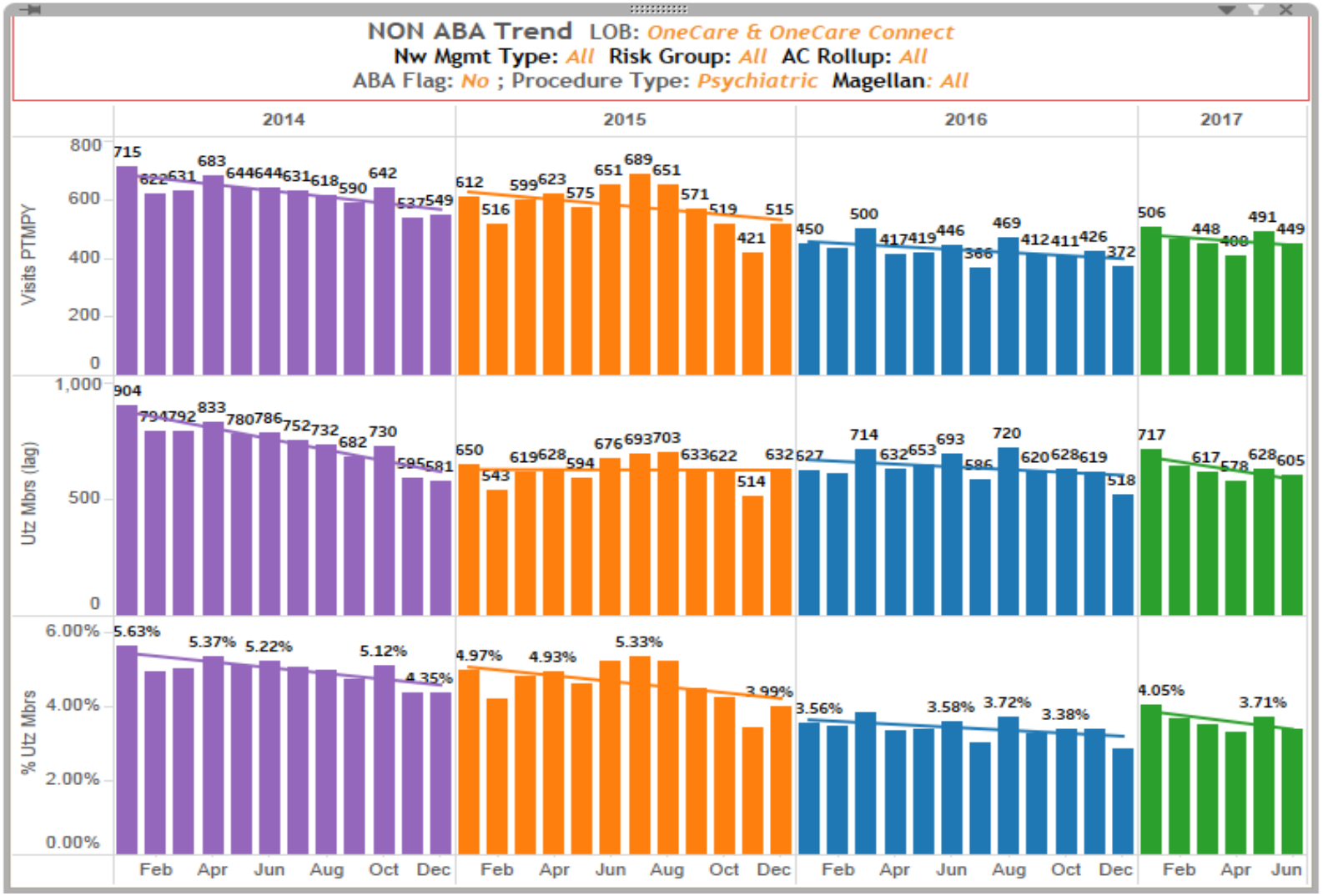
# Utilization OC / OCC just psychiatric visits

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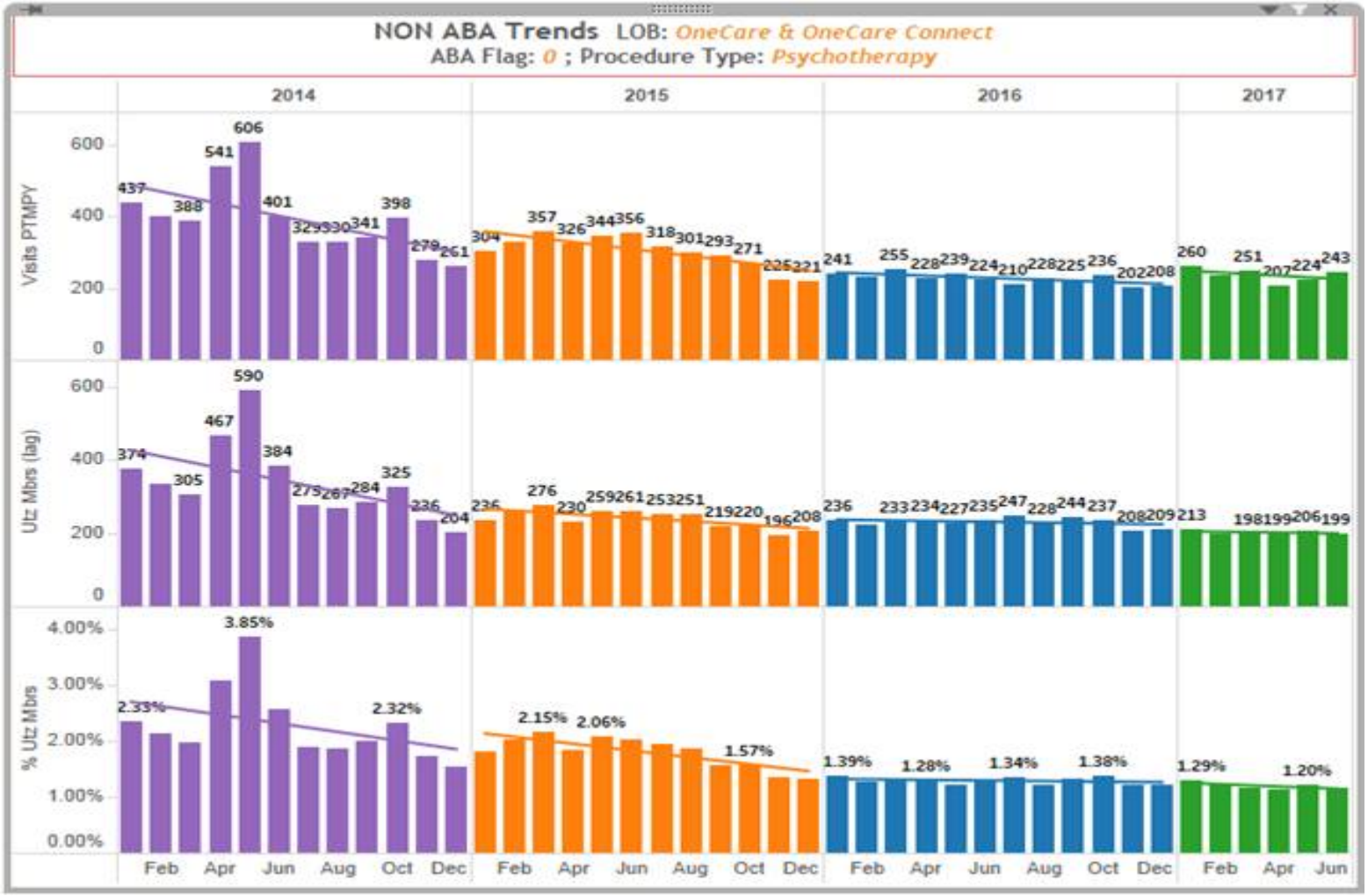
# Utilization OC / OCC just psychotherapy

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# Drug Medi-Cal Organized Delivery System Update

- Drug Medi-Cal MOU amendment between CalOptima and OC Health Care Agency (OCHCA) was approved by the CalOptima board on August 3rd, 2017
- OCHCA has submitted proposed rates to DHCS and is awaiting for approval
- DHCS readiness survey of County pending
- OCHCA will begin to cover Drug Medi-Cal services once the contract with DHCS is in place
- To prepare for implementation, OCHCA is training providers on how to obtain their Drug Medi-Cal certification

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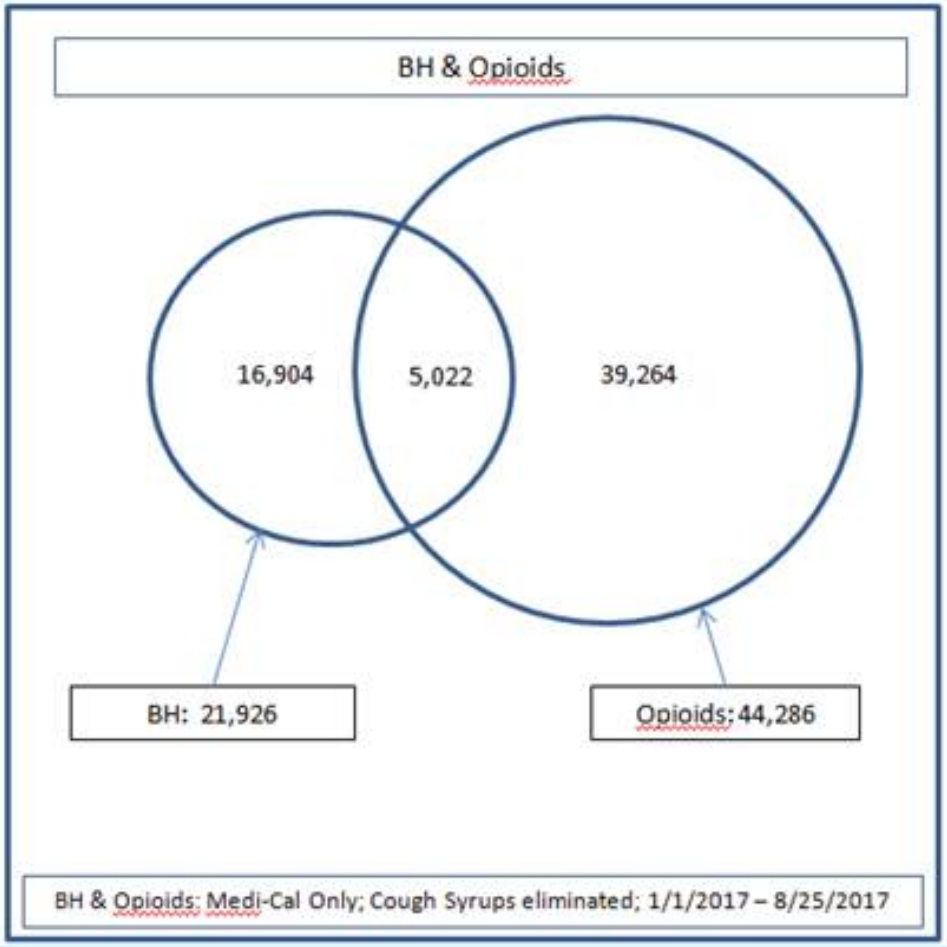
# Behavioral Health and Opioids




"11% of those with Opioid rx's are getting BH svcs"
% of BH in Opioid use: 5,022 / 44,286 = 11%

"23% of those getting BH Svcs have Opioid Rx's"
% of Opioid use in BH: 5,022 / 21,926 = 23%

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# ICT Coordination of Care M/C

- Interdisciplinary Care Team(ICT) meetings 2017 Q2
- Q2 Average participation rate 91%

| Magellan ICT Participation & Invitations | | | | |
|---|---|---|---|---|
| | April | May | June | Participation/ Invitations |
| Health Networks | 9/9 | 17/19 | 29/31 | 55/59 |
| CCN | 5/5 | 4/4 | 9/11 | 18/20 |

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# ICT Coordination of Care O/C &OCC

- Interdisciplinary Care Team(ICT) meetings 2017 Q2
- Q2 Average participation rate 100%

| Magellan ICT Participation & Invitations | | | | |
|---|---|---|---|---|
| | April | May | June | Participation Invitations |
| Health Networks | 41/41 | 54/54 | 57/57 | 152/152 |
| CCN | 2/2 | 5/5 | 2/2 | 9/9 |

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# Performance Guarantee

| Customer Service: Five Performance Guarantees | Systems & Compliance: Two Performance Guarantees |
|---|---|
| 5% or less call abandonment rate | Systems and reporting tools operational 99% of the time 24/7 |
| 80% or more of calls will be answered within 30 seconds or less | 98% of eligibility files will be processed and loaded accurately |
| Average speed of answer will be 30 seconds or less | **Reporting: One Performance Guarantee** |
| 100% of registration calls result in completed screening without disconnecting | Compliance with encounter files (837) |
| 95% of members will be successfully linked to services within 30 days | **Care Coordination: One Performance Guarantee** |
| **Claims: Two Performance Guarantees** | >80% Interdisciplinary Care Team participation |
| 90% or more of clean claims will be paid or denied within 30 days of receipt | **NCQA Status: One Performance Guarantee** |
| 99% of clean claims will be paid or denied within 45 days of receipt | *Magellan has received its NCQA accreditation for California Medicaid in August 2017* |

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# Program Updates

**Board of Directors' Quality Assurance Committee Meeting**
**September 20, 2017**

**Pshyra Jones**
**Director, Health Education & Disease Management**

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# Shape Your Life

A Program Of CalOptima
A Public Agency

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# Shape Your Life Program — IGT Update

- October 2016: RFI Released for Shape Your Life (SYL)
- December 2016: RFP Released
  - Latino Health Access
  - Dr. Riba's Health Club
  - Healthy Smiles
- March 2017: RFP Canceled
  - Unable to award multiple vendors
  - SYL Program Manager Hired in March 2017
- July 2017: Re-issued RFP
  - Reviewing best and final offers from:
    - Latino Health Access
    - Dr. Riba's Health Club
- October 2017: Estimated Contract Award Date

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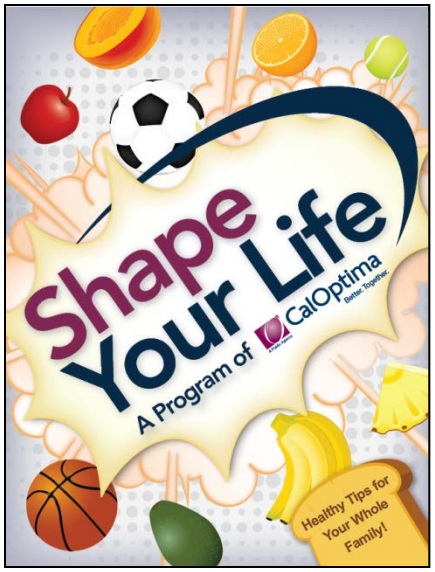
# Update: SYL and Health Education & Disease Management Department

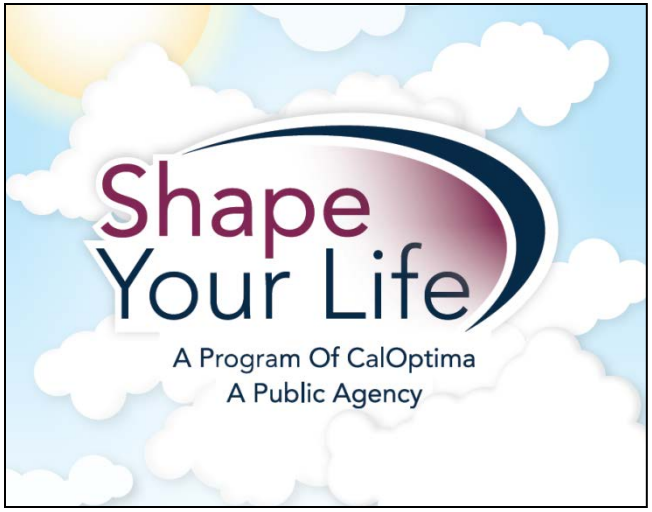
- CalOptima sponsored community classes:
  - Buena Park Community Resource Center
    - Thursdays in English
  - Anaheim Downtown Community Center
    - Fridays in Spanish
  - Anaheim Ponderosa Community Center
    - Thursdays in Spanish
  - Anaheim Mira Loma Community Center
    - Thursdays in Spanish
  - Placentia Transition Home
    - Thursdays in English (monthly)
  - CalOptima
    - Tuesdays in Spanish
    - Wednesdays in English

# Update: SYL and Health Education & Disease Management Department (cont.)

- Community classes leverage the “Snap” and “We Can” curriculums.
  - Classes are 4–6 weeks in length and offered in English and Spanish.
- Shape Your Life newsletter redesign completed.

Issue 1:




Issue 2:

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# CalOptima Perinatal Health Program

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# Comprehensive Perinatal Services Program (CPSP) Update

- March 2017: Finance and Audit Committee (FAC) approved recommendations for contract amendments with existing vendor.
- August 2017: RFI released for CPSP “like” services
- September 2017: CPSP Provider Survey released (in progress)

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# Perinatal Support Services County Resources

- CalOptima has identified more than 90 CPSP providers throughout the Medi-Cal health network affiliations.
  - At least 22 of these providers have more than one office in multiple cities.
- Additionally, the County of Orange is rich with no-cost prenatal/postnatal resources for at-risk women. Available services include:
  - Nurse Family Partnership
  - Perinatal Substance Abuse
  - Medically High-Risk Newborns
  - Bridges Hospitals

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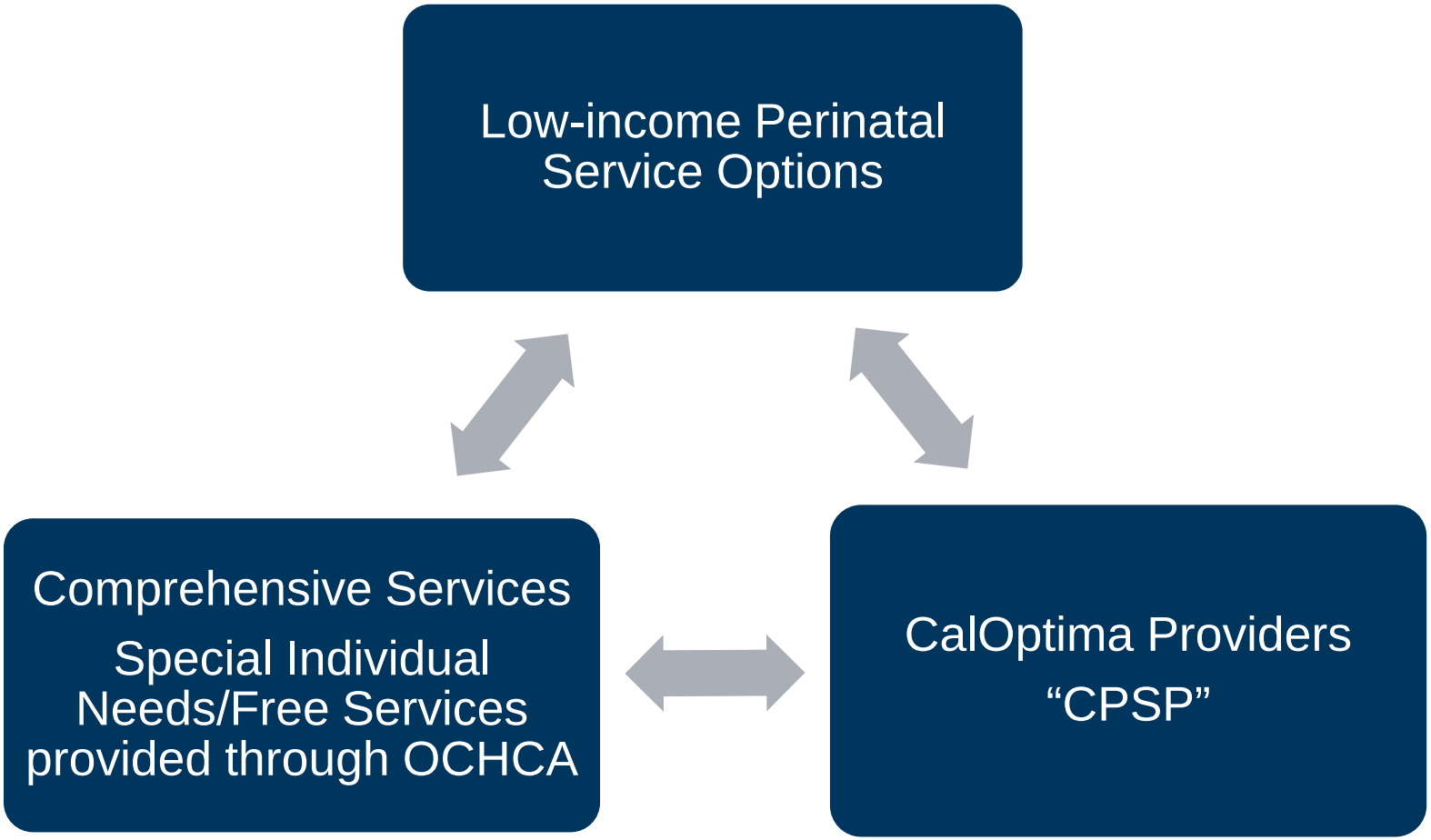
# CalOptima Perinatal Program

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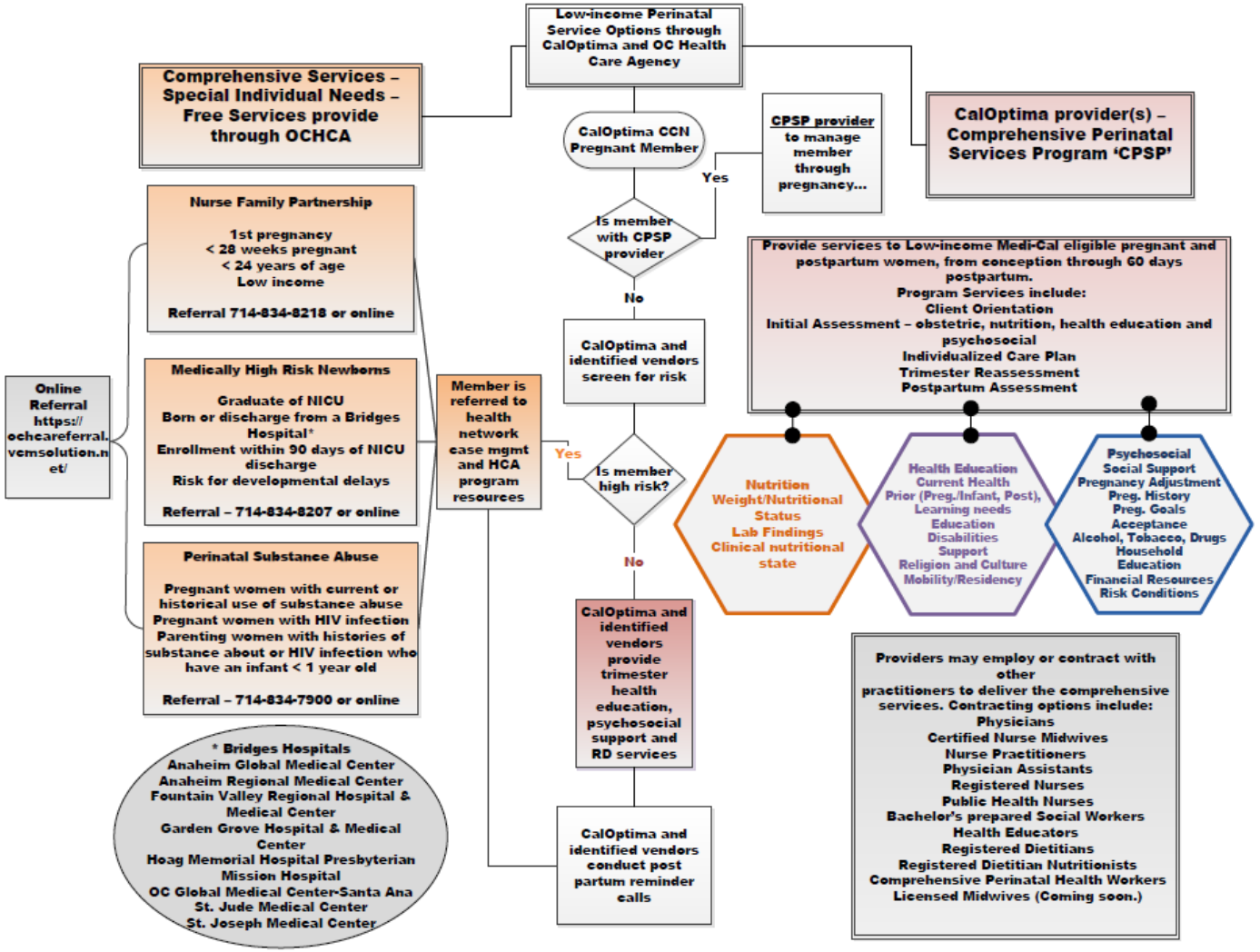
# CalOptima Perinatal Support Program Model Redesigned Overview

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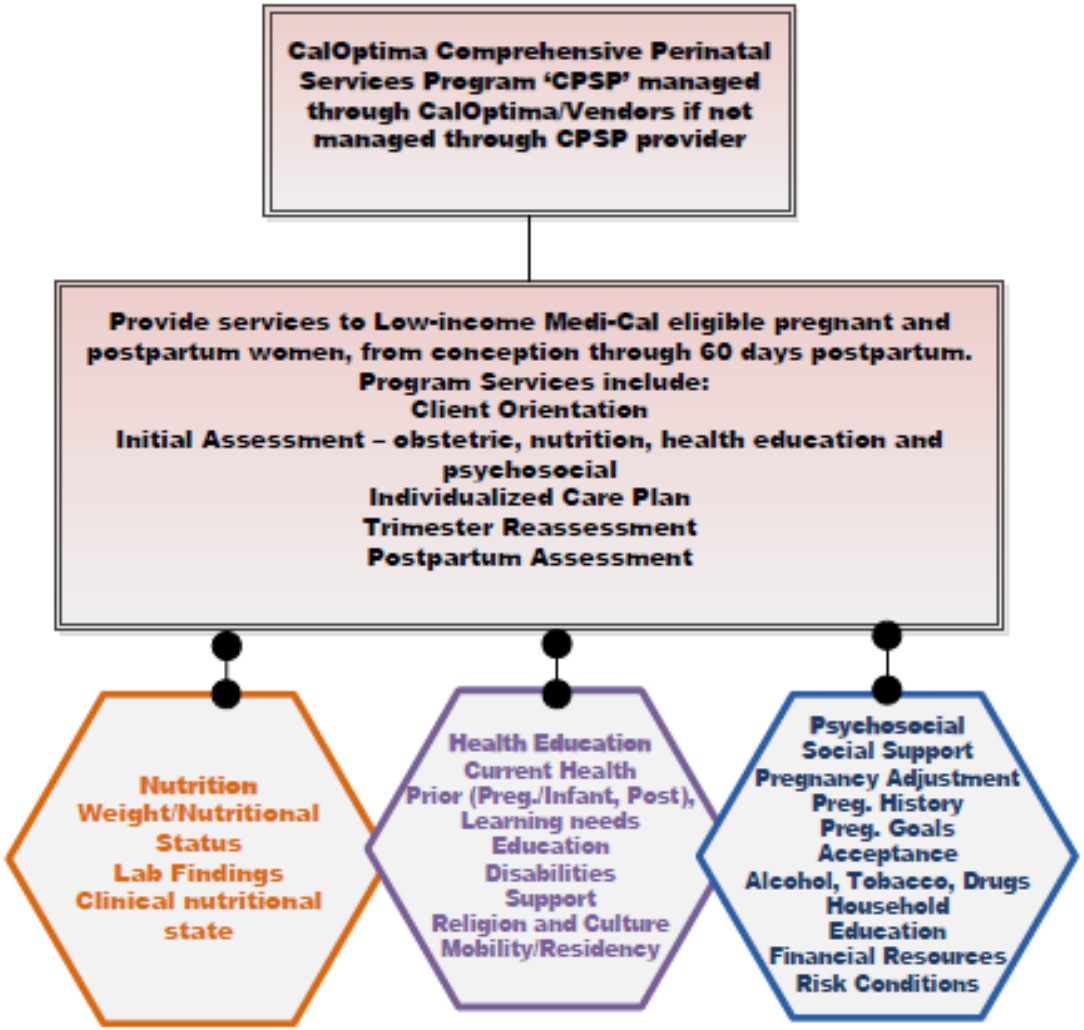
# CalOptima/Vendor Services “CPSP–like”




Coordinate with Other Services

Providers may employ or contract with other practitioners to deliver the comprehensive services. Contracting options include:

- Physicians
- Certified Nurse Midwives
- Nurse Practitioners
- Physician Assistants
- Registered Nurses
- Public Health Nurses
- Bachelor’s prepared Social Workers
- Health Educators
- Registered Dietitians
- Registered Dietitian Nutritionists
- Comprehensive Perinatal Health Workers
- Licensed Midwives (Coming soon.)

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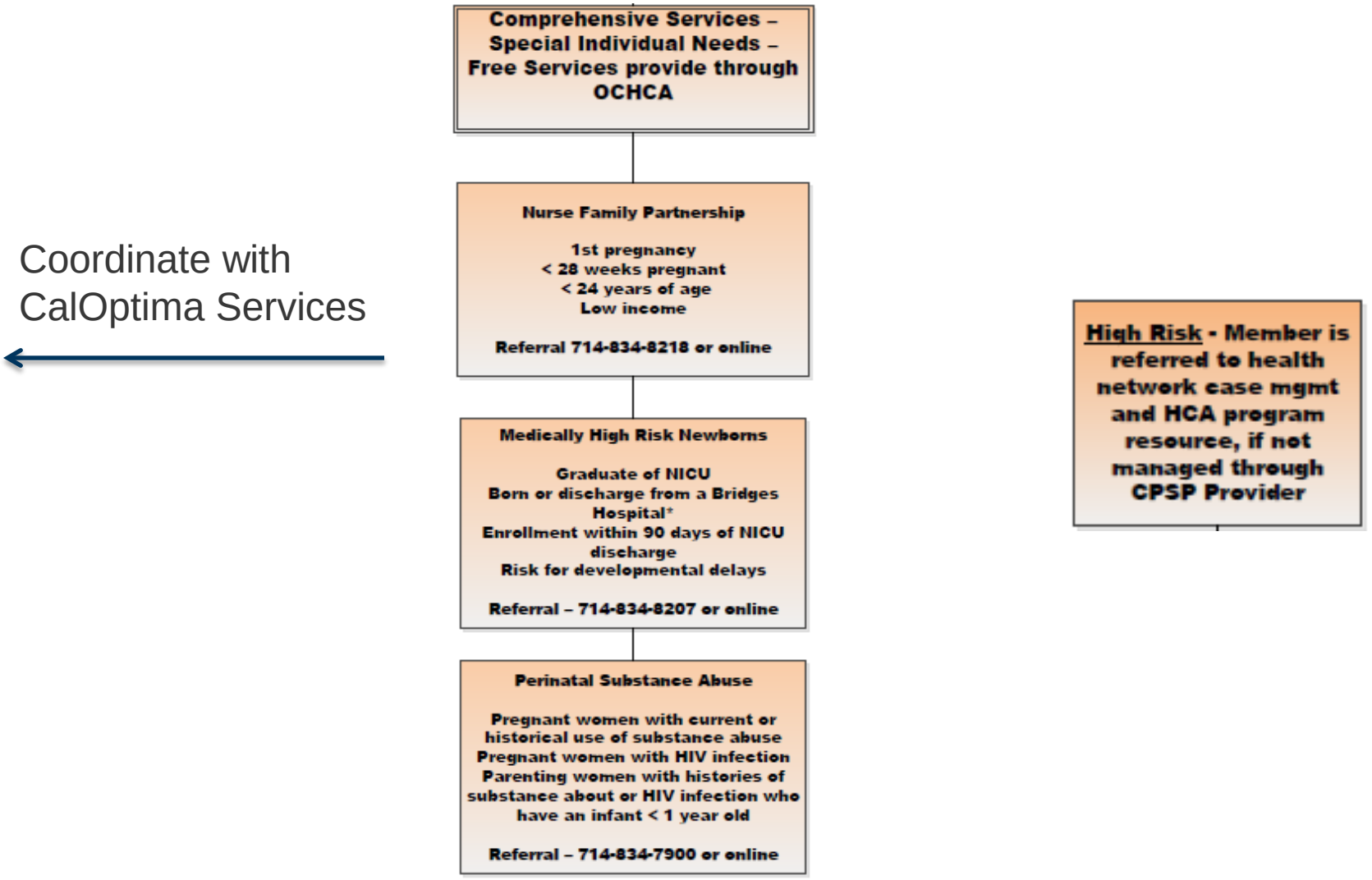
# No-Cost County Resources for High Risk

Coordinate with CalOptima Services

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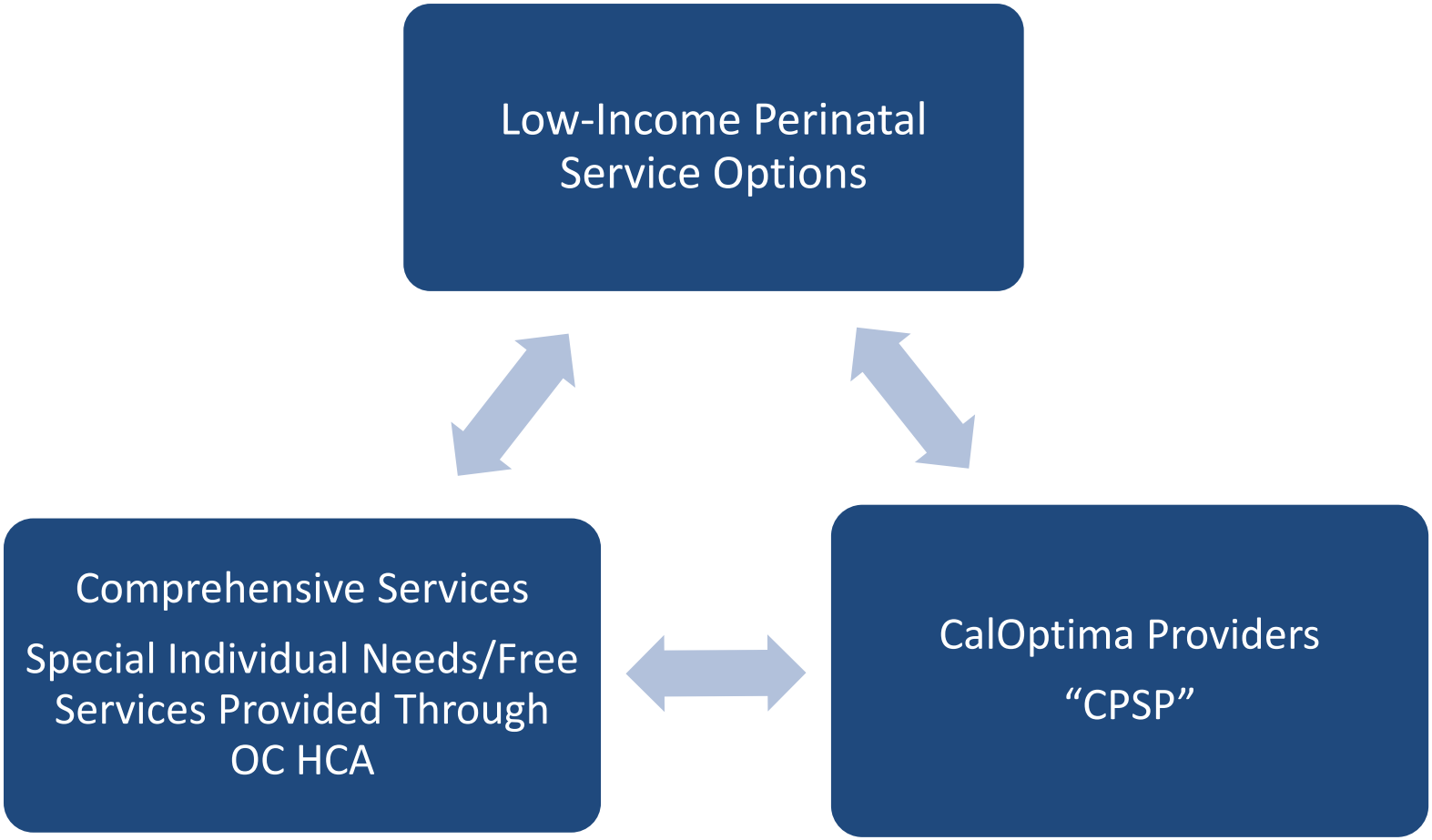
# CalOptima Perinatal Program

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# Low-Income Perinatal Service Options Through CalOptima and OC Health Care Agency

CalOptima CCN Pregnant Member

**Comprehensive Services – Special Individual Needs – Free Services Provided Through OC HCA**

**CalOptima Provider(s) Comprehensive Perinatal Services Program "CPSP"**

Is Member with CPSP Provider

Yes → **CPSP Provider** to manage member through pregnancy...

No → CalOptima and identified vendors screen for risk

Is Member high risk?

Yes → Member is referred to health network case mgmt and HCA program resources

No → CalOptima and identified vendors provide trimester health education, psychosocial support and RD services

CalOptima and identified vendors conduct postpartum reminder calls

**Nurse Family Partnership**

1st pregnancy
< 28 weeks pregnant
< 24 years of age
Low income

**Referral: 714-834-8218 or online**

**Medically High Risk Newborns**

Graduate of NICU
Born or discharge from a Bridges Hospital*
Enrollment within 90 days of NICU discharge
Risk for developmental delays

**Referral: 714-834-8207 or online**

**Perinatal Substance Abuse**

Pregnant women with current or historical use of substance abuse
Pregnant women with HIV infection
Parenting women with histories of substance abuse or HIV infection who have an infant < 1 year old

**Referral: 714-834-7900 or online**

**Online Referral**
https://ochcareferral.vcmsolution.net/

Provide services to low-income **Medi-Cal** eligible pregnant and postpartum women, from conception through 60 days postpartum.
Program Services include:
Client Orientation
Initial Assessment: obstetric, nutrition, health education and psychosocial
Individualized Care Plan
Trimester Reassessment
Postpartum Assessment

**Nutrition**
Weight/Nutritional Status
Lab Findings
Clinical Nutritional State

**Health Education**
Current Health
Prior (Preg./Infant, Post)
Learning Needs
Education
Disabilities
Support
Religion and Culture
Mobility/Residency

**Psychosocial**
Social Support
Pregnancy Adjustment
Preg. History
Preg. Goals
Acceptance
Alcohol, Tobacco, Drugs
Household
Education
Financial Resources
Risk Conditions

*** Bridges Hospitals**
Anaheim Global Medical Center
Anaheim Regional Medical Center
Fountain Valley Regional Hospital & Medical Center
Garden Grove Hospital & Medical Center
Hoag Memorial Hospital Presbyterian
Mission Hospital
OC Global Medical Center-Santa Ana
St. Jude Medical Center
St. Joseph Medical Center

Providers may employ or contract with other practitioners to deliver the comprehensive services. Contracting options include:
Physicians
Certified Nurse Midwives
Nurse Practitioners
Physician Assistants
Registered Nurses
Public Health Nurses
Bachelor's prepared Social Workers
Health Educators
Registered Dietitians
Registered Dietitian Nutritionists
Comprehensive Perinatal Health Workers
Licensed Midwives (coming soon)

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**High Risk Member is referred to health network case mgmt and OC HCA program resource, if not managed through CPSP Provider**

**Comprehensive Services – Special Individual Needs – Free Services Provided Through OC HCA**

**Nurse Family Partnership**

1st pregnancy
< 28 weeks pregnant
< 24 years of age
Low income

**Referral: 714-834-8218 or online**

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Pregnant women with HIV infection
Parenting women with histories of substance abuse or HIV infection who have an infant < 1 year old

**Referral: 714-834-7900 or online**

**CalOptima Comprehensive Perinatal Services Program "CPSP" managed through CalOptima/Vendors if not managed through CPSP provider**

Provide services to Low-income **Medi-Cal** eligible pregnant and postpartum women, from conception through 60 days postpartum.
Program Services include:
Client Orientation
Initial Assessment: obstetric, nutrition, health education and psychosocial
Individualized Care Plan
Trimester Reassessment
Postpartum Assessment

**Nutrition**
Weight/Nutritional Status
Lab Findings
Clinical Nutritional State

**Health Education**
Current Health
Prior (Preg./Infant, Post),
Learning needs
Education
Disabilities
Support
Religion and Culture
Mobility/Residency

**Psychosocial**
Social Support
Pregnancy Adjustment
Preg. History
Preg. Goals
Acceptance
Alcohol, Tobacco, Drugs
Household
Education
Financial Resources
Risk Conditions

Providers may employ or contract with other practitioners to deliver the comprehensive services. Contracting options include:
Physicians
Certified Nurse Midwives
Nurse Practitioners
Physician Assistants
Registered Nurses
Public Health Nurses
Bachelor's prepared Social Workers
Health Educators
Registered Dietitians
Registered Dietitian Nutritionists
Comprehensive Perinatal Health Workers
Licensed Midwives (coming soon)

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# Executive Summary

## Quality Improvement Committee (QIC) 2nd Quarter 2017

- Reviewed and approved:
    - 2017 Utilization Management (UM) Program Description and Work Plan
    - 2017 Case Management (CM) Program Description
    - 2017 Disease Management (DM) and Targeted Wellness Program Description
    - 2016 Quality Improvement Evaluation
    - 2016 PACE QAPI Annual Evaluation
    - 2016 Utilization Management Work Plan Evaluation
    - 2016 Case Management Effectiveness Report
    - 2016 Disease Management Effectiveness Report

- Quarterly reports provided by all key areas:
    - Utilization Management: Quarterly UM Report
    - Long Term Support Services QI Sub-Committee update:
        - Utilization goals set for CBAS, IHSS, LTC and MSSP
    - Quality Improvement: Reported on initial and re-credentialing of the provider network and related facility site review/medical record review/physical accessibility review results
    - Health Education /Disease Management: Provided an update on the implementation of the Health Appraisal (DHCS requirement) and the operational changes that will be implemented by July 2017
        - Reported on the administration of the Member Connections self-management tools
    - Quality Analytics: Reported on preliminary HEDIS results for calendar year 2016
        - All DHCS measures with required MPL have been met
        - HEDIS/CAHPS final results expected by the end of June, 2017
        - Reviewed the new Quality Metrics dashboard

        - Reported on the 2017 Pay-for-Value Program, including measures and payment methodology for Medi-Cal and OCC
        - Reviewed the 2016 P4V payment methodology for OCC
    - Behavioral Health Integration: Presented an update on BH services and initiatives progress
        - Reviewed the Behavioral Health 1st Quarter Work Plan
    - Member Experience Sub-Committee: Provided the quarterly report for all lines of business:
        - Provided an update on the Customer Services metrics and Timely Access/Appointment Availability
        - Reported Member Grievances by type and provider
        - Provided an update on the Access & Availability distance and time standards
- Quality Improvement: Reported on the results from the NCQA Mock Audit results and progress on the following Work Plans through the updated Dashboards:
        - Provided the quarterly Audit & Oversight, Pharmacy Management and Performance Improvement Projects
        - 2017 QI Work Plan Dashboard Q1 – Attachment 1a
        - 2017 HEDIS Dashboard Q1 – Attachment 1b
        - 2017 Case Management Dashboard Q1 – Attachment 1c

Accepted minutes from the following committees:

- Medical Affairs: March 13, 2017, March 27, 2017
- Behavioral Health Quality Improvement: May 02, 2017
- Long Term Support Services: March 20. 2017
- PACE: January 9, 2017, February 7, 2017
- Members Experience: GARS February 28, 2017
- Utilization Management Committee: May 25, 2017

# Quality Improvement Committee Second Quarter 2017 Update

**Board of Directors' Quality Assurance Committee Meeting**
**September 20, 2017**

**Caryn Ireland**
**Executive Director, Quality and Analytics**

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# Quality Improvement Committee (QIC) Reporting by Department

- The following departments report to the QIC quarterly meeting at a minimum:
  - Case Management and Complex Case Management
  - Behavioral Health Integration (BHI)
  - Customer Service
  - Grievance & Appeals Resolution Services (GARS)
  - Health Education & Disease Management (HE & DM)
  - Long-Term Support Services (LTSS)
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Pharmacy
  - Utilization Management (UM)

# QI Program Update

- The following documents were presented and approved:
  - 2017 Utilization Management (UM) Program Description and Work Plan
  - 2017 Case Management (CM) Program Description
  - 2017 Disease Management (DM) and Targeted Wellness Program Description
  - 2016 Quality Improvement (QI) Evaluation
  - 2016 PACE Quality Assurance (QAPI) Annual Evaluation
  - 2016 UM Work Plan Evaluation
  - 2016 CM Effectiveness Report
  - 2016 DM Effectiveness Report
- NCQA Mock Audit findings
  - Strong program elements; owners aware of gaps
  - Vendor transitions may create challenges

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# Committee Updates

- Reviewed and Approved:
  - UM Committee Report and Minutes — May 25, 2017
  - GARS Subcommittee Report — February 28, 2017
  - LTSS Subcommittee Report — March 20, 2017
  - BHI Subcommittee Report — May 02, 2017
  - Medical Affairs — March 13, 2017, and March 27, 2017
  - PACE — January 9, 2017, and February 7, 2017

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# 2017 UM Program Description & Work Plan

- Summary of Changes
  - Aligned UM Program Description with the Quality Management Program
    - Program descriptions
    - Committee references
  - Updated Conflict of Interest statement
  - Updated Committee Structure Organization Chart
    - Reflects new structure and operational unit support
  - Expanded “Measuring Effectiveness” section
    - Overutilization/underutilization measures monitored, tracked and evaluated
  - Expanded duties for key positions, including Chief Medical Officer, Medical Director of UM, Director of Behavioral Health and other UM staff and management positions

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# 2017 CM Program Description

- Describes Case Management department structure and programs
- Included program updates
  - Expansion of data collection for member satisfaction survey
  - Additional staff training in Behavioral Health and new Managed Behavioral Health Organization (MBHO) vendor processes
  - Additional focus on emergency room high-utilizers for CalOptima Community Network
  - Preparation for future programs
    - Whole Child Model
    - Health Homes
- Program structure includes oversight of delegation of CM
- CM Special Programs include:
  - Complex Case Management, including Targeted Case Management
  - Perinatal Support Services
  - Transplant Services, ESRD and Hemophilia Programs
  - Children with Special Health Care Needs

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# 2017 DM and Targeted Wellness Program Description

- Asthma, Diabetes and Heart Failure consolidated into one program description – Health Management Program
- Health Management Program description includes edits to ensure full NCQA compliance
  - Expanded identification sources to include:
    - Data collected through UM review process
    - Nurse Advice Line
- Targeted Wellness program description for NCQA Member Connection Standards transitioned to annual review schedule
- Revisions made to utilization management intervention category to ensure full NCQA compliance

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# 2016 QI Evaluation

- Completed analysis of the core clinical and service indicators for 2016
- Highlights:
  - Implementation of the new MBHO
  - Program development and service monitoring for LTSS
  - Monitored pharmacy management programs
    - Underutilization of asthma, diabetes, cardiovascular and osteoporosis medications
    - Initiatives regarding appropriate testing for Children with Pharyngitis & Upper Respiratory Infections
  - Monitored processes and outcomes for:
    - Facility Site Reviews; Potential Quality of Care issues, Quality Monitoring for CBAS and Skilled Nursing Facilities
  - Fielded cultural needs and preferences study and implemented plan of action

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# 2016 QI Evaluation (Cont.)

- Highlights (Continued):
  - Met average speed to answer and abandonment rate every quarter for Customer Service
  - Evaluated GARS by issue type and provider specialty to identify trends
  - Participated in regulatory performance improvement projects for CMS & DHCS
  - Continued actions to improve areas of concern in member experience, as measured by CAHPS
  - Monitored access and availability of network adequacy for our membership
  - Implemented activities to improve HEDIS and Stars measures
  - Implemented the Group Needs Assessment

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# 2016 PACE QAPI Evaluation

- Completed a successful Year 3 CMS/DHCS audit
- Grew membership to 183 participants (201 as of April 1)
- Implemented new Electronic Medical Record fully
- Reduced Hospital Days/K/Year, ER Visits/K/Year and 30-Days All-Cause Readmission Rates year over year
- Maintained rate of common infections in the elderly lower than all national benchmarks
- Had immunization rates lower than CMS goal
- Increased the number of participants who have completed a Physician Orders for Life-Sustaining Treatment (POLST) to 81%
- Identified opportunities for improvement and action plan for 2017

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# 2016 PACE QAPI Evaluation (Cont.)

- Areas of focus for 2017
  - Increase participant satisfaction
  - Evaluate transportation (RFP Evaluation Phase)
  - Address specialty network access and utilization
  - Refine operational dashboard
  - Leverage CalOptima's Concurrent Review department
  - Develop a robust care coordination program
  - Review HEDIS metrics for the elderly
- First report due mid-2017

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# 2016 UM Work Plan Evaluation

- Effectively participated in multiple mock and regulatory audits of the UM program throughout 2016
- Conducted UM delegated oversight
- Monitored Prior Authorization processes and turnaround times
- Completed Inter-Rater Reliability
- Monitored utilization performance for facilities and pharmacy
- Identified initiatives for 2017
  - Overutilization/underutilization tracking, trending and reporting
  - Staff oversight and internal auditing
  - Align denial language
  - Guiding Care enhancements

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# 2016 CM Effectiveness Report

- Member satisfaction:
  - All measures met internal target of 80%
  - There were no complex case management complaints in 2016
- Health Status (SF-12) Results:
  - Did not achieve the targeted increase of 10% in either Physical Health Status or Mental Health Status
- 2017 Interventions:
  - Revise survey methodology and frequency for 2017
  - Conduct additional training and education
  - Conduct department in-services on Intimate Partner Violence, Alleviating housing deficits
  - Pursue close collaboration with Behavioral Health Integration

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# 2016 DM Effectiveness Report

- CalOptima Disease Management Programs
  - Asthma (ages 3–18)
    - Enrolled members: 20,205 Medi-Cal
    - Active Participation Rate: 1.77%
  - Diabetes (age 18+)
    - Enrolled members: 30,122 Medi-Cal
    - Enrolled members: 5,242 OC/OCC
    - Active Participation Rate: 3.74% (Medi-Cal only)
  - Congestive Heart Failure (ages 18+)
    - Enrolled members: 792 OC/OCC
    - Active Participation Rate: N/A

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# 2016 DM Effectiveness (Cont.)

- Experience with DM (Member satisfaction with programs)
  - Goal: 90% satisfaction with DM programs – Goal not met
    - Helpfulness with information – 82%
    - Responded to request or concerns – 80%
    - Learned useful information – 79%
    - Information helped me manage my health better – 76.8%
    - Tell others about the program – 82.4%
- Program Effectiveness
  - Goal: Increase Asthma Medication Ratio (AMR) to 50th percentile – Goal met
  - Goal: A1C control for member with existing A1C>9. Maintain 90th percentile for Medi-Cal, increase to 75th percentile for Medicare – Goal not met

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# Second Quarter QIC Highlights
## (First Quarter data and activities)

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# Utilization Management Report

- All reporting areas represented
  - Chaired by Dr. Himmet Dajee in Dr. Francesco Federico's absence
- Reviewed and approved the 2017 UM Committee Charter
- UM projects and initiative highlights
  - Testing and implementation of Guiding Care
  - UM and PACE inpatient concurrent review integration
  - DHCS Mega Rule – new Notice of Action (NOA) templates
  - Addressing workflow deficiencies to maximize prior authorization productivity

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# Utilization Management Report (Cont.)

- Overutilization/underutilization review:
  - Identifying trends in utilization for analysis and action
    - Pharmacy: 2017 goals within target for all lines of business
    - UM: Turnaround times on target – prior authorization
    - LTSS: Turnaround times on target
    - Delegates: Turnaround times for adverse determinations on target
  - Inpatient facility and ED goals set for 2017
- Behavioral Health Update
  - Reviewed all utilization management measures against goals
- Pharmacy & Therapeutics (P&T) Committee Update and Pharmacy Costs
  - Minutes presented to UM Committee
- Benefit Management Subcommittee Update
  - Recap of discussion on code review

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# Long-Term Support Services (LTSS)

- Reviewed progress against 2016 goals
  - CBAS readmission utilization is at 21% – Goal not met
  - CBAS Emergency Department (ED) utilization is at 12% – Goal not met
  - CBAS LTC Admissions is at 0.34% – Goal met

- Re-evaluated and reset goals for 2017
  - Hospital admissions: 4.5%
  - Hospital readmissions: 20%
  - ED Visits: 13%
  - LTC Admissions: 0.27%

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# Potential Quality of Care (PQI)

## Case Activity:

| Cases | Q4 2016 | Q1 2017 |
|---|---|---|
| Total Number of Cases Closed | 190 | 161 |
| Average Turnaround Time in Days | 32 | 96 |
| % Closed Within 90 Days | 100% | 89% |
| Total Number of New Cases Opened | 236 | 299 |
| Total Number of Current Cases Still Open | 25 | 279 |

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# Credentialing

| Credentialing Activity | Q4 2016 | Q1 2017 |
|---|---|---|
| Total number of initial files completed | 43 | 32 |
| Total number of recredentialed files completed | 92 | 108 |
| Number of clean files completed | 120 | 123 |
| Number of files with issues – presented to CPRC and approved | 15 | 17 |
| Number of files with issues – presented to CPRC and denied for administrative reasons | 0 | 3 |
| Timeliness for Initials – Goal met (Within 180 days from attestation date) | 100% | 100% |
| Timeliness for Recreds – Goal not met (Within 36 Months) | 97.8% | 100% |

CPRC = Credentialing and Peer Review Subcommittee

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# Facility Site Reviews/Medical Record Reviews Physical Activity Reviews

| Site Reviews Activity | Q4 2016 | Q1 2017 |
|---|---|---|
| Total number of FSR/MRR Completed (PCP) | 69 | 65 |
| % of FSR/MRR Completed Score >80% | 100% | 100% |
| Total number of PARS Completed (PCP & HVS) | 107 | 132 |
| % of PARS with BASIC Access | 51% | 57% |
| Number Critical Element CAPS Issued | 15 | 11 |
| Number of FSR CAPs Issued | 21 | 30 |
| Number of MRR CAPS Issued | 28 | 21 |

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# Member Connections: Health Appraisals

- CalOptima administers a health appraisal (HA) to eligible individuals as a means of measuring and improving health
- The HA includes the following:
  - Member demographics
  - Personal health history, including chronic illness and current treatment
  - Self-perceived health status (BMI, smoking, physical activity, stress, preventive screenings, healthy eating, etc.)
  - Behavioral change strategies
  - Identifies members with special needs in the areas of hearing and vision impairment and language preference
  - Overall summary of results

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# Member Connections: Self-Management Tools

- CalOptima has evidence-based self-management tools to help members manage their health
- Self-management tools, derived from available evidence, should provide members with information on at least the following wellness and health promotion areas:
  - Healthy weight (BMI) maintenance
  - Smoking and tobacco use cessation
  - Encouraging physical activity
  - Healthy eating
  - Managing stress
  - Avoiding at-risk drinking
  - Identifying depressive symptoms

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# Preliminary 2017 HEDIS Results
## (Measurement Year [MY] 2016)

- On track for on-time completion
- All DHCS measures with required MPL **have been met** and exceeded MPL
- No measures at risk for "not reportable," however some measures flagged by auditor for performance below 5th and 10th percentile:
  - Adult Access to Preventive Care (below 5th)
  - Appropriate Treatment for Children with Pharyngitis (below 10th)
- Several measures have exceeded last year's results
- Controlling Blood Pressure — more out of control blood pressures/lower score
- CAHPS Member Experience fielding completed

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# Pay For Value

- New Pay for Value program for OneCare Connect:
  - Payment methodology includes performance and improvement.
  - Payment methodology includes only clinical measures.
  - OneCare (MY 2015) rates are used for improvement calculations.
  - 2016 was the first full year for OneCare Connect

| 2016 Measurement Year Measures |
| --- |
| Antidepressant Medication Management: Effective Acute Phase Treatment |
| Antidepressant Medication Management: Effective Continuation Phase Treatment |
| Controlling High Blood Pressure |
| Part D Medication Adherence for Oral Diabetes Medications |
| Plan All-Cause Readmissions |

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# Behavioral Health Integration (BHI)

- BH HEDIS Measures – ADD, AMM, FUH
  - ADD/FUH performing lower than expected; presented to BHQI for intervention suggestions
- Adoption of Behavioral Health Clinical Practice Guidelines
  - BHI responsible for five guidelines
- Develop and monitor UM metrics and process to assess Behavioral Health in Long-Term Care facilities
- Integration of Behavioral Health Services with ICTs
  - Monitor MBHO participation rates

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# Member Experience

- Launched the new Member Experience Subcommittee
- Fielded the Clinician and Group Consumer Assessment of Health Care Providers & Systems (CG-CAHPS) – (Q3 and Q4 2016)
- Disseminated individual provider scorecards in March 2017
- Fielded the 2017 Member Experience (CAHPS) surveys (Q1 and Q2 2017)
- Reviewed Member Communications Plan
- Continue working with Magellan on Member Experience and Access and Availability monitoring for 2017

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# Member Experience (Cont.)

## Customer Service Results: Quarter 1

| Key Performance Indicator (KPI) Goal | Medi-Cal | OneCare Connect | OneCare |
|---|---|---|---|
| Abandonment Rate – Not to Exceed 5% | Met | Met | Met |
| Average Speed of Answer (ASA) – Not to Exceed 30 Seconds | Not Met | Met | Met |

### Analysis:

- ASA for Medi-Cal in January failed to meet the required KPI impacting Q1 results
  - Continual increase in call volume and average length of call for both members and providers without staffing increase
    - January 2017 call volume increased 18% from December 2016
    - Average length of call increased 17%
    - Increased number of open positions

### Resolution:

- Customer Service reviewed staffing requirements to support the increased call volume and length of call for both members and providers
  - Requested and received 10 additional Customer Service Representative positions January 2017

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# Member Experience (Cont.)

## Customer Service Results: Quarter 1

| Key Performance Indicator (KPI) Goal | Medi-Cal | OneCare Connect | OneCare |
|---|---|---|---|
| First Call of Resolution – 85% of Member Calls Resolved the First Time the Member Calls | Met | Met | Met |

### Analysis:

- Customer Service achieved the required standard for Q1
- Identified the top reasons a member calls back within 30 days
    - Medi-Cal
        - Provider information and pharmacy services
    - OneCare Connect
        - Transportation services and plan benefits
    - OneCare
        - Member inquiring about eligibility and dental services

### Resolution:

- Conducting monthly meetings with transportation vendor to address service delays
- Tracking the reason for PCP, health network and pharmacy home changes to identify trends
- Continue to educate members on their eligibility and plan benefits

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# Member Experience (Cont.)

## Customer Service Results: Quarter 1

### Provider Termination:

• Members must receive written notification of their provider termination from CalOptima within 30 days from the date CalOptima is notified of the termination.

| Key Performance Indicator (KPI) Goal | KPI Q1 Results: | Met/Not Met |
|---|---|---|
| 85% | 92% | Met |

**Analysis:**

13 PCPs termed in first quarter, resulting in 521 members receiving the required written notification

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# Member Experience (Cont.)

## Access and Availability

- Member Experience Subcommittee reviewed the April 2017 Availability report at the plan level for:
  - Medi-Cal, OneCare and OneCare Connect
- Analysis
  - Distance and time standards: Met by all three lines of business
  - Minimum number of practitioners
    - OneCare and OneCare Connect met all standards
    - Medi-Cal met standards for PCPs and Behavioral Health Specialists
  - Medi-Cal did not meet the standard ratios for minimum number of providers for three specialties

| Specialties | Standard Ratio | 4/1/2017 Ratio | Met/Not Met |
|---|---|---|---|
| Dermatology | 1:5,000 | 1:7,654 | Not Met |
| Endocrinology | 1:5,000 | 1:12,048 | Not Met |
| Nephrology | 1:5,000 | 1:6,707 | Not Met |

*GG.1600 and MA:7007 Access and Availability Policies and Procedures

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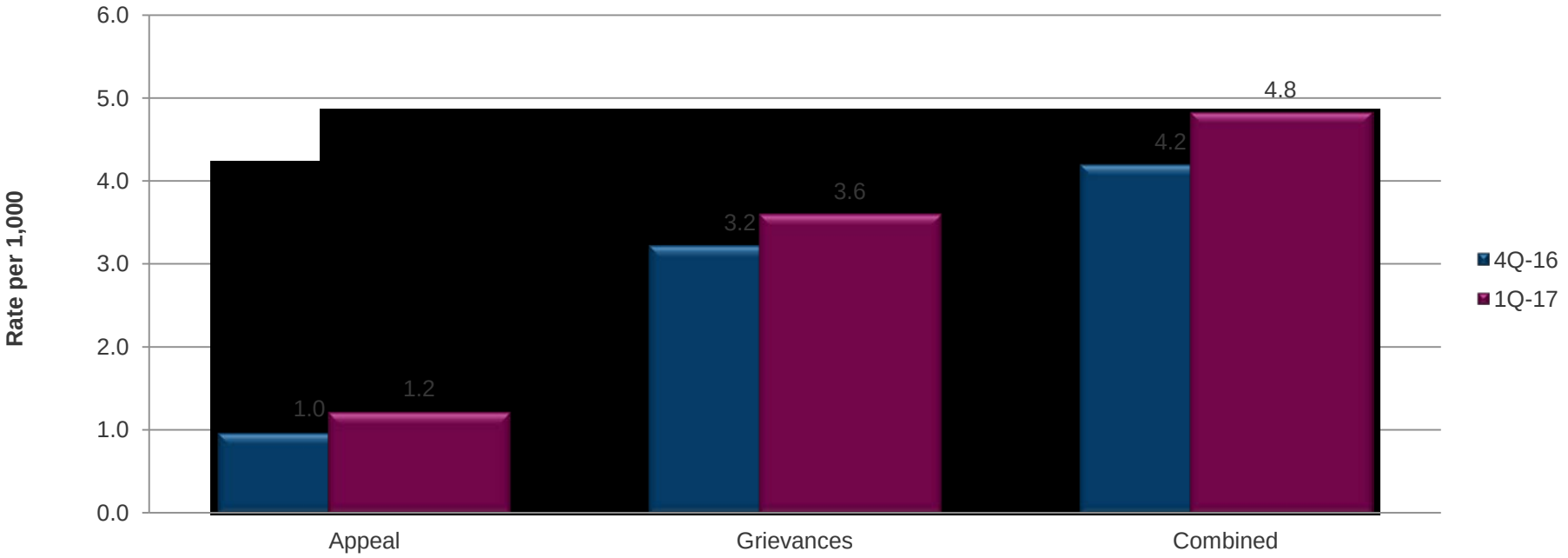
# Member Experience

## Medi-Cal Member Complaints




| | Total Complaints | Appeals | Grievances | Membership |
|---|---|---|---|---|
| 4Q 2016 | 826 | 192 | 634 | 774,869 |
| 1Q 2017 | 921 | 233 | 688 | 774,750 |

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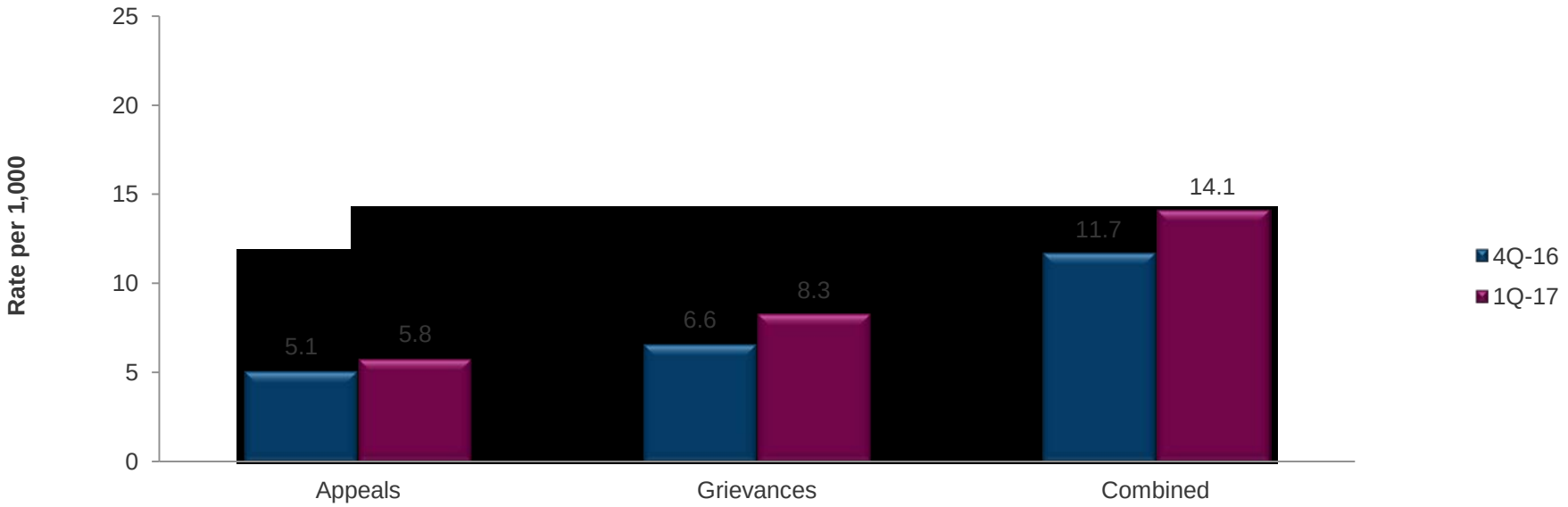
# Member Experience

## OneCare Connect Member Complaints




| | Total Complaints | Appeals | Grievances | Membership |
|---|---|---|---|---|
| 4Q 2016 | 201 | 88 | 113 | 17,369 |
| 1Q 2017 | 230 | 95 | 135 | 16,297 |

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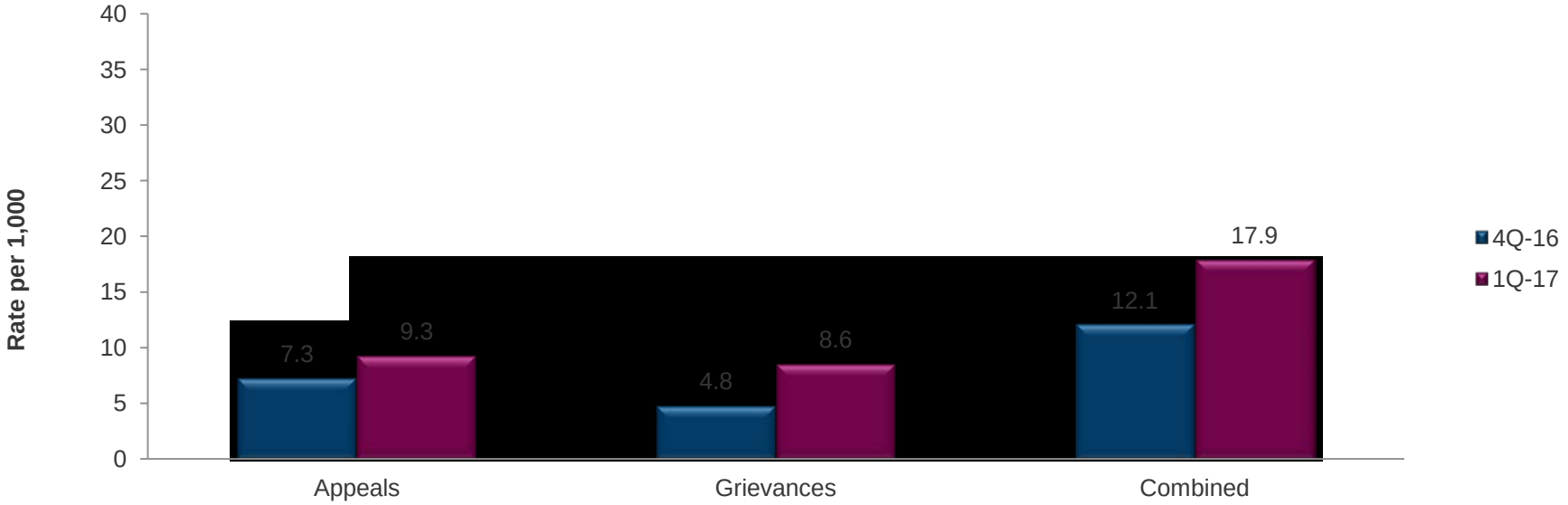
# Member Experience

## OneCare Member Complaints




| | Total Complaints | Appeals | Grievances | Membership |
|---|---|---|---|---|
| 4Q 2016 | 16 | 10 | 6 | 1,232 |
| 1Q 2017 | 18 | 12 | 11 | 1,285 |

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# First Quarter Work Plan Update (Attachment 1a)

- Updates were also made to the QI Work Plan for the following areas:
  - Audit & Oversight/Delegation Oversight
    - UM, CM and Behavioral Health
  - Review of Pharmacy Management
    - No significant change in potential underutilization for diabetics with hypertension without an ACE/ARB
    - Continued opioid overutilization interventions
    - Provided ongoing monitoring of specialty drug trends: Hepatitis C
    - Continued monitoring of specialty drug utilization
      - Specialty Hepatitis C medications
      - Physician-administered drugs
    - Medication Adherence Measures – Progress toward goals
  - Performance Improvement Projects
    - PIPs, QIPS and CCIPS

# First Quarter Work Plan Update (Cont.)

- HEDIS Work Plan Updates (Attachment 1B)
  - Progress Year-to-Date on MY 2017 HEDIS measures
  - Includes intervention strategies

- Case Management Work Plan Updates (Attachment 1C)
  - Health Risk Assessments
  - Continuity and coordination of Medical/BHI
  - Review of emergency department communication with PCPs
  - Member satisfaction with CM programs
  - Identification of complex cases (Health Networks)

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# 2017 QI Workplan Update - Q1

Attachment 1a

| 2017 QI Work Plan | Owner | Goal | Red - At Risk<br>Yellow - Concern<br>Green - On Target | Monitoring and Next Steps | Target Completion |
|---|---|---|---|---|---|
| I. C. Program Scope-2017 UM Program and UM Work Plan annual oversight | Debra Armas | Annual Adoption | | Adopted and approved. | 5/22/2017 |
| I. D. Program Scope-2016 UM Program Annual Evaluation | Debra Armas | Annual Evaluation | | Adopted and approved. | 5/22/2017 |
| I. E. Quality of Care-2017 Case Management Program annual oversight | Sloane Petrillo | Annual Adoption | | CM program reviewed and approved at QIC | 4/11/2017 |
| I. F. Quality of Care-2016 Case Management Program Evaluation | Sloane Petrillo | Annual Evaluation of CCM Program Effectiveness | | CCM Effectivness approved at QIC | 5/1/2017 |
| I. G. Quality of Care-2017 Disease Management Program annual oversight | Pshyra Jones | Annual Adoption | | DM program reviewed and approved at QIC | 4/11/2017 |
| I. H. Quality of Care-2016 Disease Management Program Evaluation | Pshyra Jones | Annual Evaluation of DM Program Effectiveness | | DM Effectivness approved at QIC | 5/12/2017 |
| I. I. Quality of Care-Credentialing Peer Review Committee (CPRC) Oversight | Medical Director | Quarterly Adoption of Report | | Q1 Activity Reviewed and Approved | 4/11/2017 |
| I. J. NCQA Monitoring & Compliance | Kelly Rex-Kimmet | Annual HIP Rating , Maintain Commendable Status | | Currently monitoring activity, as with previous year, on the border between commendable and accredited. Will report final results in August of 2017 | Q3 |
| **Case Management** | | | | | |
| II. A. Quality of Clinical Care- Review of health risk assessments to OCC, OC, SPD members | Sloane Petrillo | Initials OCC,OC, SPD:(Collection Rate)<br>56% Of high risk; 43% low risk; 78% initial; 34% of annual; 63% initial<br>Annual OCC, OC, SPD Collection Rate | Initials OCC | OCC initials met goal 60% high risk, 71.6% low risk | Q2 |
| | | | Initials OC | Q1 met goal for outreach, but fell slightly short of goal for collection. Monitor in Q2 | Q2 |
| | | | Initials SPD | QI met goal: 65% initial | Q2 |
| | | | Annual OCC | Did not meet Q1 goal--Q1 rate was 15%. New process instituted for annual calls during Q1 expected to increase annual collection rate. | Q2 |
| | | | Annual OC | Met goal | Q2 |
| | | | Annual SPD | No goal for this measure | Q2 |
| II. B. Quality of Clinical Care- Continuity & Coordination of Medical/BH | Sloane Petrillo | ICT Particiation; 100% for BHI,85% MBHO, 10% Individual providers, 20% County mental health | BHI Integration | BHI participation for ICT remains at 100%. The rates for county participation are rising, with 55% participation by county in Q1. Individual provider participation does not meet goal, however providers were represented at ICT and provided feedback via MBHO.. | Q2 |
| II. C. Patient Safety, Quality of Care Case Management-High ER utilization | Sloane Petrillo | 5% reduction in ER visits among intervention cohort<br>Process Measure: Enroll 10 High ED utilizers quarterly . | ER Utilization | Work group established in !1. Baseline data collected on cohort of 10 high utilizers and meeting convened. | Q2 |
| II. D. Quality of Clinical Care-Review of member satisfaction with CM programs | Sloane Petrillo | Satisfaction with Case Management - 88% | Satisfaction with Case Management | Annual survey exceeded goal of 88% for the year. | Q2 |
| II. E. Quality of Adherence to Complex Case Management NCQA Standards | Sloane Petrillo | All HN will achieve an average score of 85% or greater on their monthly file reviews | CCM | UCMG and Altamed did not meet the overall goal. CAP request has been submitted for Altamed. Will watch UCMG for improvement in Q2. | Q2 |

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# 2017 QI Workplan Update - Q1

| | | | | | |
|---|---|---|---|---|---|
| **Behavioral Health** | | | | | |
| III. A. Quality of Clinical Care: HEDIS Measure for M/C & OCC | Dr. Donald Sharps | At or above the 50th Percentile | | BHQI Work group continues to monitor HEDIS activity and has been successful in updating reports generated for intervention on the ADD measure. Additional work is being done to analyze the data for the AMM measure and FUH to determine how to best approach intervention strategies. | Q2 |
| III. B. Quality of Clinical Care: Interdisciplinary Care Treatment Team Participation | Dr. Donald Sharps | 10% Improvement over 2016 | | 1. Present Q1 data at May 2 BHQI<br>2. comparison to 2016 final count<br>3. identify areas or improvement and best practices taken to gain current results | Q2 |
| III. C. Quality of Clinical Care: Behavioral Health Practice Guidelines | Dr. Donald Sharps | 100% | | Review and Adoption of CPGs and update CalOptima Website | Q2 |
| III. D. Access and Coordination of Care | Dr. Donald Sharps | Maintain amount of services from previous MBHO; Establish gap analysis and needs for BH support to PCPs and in LTC; Develop unifrom process for accessing BH in LTC | | Collaborate with LTC dept Nurses to take survey out to 68 facliities. Assist in obtaining survey feedback. | Q2 |
| **LTSS** | | | | | |
| IV. A. Safety of Clinical Care and Quality of Clinical Care-Review and assess LTSS<br>placement for members participating with each organization/program | Tracy Hitzeman | CBAS - 277/PTMPY<br>IHSS- 319/PTMPY<br>LTC - 403/PTMPY<br>MSSP - 516/PTMPY | | Of the 4 goals for LTSS, CBAS is the only area that met the goal. Hospital admits for all LTSS programs were higher than the comparative group (non-LTSS population with matching demographics). This is to be expected as the LTSS members tend to have higher acuity levels and co-morbidities. LTSS rates tend to be higher during Q4 and Q1, when pneumonia and respiratory diseases are higher. This is a yearly goal, thus we will continue to be monitor in Q2 and Q3. | Q2 |
| IV. B. Safety of Clinical Care and Quality of Clinical Care-Review and assess emergency<br>department visits for LTSS members participating with each organization/program | Tracy Hitzeman | CBAS - 484/PTMPY<br>IHSS - 662/PTMPY<br>LTC - 390/PTMPY<br>MSSP - 874/PTMPY | | IHSS and MSSP met the goal. Emergency room visits for all LTSS programs are higher than the comparative group (non-LTSS population with matching demographics). This is to be expected as the LTSS members tend to have higher acuity levels and co-morbidities. LTSS rates tend to be higher during Q4 and Q1, when pneumonia and respiratory diseases are higher. Will continue to monitor. | Q2 |
| IV. C. Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions<br>for LTSS members participating with each organization/program: **Hospital Readmissions** | Tracy Hitzeman | CBAS - 20%<br>IHSS - 23%<br>LTC - 40%<br>MSSP - 20% | | CBAS, IHSS and LTC met the goal. MSSP Re-Admissions: During our validation process it was discovered that one member, who re-admitted to the hospital twice, was only in a referral status for the MSSP program and should not have been counted. Evaluated how this happened and implemented corrective action. | Q2 |
| IV. D. Safety of Clinical Care and Quality of Clinical Care-Review and Assess Readmissions for<br>LTSS members participating with each organization/program: **Long Term Care Admissions** | Tracy Hitzeman | CBAS - Establishing Goals<br>IHSS - Establishing Goals<br>MSSP - Establishing Goals | | CBAS - 13 members were admitted to LTC during reporting period; IHSS - 146 members admitted to LTC; MSSP - 14 members admitted to LTC. | Q2 |
| IV. E. Quality of Clinical Care-Review of health risk assessment (HRA) for OneCare<br>Connect (OCC) Long Term Care (LTC) members | Tracy Hitzeman | Goal is measured as part of CM, need to make sure it is captured in CM | | See CM Reporting Lines 14-19 | Q2 |

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# 2017 QI Workplan Update - Q1

| | | | | | |
|---|---|---|---|---|---|
| IV. F. CBAS Member Satisfaction | Laura Guest | Achieve an overall satisfaction rating of 90%. | | Complete the survey tool and send to Communication for approval. | 6/30/2017 |
| IV. G. SNF Member Satisfaction | Laura Guest | Achieve an overall satisfaction rating of 90%. | | Complete the survey tool and send to Communication for approval. | 6/30/2017 |
| **Health Education & Disease Management** | | | | | |
| V. A. Quality of Care- All new members will complete the Initial Health Assessment and related IHEBA/SHAs | Pshyra Jones | Improve plan performance over 2016 by 10% | | Continue with new member IVR and welcome call interventions. Continue to monthly monitoring and reporting HN completion rates. | 12/31/2017 |
| V. B. Quality of Clinical Care-Review of Disease Management Programs | Pshyra Jones | Medical: Increase: 75th percentile for Asthma Medication Ratio (AMR) Ages 5-11; 75th percentile for Medication Management for People with Asthma (MMA), ages 5-85; 50th percentile for HbA1c Testing; 90th percentile for HbA1c Poor Control; 75th percentile for Eye Exams; 50th percentile for Annual Monitoring for Patients on Persistent Medications<br>(MPM) Ace Inhibitors or ARBs - Increase to 50th percentile for HbA1c Testing - Medicare; 50th percentile for Controlling High Blood Pressure (CBP);<br>85% satisfaction with DM Programs | | Continue with DM health coach and targeted interventions. | 12/31/2017 |
| V. C. Quality of Care-Clinical Practice Guidelines adoption for Medi-Ca line of business | Pshyra Jones | 100% | | Will be presented to QIC in Q2 | 12/31/2017 |
| V.D. Quality of Clinical Care-Review of Cardiovascular Disease | Pshyra Jones | As determined by CMS | | Continue with DM health coach and targeted interventions. | 12./31/2017 |
| V. E. Implementation of Population Health & Wellness Programs | Pshyra Jones | Implement revised program design-2017; Evaluate progress semi-annually | | Reissue RFP for Shape Your Life | 5/31/2017 |
| | | | Diabetes QIP | 1. Continue with intervention activities and collect data through June 30, 2017. Module 5 submission is August, 2017. | 1. August, 2017 |
| | | | Readmission QIP | 2. QIP: Continue with intervention activities and collect data. Next submission is January, 2018. | 2. January, 2019 |

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# 2017 QI Workplan Update - Q1

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|---|---|---|---|---|---|
| V. F. Quality of Clinical Care-Quality and Performance Improvement Projects | Pshyra Jones /Kelly Rex-Kimmet | HbA1c Testing rate at the 50th percentile based on the 2016 NCQA Quality Compass; 16.8% readmissions rate; 80% HbA1c Testing; 25% IHA rate; 35% IHSS Participation rate | MC Diabetes PIP | 3. In 2016, rates for HbA1c testing fell just short (1.77%) of the 50th percentile. With continued monitoring and strategizing from the Diabetes Chronic QI Work Team and utilizing the 2017 Prospective rate report, we are starting to see improvements in 2017. | 3. January, 2019 |
| | | | MC IHA PIP | 4. Continue with intervention activities. Collecting data for Q1, 2017 and through June 30, 2017. Module 5 submission is August, 2017 | 4. August, 2017 |
| | | | OCC LTSS PIP | 5. Continue with intervention activities. Provide educational resources and support to targeted health networks. Collecting data for the IHSS SW participation through June 30, 2017. Submission for Module 5 is August, 2017 | 5. August, 2017 |
| **Access & Availability** | | | | | |
| VI. A. Quality of Service and Quality of Clinical Care-Review of notification to members | Belinda Abeyta & Laura Grigoruk | 85% | | Continue monthly monitoring of Member notifications of provider terminations to ensure timely notification to the Member. | Q2 |
| VI. B. Access to Care-Credentialing of provider network is monitored | Esther Okajima | 90% of initial credentialing applications are processed within 120 days of receipt of application | | Continue to monitor TAT times to reduce to <120 days. Still working through backlog from Q4 2016 and Q1 12017 with staff shortage, upgrade to credentialing system, holidays and new workflow. | 6/30/2017 |
| VI.C. Access to Care-Recredentialing of provider network is monitored | Esther Okajima | 100% of all recredentialing files are processed within 36 months of last credentialing date | | Continue to ensure that recredentialing files do not lapse. Challenged with making sure that providers with multiple addresses are not in-appropriate closed in the system, which would lead to files not be credentialed timely. | 6/30/2017 |
| VI.D. Accessibility: Review of access to care | Marsha Choo | Appointment: 90% minimum performance level; Phone: ASA 30 seconds; Abandonment rate <5% | | Finalize the high volume and high impact specialty list for monitoring<br><br>Update the Timely Access scope of work and survey tool; Issue amendment to contract<br><br>Close out previous access CAPs<br><br>Share 2016 Access and Availability Results (i e. HN Quality Forum, HN Forum, CCN Lunch and Learn)<br><br>Issue CAPS for 2016 Access Results<br><br>Field 2017 Timely Access Study | Q2 2017 |
| VI. E. Availability: Review of availability of practitioners | Marsha Choo & Dr. Donald Sharps | Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007 | | Finalize the high volume and high impact specialty list for monitoring<br><br>Run the 4/1/2017 Availability Report<br><br>Continuous recruitment efforts by our Provider Relations Staff | Q2 2017 |
| **Patient Safety** | | | | | |

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# 2017 QI Workplan Update - Q1

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| VII. A. Safety of Clinical Care-Providers shall have timely and complete facility site reviews | Esther Okajima | 100% of FSR/MRR/PARS Initial or Full Scope Surveys are completed within initial and re-credentialing timeframes | | Continue to monitor CAPS that are issued with FSR/MRR. Also, % of PARS with Basic Access is > 50%. Many of the deficiencies are not being addressed. Begin tracking deficiencies and corrections for PARS | 6/30/2017 |
| VII. B. Safety of Clinical Care-Review and follow-up on member's potential Quality of Care Complaints | Laura Guest | Achieve a turnaround time of 90 days on 90% of cases received; Review data for trends and patterns for potential further actions | | Continue to monitor the TAT weekly. | 6/30/2017 |
| VII. C. Safety of Clinical Care and Quality of Clinical Care-Reviewed through Pharmacy Management | Kris Gericke, PharmD | Reductions in underutilization and overutilization measures | | On target, and monitroing progress. | Q2 |
| VII. D. Safety of Clinical care and Quality of Clinical Care-Review of Specialty Drug Utilization | Kris Gericke, PharmD | Review and reporting of Specialty Drug trends, identify any actions<br>necessary with the member or provider/HN | | On target, and monitroing progress. | Q2 |
| VII. E. Patient Safety-Review and assessment of CBAS Quality Monitoring | Laura Guest | Complete on-site audit review of all CBAS centers receiving a CAP from CDA. | | Continue monitoring of the CBAS centers. Those centers receiving CAPS will have increased monitoring to ensure CAP compliance. | 6/30/2017 |
| VII. F. Patient Safety-Review and assessment of SNF Quality Monitoring | Laura Guest | Complete the on-site assessment of all contracted SNFs in Orange County, and attain a goal that 90% of the facilities will be in compliance with the Plan of Correction provided by DHCS. | | Continue monitoring of the SNFs. | 6/30/2017 |
| VII. G. Safety of Clinical Care-Review of antibiotic usage | Kelly Rex-Kimmet/Marsha Choo | Appropriate Testing for Children with Pharyngitis: 63 24% (25th percentile); | | This measure tends to score low. Interventions have are progress. Will continue to monitor until final rates are published. | Q2 |
| | | Appropriate treatment for Children with URI: 93.38% (75th percentile) | | On track, continue to monitor. | Q2 |
| | | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) 22.25% (25th percentile) | | AAB PDSA - Cycle 1 completion (April, 2017). Goal was to complete medical director outreach/training on AAB measure to five (5) targeted provider offices. Cycle 2 targeted completion (July, 2017). These measure tend to score low. Interventions have are progress. Will continue to monitor until final rates are published. | Q2 |
| VII. H. Pharmacy Benefit Manager (PBM) Oversight Management | Kris Gericke, PharmD | PBM Performance Guarantees met<br>Per Contract | | There was timing issue of receiving reports | Q2 |
| **Member Experience** | | | | | |

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# 2017 QI Workplan Update - Q1

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| VIII. A. Quality of Service- Review of Member Satisfaction | Kelly Rex-Kimmet/Marsha Choo | Annual CAHPS Results | | Review the following member experience data:<br>- Customer Service data<br>- GARS data<br>- Beacon 2015 Access Data<br>- Availability Data | Q2 2017 |
| VIII.B. Quality of Service- Reviewed through customer service first call resolution | Belinda Abeyta | 85% of calls resolved at first call | | Continue monthly review of call center data to determine opportunities for improvement of the First Call Resolution Rates with Medi-Cal, OCC and OCC. | Monthly Monitoring |
| VIII. C. Quality of Service- Reviewed through customer service access | Belinda Abeyta | ASA 30 Seconds<br><3%<br>First Call Resolution 85% | | Medi-Cal failed to achieve ASA for January due to staffing shortage. 7 CSR and 3 Sr. CSR's were approved at January's Resource Work Group. Temp-hire staff started in February. Daily, weekly and monthly monitor of Call Centers KPI's. | Daily, weekly and monthly monitor of Call Centers KPI's |
| VIII. D. Quality of Care & Service reviewed through GARS & PQI (MOC) | Janine Kodama & Laura Guest | Identify through the bi-annual review of GARS and PQI cases with high severity and/or high quantity of cases by provider, and complete the plan of action for follow-up of these providers. | | Continue monitoring number of new cases opened and closed cases. The current case count of PQI cases is 375. There are 92 cases over 30 days. Looking at improving processes to close cases while satisfying requirements. Continue to Follow-up on severity codes requiring action with CPRC. | 6/30/2017 |
| **HEDIS/STARS Improvement** | | | | | |
| IX. A. Improve identified HEDIS Measures listed on "Measures" worksheet | Kelly Rex-Kimmet/ Marsha Choo | See Measures Worksheet | | See attachment | See attachment |
| IX. B. Improve identified STARS measures listed on "Measure" worksheet | Kelly Rex-Kimmet & Kris Gericke & Tracy Hitzeman | See Measures Worksheet | | See attachment | See attachment |
| IX. C. Improve CAHPS measures listed on "Measures" worksheet | Kelly Rex-Kimmet/Marsha Choo | See Measures Worksheet | | Update and send out CG-CAHPS provider scorecards<br><br>Issue RFP for provider coaching<br><br>Continuous training for Customer Service Representatives | Q2 2017 |
| IX. D. STARS Medication Related Measures | Kris Gericke | Star measure scores above the national MA-PD average as reported by CMS | | There was timing issue of receiving reports. Will be available in Q2 and reported in Q3.M76 | Q3 |
| IX. E. HEDIS: Health Network support of HEDIS & CAHPS Improvement | Kelly Rex-Kimmet/Marsha Choo | 24 33% | | Share the 2017 Survey Schedule with the HNs<br><br>Share CG-CAHPS data with the HNs<br><br>Share the 2017 HEDIS prospective rates with patient list for interventions with the HNs<br><br>Continue HN individual Quality Meetings | Q2 2017 |
| **Delegation Oversight** | | | | | |

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# 2017 QI Workplan Update - Q1

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| X. A. Delegation Oversight of CM | Sloane Petrillo | OCC, OC, SPD Goal 90% | OCC | See results above, line 23 | |
| | | | OC | See results above, line 23 | |
| | | | SPD | See results above, line 23 | |
| X. B. Quality of Care & service of UM through delegation oversight reviews | Solange Marvin | 98% | | Medi-Cal<br>Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (January 2016 -March 2017) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe.<br>OneCare<br>Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (January 2016 -March 2017) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe.<br>OneCare Connect<br>Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (January 2016 -March 2017) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe.<br><br>Next Step: Corrective Action Plan issued and continued monitoring from performance Improvement. | Ongoing |
| X. C. Delegation Oversight of BH Services | Dr. Edwin Poon | 98% | | Results will be presented at the BHQI on May 2, 2017. Hold monthly intense monitoring meeting with MBHO to review findings. | Q2 |
| **Organizational Projects** | | | | | |
| XI. A. Value Based P4P 2017 | Sandeep Mital | Implement 2017 prospective rates by 3/1/17; Design 2018 P4V by 4th Quarter, 2017 | | Calculate MY2016 P4V incentives after HEDIS and CAHPS final scores are available in the 3rd quarter of this year | Oct-17 |
| XI. B. MOC Dashboard 2016-2019 | Esther Okajima | Meet or exceed defined MOC Metrics | | In Q1, Caloptima wrote and submitted the 2018 MOC and related MOC metrics to CMS which was accepted. The current dashbaord will be reviewed in Q2 | Q2 |

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## HEDIS MEASURES

| HEDIS Medi-Cal Measures | Objective | Planned Activity | Goal | Results/ Metrics<br><br>Medi-Cal Prospective Rates: (April, 2017) | Red: At Risk Yellow: Concern Green: On Track | Monitoring and Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| **Comprehensive Diabetes Care (CDC)**<br>Medicaid:<br>a) A1C Screening: 85.95% (50th percentile)<br>b) A1C Control <8.0%: 52.55% (75th percentile)<br>c) A1C Control >9.0%: 36.87% (lower score is better) (75th percentile)<br>d) Eye Exams: 61.5 (75th percentile)<br>e) Nephropathy Screening: 90.51% (50th percentile)<br>f) BP Control: 68.61% (75th percentile) | Increase the comprehensive diabetes care measures MC and OC members - in conjunction with Diabetes Disease Management Program | Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care.<br><br>Also explore the use of member engagement technologies to improve rates.<br><br>These measures are also incentivized through our P4V program. (interventions based on unique member characteristics) | a. 85.95%<br>b. 52.55%<br>c. 36.87%<br>d. 61.5%<br>e. 90.51%<br>f. 68.61% | Not available yet | Green | • Implemented Diabetes PIP/QIPs to increase HbA1c testing for the MC and OC populations<br>• Sent PCPs list of patients in the Disease Management program to conduct outreach<br>• Diabetes Talk newsletter<br>• Diabetes workgroup (Lead by Dr. Dajee) | On-going |
| **HEDIS/STARS Improvement: Review | Reduce 30 day All Cause | Readmission Rate will be minimized through | Medi-Cal <14% Readmission | Not available yet Not | Yellow | • Currently implementing the transition of care (TOC) program | On-going |



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| HEDIS Medi-Cal Measures | Objective | Planned Activity | Goal | Results/ Metrics<br><br>Medi-Cal Prospective Rates: (April, 2017) | Red: At Risk Yellow: Concern Green: On Track | Monitoring and Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| **all-cause hospital readmissions** with Medi-Cal & OneCare Connect members **(PCR)** | Readmissions (PCR) | member education and Quality Incentive Program.<br><br>A reporting mechanism will be established followed by analysis of data. | rate | available yet | | which has two interventions; 1) Health Coach outreach directly to members and 2) Discharge mail kits to members who did not participate in the health coaching<br><br>• Update (TOC) program; reassess interventions, educational materials, etc. | |
| Flu/Pneumonia<br><br>(CAHPS Survey) | Increase the flu and pneumococcal screening rate in:<br>1. MC members 18-64 years old and<br>2. OC members 65 years old and older to meet goal | Compliance with flu and pneumococcal immunizations will increase through flu reminders and education. | 90% | Not available yet | Green | • Reminder flu/pneumonia mailing sent end of March, 2017 | Annual |
| **HEDIS:** Review of prenatal & postpartum care services (PPC) | Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal | The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider | MC Prenatal: 82.25% (50th percentile)<br>MC Postpartum: 67.53% (75th percentile) | Not available yet | Green | • Prenatal and postpartum mailings to members (bi-weekly)<br>• Text 4 baby program; expanding to "personalized messaging"<br>• CE Healthy Birth Spacing (2/9/17)<br>• PNR/MOMs database data review<br>• Developed small workgroup to | • On-going |

| HEDIS Medi-Cal Measures | Objective | Planned Activity | Goal | Results/ Metrics<br><br>Medi-Cal Prospective Rates: (April, 2017) | Red: At Risk Yellow: Concern Green: On Track | Monitoring and Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| | | education and sharing of provider data.<br>Utilize Text-For-Baby custom messages to encourage member compliance. | | | | improve Maternal Data Mart; goal to produce timely and accurate reports for PPC<br>• Updated educational insert for prenatal<br>• Health Education Dept – Maternal Health program | |
| **Lead Screening (Monitoring Measure)** | Increase lead screening rate | • Analyze data to determine low performing HN. Implement initiatives to address identified barriers to better performance (data strategy as well as provider outreach) | MC: 75.7% (66$^{th}$ percentile) | Not available yet | Green | • Healthy You Mailing (About Your Baby) | • On-going |

| HEDIS Medi-Cal Measures | Objective | Planned Activity | Goal | Results/ Metrics<br><br>Medi-Cal Prospective Rates: (April, 2017) | Red: At Risk Yellow: Concern Green: On Track | Monitoring and Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| **HEDIS:** Review and assessment prescribed ADHD medication (ADHD) | Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal | Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members. | Initiation Phase: 42.19% (50th percentile) Maintenance Phase: 52.47% (50th percentile) | Not available yet | Green | • ADD mailing to both members and providers for the initial phase. Members received reminder to go in for follow up visits. PCP/Prescribers are notified of members on ADHD medication.<br>• Updating CORE reports and member/provider letters | • On-going |
| **HEDIS**: Review and assessment of antidepressant medication management (AMM) | Increase the antidepressant medication management rate in MC and OC members with a diagnosis of major depression to meet goal | Antidepressant medication management rates will increase with the distribution of member health education material. | **MC**: Acute Phase Treatment: 59.52 (75th percentile) **MC:** Continuation Phase Treatment: 41.46% (66$^{th}$ percentile) **OC:** Effective Phase Treatment 68.66% (50$^{th}$ percentile) **OC:** Continuation Phase Treatment 54.76% (50$^{th}$ | Not available yet | Green | • Provider educational faxes (monthly)<br>• ICT medication reconciliation tool in guiding care | • On-going |

| HEDIS Medi-Cal Measures | Objective | Planned Activity | Goal | Results/ Metrics<br><br>Medi-Cal Prospective Rates: (April, 2017) | Red: At Risk Yellow: Concern Green: On Track | Monitoring and Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| | | | percentile) | | | | |
| ****HEDIS/STARS**: Review and assessment of osteoporosis management (OMW) | Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal | Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education. | OC: 47.6% (66th percentile) | Not available yet | Green | • Pharmacy Provider Faxes (OMW)/Bi-monthly faxes<br>• QA developing database to streamline provider faxes for pharmacy | • On-going |
| **HEDIS:** Review and assessment of childhood immunization rates | Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal | Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10)<br>This measure is also incentivized in our P4V program. | MC: Combo 10: 40.9% (75th percentile) | Not available yet | Green | • Healthy You newsletters for babies (0-2 years) and children (3-12 years)<br>• Child Health Guide mailings to children who were recently admitted to the hospital<br>• Q2, 2017: Interactive voice recordings (IVR) calls; promoting immunizations for children from 0-before 2nd birthday | • On-going |
| **HEDIS:** Review and assessment of use of imaging studies for low back pain | Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain) | Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education | MC: 73.71% (50th percentile) | Not available yet | Green | • Continue to monitor | |

| HEDIS Medi-Cal Measures | Objective | Planned Activity | Goal | Results/ Metrics<br><br>Medi-Cal Prospective Rates: (April, 2017) | Red: At Risk Yellow: Concern Green: On Track | Monitoring and Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| **HEDIS:** Review and assessment of adult's access to preventive/ambulatory health (AAP) | Increase MC and OC adult's access to preventive/ambulatory health to meet goal | Comprehensive member and provider outreach with reminders to increase access for adults | MC: 82.15% (50th percentile)<br>OC: 95.56% (50th percentile) | Not available yet | Yellow | • Adult team to discuss possible interventions | • On-going |
| Review and assessment of children's access to primary care practitioners (CAP)<br>• 12-24 months<br>• 25mo-6 years<br>• 7-11 years<br>• 12-19 years | Increase children's access to primary care practitioners to meet goal | Comprehensive member and provider outreach with reminders to increase access for children | MC: 1) 12-24 months 95.74% (50th percentile)<br>2) 25 months -6 years 90.98% (75th percentile)<br>3) 7-11 years 93.25% (75th percentile)<br>4) 12-19 years 89.37% (50th percentile) | Not available yet | Yellow | • Healthy You newsletters for babies (0-2 years) and children (3-12 years)<br>• Child Health Guide mailings to children who were recently admitted to the hospital<br>• Health and Wellness Event (Quarter 2-3)<br>• Child team to discuss possible interventions. | • On-going |
| **HEDIS:** Review and assessment of cervical cancer screening (CCS) | Increase the cervical cancer screening in our MC female members 21-64 to meet goal | Increase cervical cancer screening through member and provider outreach and education with reminders. | MC: 55.94% (50th percentile) | Not available yet | Green | • CCS member incentive – launch in Q2, 2017<br>• CCS PDSA: Provider Office Staff incentive<br>• CCS extended office hours; launch in Q2, 2017<br>• Q2-3: CCS IVR calls outreach to members who have not received screening<br>• Preconception insert in Prenatal | • On-going |

| HEDIS Medi-Cal Measures | Objective | Planned Activity | Goal | Results/ Metrics<br><br>Medi-Cal Prospective Rates: (April, 2017) | Red: At Risk Yellow: Concern Green: On Track | Monitoring and Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| | | | | | | mailings (Promoting cervical health before getting pregnant) | |
| **HEDIS:** Review and assessment of well child visits in the first 15 months of life (W15) | Increase the well care visits for MC children in their first 15 months of life to meet goal | Increase of well care visit for children in their first 15 months of life through member and provider outreach and education with reminders | MC: 59.57% (6 or more visits) (50th percentile) | Not available yet | Green | • Healthy You newsletters for babies (0-2 years) and children (3-12 years)<br>• Child Health Guide mailings to children who were recently admitted to the hospital | • On-going |
| **HEDIS:** Review and assessment of breast cancer screening (BCS) | Increase the breast cancer screening for MC and OC female members to meet goal | Increase the breast cancer screening through member and provider education and outreach with reminders as ways to decrease barriers to screening | MC: 71.52% (90th percentile)<br>OC: 71.36% (50th percentile) | Not available yet | Green | • BCS member mailing<br>• Updated breast cancer brochure | • On |
| **HEDIS/STARS:** Review and assessment of colorectal cancer screening (COL) | Increase the colorectal cancer screening for OC members to meet goal | Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening | OC: 67.27% (50th percentile) Monitor for Medicaid population. Develop internal benchmark as National Medicaid Benchmark does not exist. | Not available yet | Green | • March, 2017: Colorectal cancer mailing sent to targeted OC/OCC members who have not had a colorectal screenings based on our records | • On-going |
| **HEDIS:** Avoidance of Antibiotic Treatment in Adults with Acute | Increase the AAB measure for MC members above | PDSA project for this measure: Outreaching to 5 high prescribing/low | 50th percentile | Not available yet | Green | • Cycle 1 submission: 2/21/17<br>• Cycle 2 submission: 6/21/17 | • On-going |

| HEDIS Medi-Cal Measures | Objective | Planned Activity | Goal | Results/ Metrics<br><br>Medi-Cal Prospective Rates: (April, 2017) | Red: At Risk Yellow: Concern Green: On Track | Monitoring and Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| Bronchitis (AAB)<br>• | the minimum performance level (MPL) | performing providers for this measure by Medical Director | | | | | |

## STAR MEASURES

| STARS Measures | Objective | Planned Activity | OC Goal | Results/ Metrics | Red – At Risk Yellow – Concern Green – On Target | Monitoring/Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| **HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC) **OneCare/OneCare Connect**<br><br>***HEDIS Medicare:***<br>a) A1C Screening: 91.4%<br>b) A1C Control <8.0%: 72.8%<br>c) A1C Control >9.0 | Increase the comprehensive diabetes care measures OC and OCC members - in conjunction with Diabetes Disease Management Program | Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care.<br><br>Also explore the use of member engagement technologies to improve | Medicare:<br>1) A1C Control >9:.0 16% (lower score is better; CMS 5 star goal)<br>2) Eye Exams: 82% (maintain 2016 above CMS 5-star goal)<br>3) Nephropathy Screening: 96% (CMS 4 | Not available yet | Green | • Implemented Diabetes PIP/QIPs to increase HbA1c testing for the MC and OC populations<br>• Sent PCPs list of patients in the Disease Management program to conduct outreach<br>• Quarterly diabetic eye exam member mailing<br>• Diabetes Talk newsletter | On-going |

| STARS Measures | Objective | Planned Activity | OC Goal | Results/ Metrics | Red – At Risk Yellow – Concern Green – On Target | Monitoring/Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| 18.8% (lower score is better)<br>d) Eye Exams: 82%<br>e) Nephropathy Screening: 95.8%BP Control: 79.3% | | rates.<br><br>These measures are also incentivized through our P4V program. (interventions based on unique member characteristics) | star goal) | | | | |
| **HEDIS/STARS Review Adult BMI Assessment | Increase the BMI assessment in adults | Assessment of BMI will increase through provider education and dissemination of BMI assessment tools. | Medicare: 96% (CMS 5 star goal) | Not available yet | Green | • Adult Team to discuss interventions | |
| **HEDIS/STARS Improvement: Review Care of Older Adult | Increase the Care of Older Adult Rate in:<br>1) Medication Review<br>2) Pain Screening<br>3) Functional Status Assessment | Care of Older Adult measures to increase through provider education and dissemination of provider tools. | OneCare Only:<br>1) Medication Review: 87% (CMS 5 star goal)<br>2) Pain Screening: 88% (CMS 5 star goal)<br>3) Functional Status Assessment: 74% (CMS 4 star goal) | Not available yet | Green | • Adult Team to discuss interventions | |
| **HEDIS/STARS Improvement: Review all-cause hospital readmissions with | Reduce 30 day All Cause Readmissions (PCR) | Readmission Rate will be minimized through member education and Quality Incentive Program. | Medicare: <10% Readmission rate (CMS 4 star goal) | Not available yet | Yellow | • Currently implementing the transition of care (TOC) program which has two interventions; 1) Health Coach outreach directly to | On-going |

| STARS Measures | Objective | Planned Activity | OC Goal | Results/ Metrics | Red – At Risk Yellow – Concern Green – On Target | Monitoring/Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| OneCare & OneCare Connect members (PCR) | | A reporting mechanism will be established followed by analysis of data. | | | | members and 2) Discharge mail kits to members who did not participate in the health coaching<br>• Update (TOC) program; reassess interventions, educational materials, etc. | |
| **HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates* | Increase the flu and pneumococcal screening rate in OC and OCC members 65 years old and older to meet goal | Compliance with flu and pneumococcal immunizations will increase through flu reminders and education. | Medicare: 74% (CMS 4 star goal) | Not available yet | Green | • Flu mailing was sent to OC/OCC members at the end of February, 2017 | |
| **HEDIS**: Review and assessment of antidepressant medication management (AMM) | Increase the antidepressant medication management rate in MC and OC members with a diagnosis of major depression to meet goal | Antidepressant medication management rates will increase with the distribution of member health education material. | OC: Effective Phase Treatment 68.66% (50th percentile)<br>OC: Continuation Phase Treatment 54.76% (50th percentile) | Not available yet | Green | • Provider educational faxes; pharmacy and provider update<br>• ICT medication reconciliation tool | • |
| **HEDIS/STARS: Review and assessment of | Increase the osteoporosis management in | Osteoporosis management in women who had a fracture will increase | Medicare: 51% (CMS 4 start goal) | Not available yet | Green | • OMW provider faxes, notifying providers of members to conduct outreach to. | • |

| STARS Measures | Objective | Planned Activity | OC Goal | Results/ Metrics | Red – At Risk Yellow – Concern Green – On Target | Monitoring/Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| osteoporosis management (OMW) | women who had a fracture rate in OC and OCC women who suffered a fracture to meet goal | through improved member identification using claims and pharmacy data and provider education. | | | | • ICT medication reconciliation tool<br>• QA developing database to streamline provider faxes for pharmacy | |
| **HEDIS/STARS:** Review and assessment of colorectal cancer screening (COL) | Increase the colorectal cancer screening for OC members to meet goal | Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening | OC: 67.27% (50th percentile) Monitor for Medicaid population. Develop internal benchmark as National Medicaid Benchmark does not exist. | Not available yet | Green | • March, 2017: Colorectal cancer mailing sent to targeted OC/OCC members who have not had a colorectal screenings based on our records | |
| **HEDIS:** Review and assessment of breast cancer screening (BCS) | Increase the breast cancer screening for MC and OC female members to meet goal | Increase the breast cancer screening through member and provider education and outreach with reminders as ways to decrease barriers to screening | MC: 71.52% (90th percentile)<br>OC: 71.36% (50th percentile) | Not available yet | Green | • BCS member incentive – launch in Q2, 2017<br>• BCS member mailing in October, 2017 | |

| STARS Measures | Objective | Planned Activity | OC Goal | Results/ Metrics | Red – At Risk Yellow – Concern Green – On Target | Monitoring/Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| **HEDIS/STARS: Review and assessment of monitoring physical activity | Increase the monitoring of physical activity for OC and OCC members to meet goal | Increase of monitoring of physical activity through provider outreach and education and dissemination of provider tools | Medicare: 57% (CMS 5 star goal) | Not available yet | Green | • Provider education | |
| **HEDIS/STARS: Review and assessment of controlling blood pressure (CBP) | Increase of controlling blood pressure rate | Increase of controlling blood pressure rate through provider and member outreach and education | Medicare: 75% (CMS 5 star goal) | | Green | • Disease Management health coaches –distribute blood pressure cuffs for eligible members | |
| **HEDIS/STARS: Improvement: Rheumatoid Arthritis Management | Increase of rheumatoid arthritis management rate | Increase of rheumatoid arthritis management through provider education | Medicare: 72% (CMS 3 star goal) | Not available yet | Green | • Provider Faxes regarding RA members | On-going |
| **HEDIS: Follow-up after Hospitalization for Mental Illness (7 days / 30 days) | Increase follow-up after hospitalization for mental illness | Increase follow-up after hospitalization through collaboration with our behavioral health partner to conduct provider education and member outreach through reminders. | Medicare: 56% (Quality Withhold Goal) | Not available yet | Green | • Behavioral health team to discuss possible interventions with Magellan. | |
| **HOS/STARS: Health Outcome Survey Measures | Improve HOS measures for Star Rating | Develop and implement activities around:<br>1) Reducing Risk of Falls<br>2) Improving Physical Health | Medicare:<br>1) Reducing Risk of Falls: 73% (CMS 5 star goal)<br>2) Improving | Not available yet | Green | * TBD | |

| STARS Measures | Objective | Planned Activity | OC Goal | Results/ Metrics | Red – At Risk Yellow – Concern Green – On Target | Monitoring/Next Steps | Target Completion |
|---|---|---|---|---|---|---|---|
| | | Status<br>3) Improving Mental Health Status | Physical Health Status: 72% (CMS 4 star goal)<br>3) Improving Mental Health Status: 87% (CMS 5 star goal | | | | |

# HRA Collection

| Newly Eligible OCC | Jan | % | Overall % | Feb | % | Overall % | Mar | % | Overall % | Quarter 1 Collected/non responder Average |
|---|---|---|---|---|---|---|---|---|---|---|
| OCC Collection High | 52 | 38.5% | 63% | 34 | 23.9% | 65% | 58 | 35.5% | 74% | 67% |
| OCC Collection Low | 83 | 61.5% | | 108 | 76.1% | | 105 | 64.5% | | |
| OCC (non responders) High | 36 | 45.5% | 37% | 59 | 78.6% | 35% | 0 | 0% | 26% | 33% |
| OCC (non responders) Low | 43 | 54.5% | | 16 | 21.4% | | 58 | 100% | | |
| **OCC Totals** | **214** | | **100%** | **217** | | **100%** | **221** | | **100%** | **100%** |

**Note: Total of 30 calls are required to outreach between 5/26/17-5/30/17.**

| Newly Eligible SPD | Jan | % | Overall % | Feb | % | Overall % | Mar | % | Overall % | Quarter 1 Collected/non responder Average |
|---|---|---|---|---|---|---|---|---|---|---|
| SPD Collection High | 90 | 18.4% | 63% | 60 | 13.8% | 64% | 105 | 21.9% | 68% | 65% |
| SPD Collection Low | 400 | 81.6% | | 375 | 86.2% | | 375 | 78.1% | | |
| SPD (non responders)High | 54 | 18.5% | 37% | 19 | 7.6% | 36% | 45 | 19.8% | 32% | 35% |
| SPD (non responders)Low | 237 | 81.5% | | 229 | 92.4% | | 182 | 80.2% | | |
| **SPD Totals*** | **781** | | **100%** | **683** | | **100%** | **707** | | **100%** | **100%** |

* Note: Total count excluded members with other primary insurance

| Newly Eligible OC | Jan | % | Feb | % | Mar | % | Quarter 1 Average |
|---|---|---|---|---|---|---|---|
| HRA's Collected | 33 | 67.0% | 41 | 77.0% | | | 72% |
| HRA (non responders) | 16 | 33.0% | 12 | 23.0% | | | 28% |
| **OC Totals** | **49** | **100%** | **53** | **100%** | | | **100%** |

| **Annual** OCC Members | Jan | % | Feb | % | Mar | % | Quarter 1 Average |
|---|---|---|---|---|---|---|---|
| HRAs collected | 176 | 3% | 129 | 16.0% | 197 | 27.0% | 15% |
| HRAs (non responders) | 5201 | 97% | 655 | 84.0% | 546 | 73.0% | 85% |
| **Total** | **5377** | **0%** | **784** | **100%** | **743** | | **100%** |

**Note: Outreach call was documented outside the script**

| Mailed SPD Annual HRA | |
|---|---|
| *January* | 767 |
| *February* | 840 |
| *March* | 1276 |
| **Total^** | **2883** |

**^ Note: No CORE report for SPD annual members**

| Goals | % Goal | JAN | FEB | MAR | Q1 Avg |
|---|---|---|---|---|---|
| OCC-Collect High Risk | **56%** | 59.0% | 36.5% | 100% | **65.2%** |
| OCC-Collect Low Risk | **43%** | 65.8% | 87.1% | 64.4% | **72.4%** |
| OC-Collect initial OC HRA's | **78%** | 67% | 77% | | **72.0%** |
| OC-Collect annual OC HRA's | **34%** | 60% | 55% | | **57.5%** |
| SPD-Collect initial SPD HRA's | **63%** | 63% | 64% | 68% | **65.0%** |

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# HRA Collection

| Newly Eligible OCC | April | % | Overall % | May | % | Overall % | June | % | Overall % | Quarter 2 Collected/non responder Average |
|---|---|---|---|---|---|---|---|---|---|---|
| OCC Collection High | 54 | 26.0% | 71% | | | | | | | |
| OCC Collection Low | 94 | 45.2% | | | | | | | | |
| OCC (non responders) High | 15 | 7.2% | 29% | | | | | | | |
| OCC (non responders) Low* | 45 | 21.6% | | | | | | | | |
| **OCC Totals** | **208** | | **100%** | **0** | | **0%** | **58** | | **0%** | |

*Note: Of 45 low, there are 25 members require 3rd attempt to be made between 06/26/17-06/30/17.

| Newly Eligible SPD | April | % | Overall % | May | % | Overall % | June | % | Overall % | Quarter 2 Collected/non responder Average |
|---|---|---|---|---|---|---|---|---|---|---|
| SPD Collection High | 109 | 14.2% | 65% | | | | | | | |
| SPD Collection Low | 388 | 50.5% | | | | | | | | |
| SPD (non responders)High | 54 | 7.0% | 35% | | | | | | | |
| SPD (non responders)Low | 217 | 28.3% | | | | | | | | |
| **SPD Totals*** | **768** | | **100%** | **0** | | **0%** | **0** | | **0%** | |

* Note: Total count excluded members with other primary insurance.

| Newly Eligible OC | April | % | May | % | June | % | Quarter 2 Average |
|---|---|---|---|---|---|---|---|
| HRA's Collected | 44 | | 36 | | 0 | | |
| HRA (non responders) | 19 | | 27 | | 83 | | |
| **OC Totals** | **63** | **0%** | **63** | **0%** | | | |

*incomplete data when prior to due date

Apr HRA due by 6/30/17
Data as of 6/13/17

May HRA due by 7/30/17
Data as of 6/13/17

Jun HRA due by 8/30/17
Data as of 6/13/17

| **Annual** OCC Members | April | % | May | % | June | % | Quarter 2 Average |
|---|---|---|---|---|---|---|---|
| HRAs collected | 25 | 6% | | | | | |
| HRAs (non responders) | 395 | 94% | | | | | |
| **Total** | **420** | **100%** | **0** | **0%** | **0** | | |

| Mailed SPD Annual HRA | |
|---|---|
| *April* | 884 |
| *May* | |
| *June* | |
| **Total^** | |

| Goals | % Goal | Apr | May | Jun | Q2 Avg |
|---|---|---|---|---|---|
| OCC-Collect High Risk | **56%** | | | | |
| OCC-Collect Low Risk | **43%** | | | | |
| OC-Collect initial OC HRA's | **78%** | | | | |
| OC-Collect annual OC HRA's | **34%** | | | | |
| SPD-Collect initial SPD HRA's | **63%** | | | | |

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| JANUARY | | | |
|---|---|---|---|
| **OCC** | | | |
| | **Participation** | **Invitation(s) (denom.)** | **%** |
| Participation in ICT for BHI | 34 | 34 | 100.00% |
| Participation in ICT for County MH Adult | 0 | 0 | |
| Participation in ICT for County MH Children and Youth | 0 | 0 | |
| Participation in ICT for FSP | 0 | 0 | |
| Magellan Participation in ICT (CCN) | | | |
| Magellan Individual Provider Participation in ICT (CCN) | | | |
| Magellan Participation in ICT (HN-OCC) | | | |
| Magellan Individual Provider Participation in ICT (HN-OCC) | | | |
| | | | |
| **OC** | | | |
| | **Participation** | **Invitation(s) (denom.)** | **%** |
| Participation in ICT for BHI | | | |
| Participation in ICT for County MH Adult | | | |
| Participation in ICT for County MH Children and Youth | | | |
| Participation in ICT for FSP | | | |
| Magellan Participation in ICT (CCN) | | | |
| Magellan Individual Provider Participation in ICT (CCN) | | | |
| Magellan Participation in ICT (HN-OC) | | | |
| Magellan Individual Provider Participation in ICT (HN-OC) | | | |
| | | | |
| **SPD** | | | |
| | **Participation** | **Invitation(s) (denom.)** | **%** |
| Participation in ICT for BHI | 45 | 45 | 100.00% |
| Participation in ICT for County MH Adult | 1 | 2 | 50.00% |
| Participation in ICT for County MH Children and Youth | 0 | 2 | 0.00% |
| Participation in ICT for FSP | 0 | 0 | |
| Participation in ICT for ASO | 0 | 1 | 0.00% |
| Magellan Participation in ICT (CCN) | | | |
| Magellan Individual Provider Participation in ICT (CCN) | | | |
| Magellan Participation in ICT (HN-SPD) | | | |
| Magellan Individual Provider Participation in ICT (HN-SPD) | | | |

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# BEHAVIORIAL HEALTH

| FEBRUARY | | | |
|---|---|---|---|
| **OCC** | | | |
| | **Participation** | **Invitation(s) (denom.)** | **%** |
| Participation in ICT for BHI | 31 | 31 | 100.00% |
| Participation in ICT for County MH Adult | 0 | 0 | |
| Participation in ICT for County MH Children and Youth | 0 | 0 | |
| Participation in ICT for FSP | 0 | 1 | 0.00% |
| Magellan Participation in ICT (CCN) | | | |
| Magellan Individual Provider Participation in ICT (CCN) | | | |
| Magellan Participation in ICT (HN-OCC) | | | |
| Magellan Individual Provider Participation in ICT (HN-OCC) | | | |
| | | | |
| **OC** | | | |
| | **Participation** | **Invitation(s) (denom.)** | **%** |
| Participation in ICT for BHI | | | |
| Participation in ICT for County MH Adult | | | |
| Participation in ICT for County MH Children and Youth | | | |
| Participation in ICT for FSP | | | |
| Magellan Participation in ICT (CCN) | | | |
| Magellan Individual Provider Participation in ICT (CCN) | | | |
| Magellan Participation in ICT (HN-OC) | | | |
| Magellan Individual Provider Participation in ICT (HN-OC) | | | |
| | | | |
| **SPD** | | | |
| | **Participation** | **Invitation(s) (denom.)** | **%** |
| Participation in ICT for BHI | 79 | 79 | 100.00% |
| Participation in ICT for County MH Adult | 0 | 1 | 0.00% |
| Participation in ICT for County MH Children and Youth | 1 | 1 | 100.00% |
| Participation in ICT for FSP | 0 | 0 | |
| Participation in ICT for ASO | 0 | 3 | 0.00% |
| Magellan Participation in ICT (CCN) | | | |
| Magellan Individual Provider Participation in ICT (CCN) | | | |
| Magellan Participation in ICT (HN-SPD) | | | |
| Magellan Individual Provider Participation in ICT (HN-SPD) | | | |

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| MARCH | | | |
|---|---|---|---|
| **OCC** | | | |
| | **Participation** | **Invitation(s) (denom.)** | **%** |
| Participation in ICT for BHI | 44 | 44 | 100.00% |
| Participation in ICT for County MH Adult | 0 | 1 | 0.00% |
| Participation in ICT for County MH Children and Youth | 0 | 0 | |
| Participation in ICT for FSP | 0 | 0 | |
| Magellan Participation in ICT (CCN) | | | |
| Magellan Individual Provider Participation in ICT (CCN) | | | |
| Magellan Participation in ICT (HN-OCC) | | | |
| Magellan Individual Provider Participation in ICT (HN-OCC) | | | |
| | | | |
| **OC** | | | |
| | **Participation** | **Invitation(s) (denom.)** | **%** |
| Participation in ICT for BHI | | | |
| Participation in ICT for County MH Adult | | | |
| Participation in ICT for County MH Children and Youth | | | |
| Participation in ICT for FSP | | | |
| Magellan Participation in ICT (CCN) | | | |
| Magellan Individual Provider Participation in ICT (CCN) | | | |
| Magellan Participation in ICT (HN-OC) | | | |
| Magellan Individual Provider Participation in ICT (HN-OC) | | | |
| | | | |
| **SPD** | | | |
| | **Participation** | **Invitation(s) (denom.)** | **%** |
| Participation in ICT for BHI | 121 | 121 | 100.00% |
| Participation in ICT for County MH Adult | 4 | 5 | 80.00% |
| Participation in ICT for County MH Children and Youth | 1 | 1 | 100.00% |
| Participation in ICT for FSP | 1 | 3 | 33.33% |
| Participation in ICT for ASO | 0 | 0 | |
| Magellan Participation in ICT (CCN) | | | |
| Magellan Individual Provider Participation in ICT (CCN) | | | |
| Magellan Participation in ICT (HN-SPD) | | | |
| Magellan Individual Provider Participation in ICT (HN-SPD) | | | |

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| ED Top 10 Utlizers 12/1/16-04/09/17 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Rank** | **Member CIN** | **Last Name** | **First Name** | **LOB** | **Member DOB** | **Er Visit Count** | **Ac** | **Assigned To** |
| 1 | 97985090C | Bouttee | Theodore M. | Medi-Cal | 5/27/59 | 140 | M1 | Cierra |
| 2 | 97045481E | Arambula | Kristina M. | Medi-Cal | 9/8/85 | 32 | M3 | Roseann |
| 3 | 95131671E | Sanchez | Luis N. | Medi-Cal | 8/26/76 | 40 | 64 | Karen H |
| 4 | 90410723F | Bullard | Ashley R. | Medi-Cal | 4/23/90 | 34 | M3 | Noushin |
| 5 | 90036673A | Kaufman | Somsai T. | Medi-Cal | 6/12/66 | 21 | M1 | Cierra |
| 6 | 96854905C | Knitter | Lynda S. | Medi-Cal | 6/2/58 | 27 | 60 | Roseann |
| 7 | 90473586D | Tecomulapa-Gomez | Florencio G. | Medi-Cal | 8/1/74 | 18 | M1 | Cierra |
| 8 | 97766962D | Weaver | Sara | Medi-Cal | 5/11/93 | 25 | M1 | Noushin |
| 9 | 90063551F | Eardley | Jon | Medi-Cal | 1/22/61 | 16 | 60 | Roseann |
| 10 | 95587709F | Palmer | Joshua | Medi-Cal | 3/21/81 | 24 | M1 | Karen H |
| | | | | | | **377** | | |

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## Member Satisfaction Q2-4 2016

| Results | |
|---|---|
| ***Member Satisfaction*** | |
| | **Score** |
| Overall Satisfaction with CM | 87% |
| Case Management was beneficial | 96% |
| Educational materials were helpful | 87% |
| CM was helpful with medical questions | 96% |
| Community resources were helpful | 87% |
| Questions were answered to Satsifaction | 100% |

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**Complex case management Q1 2017**

| *Mbrs referred to CCM Complex Cases* | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | ***January*** | | | ***February*** | | | ***March*** | | |
| **Health Network** | **# of cases reported** | **# of Cases reviewed** | **Score %** | **# of cases reported** | **# of Cases reviewed** | **Score %** | **# of cases reported** | **# of Cases reviewed** | **Score %** |
| AltaMed | 9 | 4 | 49% | 13 | 4 | 0% | 1 | 1 | 0% |
| AMVI | 105 | 1 | 83% | 36 | 4 | 90% | 2 | 0 | 0% |
| Arta Western | 1 | 1 | 100% | 2 | 1 | 100% | 2 | 1 | 100% |
| CCN | 90 | 5 | 91% | 94 | 5 | 93% | 93 | 5 | 98% |
| CHOC | 9 | 2 | 100% | 8 | 3 | 100% | 7 | 5 | 100% |
| FCMG | 5 | 3 | 100% | 6 | 5 | 100% | 5 | 5 | 100% |
| Hertiage ADOC | 0 | 0 | | 0 | 0 | | 0 | 0 | |
| Hertiage Regal | 0 | 0 | | 0 | 0 | | 0 | 0 | |
| Kaiser | 5 | 4 | 100% | 5 | 4 | 100% | 8 | 5 | 96% |
| Monarch | 15 | 5 | 92% | 31 | 3 | 98% | 13 | 5 | 99% |
| Noble | 9 | 5 | 100% | 10 | 5 | 100% | 10 | 5 | 100% |
| OCA | 1 | 1 | 100% | 3 | 1 | 100% | 0 | 0 | |
| Prospect | 276 | 6 | 65% | 153 | 5 | 69% | 27 | 5 | 89% |
| Talbert | 3 | 3 | 98% | 3 | 3 | 96% | 3 | 3 | 85% |
| UCMG | 6 | 0 | | 0 | 0 | | 8 | 4 | 61% |
| **Totals:** | **534** | **40** | | **364** | **43** | | **179** | **44** | |
| *** Pending completion** | | | | | | | | | |

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## HN Performance Q1 2017

| Results | | | |
|---|---|---|---|
| ***OneCare Connect (OCC)*** | | | |
| **HN** | **Jan** | **Feb** | **Mar** |
| AltaMed | 69.20% | 82.50% | 88.00% |
| AMVI | 100.00% | 100.00% | 97.50% |
| Arta | 92.50% | 100.00% | 100.00% |
| Heritage ADOC | 0%* | 90.00% | 80.00% |
| Heritage Regal | 81.30% | 100.00% | 100.00% |
| FCMG | 78.80% | 88.20% | 82.90% |
| OCA | 93.30% | 0%* | 100.00% |
| Talbert | 96.70% | 96.30% | 98.80% |
| Monarch | 88.00% | 92.80% | 91.30% |
| Prospect | 88.30% | 97.70% | 98.10% |
| Noble | 100.00% | 100.00% | 100.00% |
| UCMG | 62.50% | 82.50% | 76.70% |
| CCN | 85.00% | 78.80% | 96.80% |
| *** No bundles due or returned** | | | |
| **Indicates payment Modifier <80%** | | | |

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## HN Performance Q1 2017

| Results | | | |
|---|---|---|---|
| ***SPD*** | | | |
| **HN** | **Jan** | **Feb** | **Mar** |
| AltaMed | 95.07% | 96.09% | 98.86% |
| AMVI | 95.20% | 97.00% | 97.00% |
| Arta | 99.37% | 97.91% | 98.41% |
| CHOC | 99.69% | 100.00% | 100.00% |
| Heritage ADOC | 100.00% | 100.00% | 0%* |
| Heritage Regal | 100.00% | 97.25% | 88.50% |
| FCMG | 95.76% | 97.05% | 95.65% |
| OCA | 0%* | 0%* | 100.00% |
| Talbert | 99.29% | 98.80% | 100.00% |
| Monarch | 97.58% | 98.86% | 99.49% |
| Prospect | 96.12% | 94.50% | 94.19% |
| Noble | 95.06% | 94.00% | 97.33% |
| UCMG | 97.15% | 97.67% | 92.78% |
| CCN | 97.58% | 93.02% | 94.21% |
| *** No bundles due or returned** | | | |
| **Indicates payment Modifier <80%** | | | |

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## HN Performance Q1 2017

| Results | | | |
|---|---|---|---|
| ***OneCare (OC)*** | | | |
| **HN** | **Jan** | **Feb** | **Mar** |
| FCMG | 0%* | 88.50% | 100.00% |
| AltaMed | 0.00% | 94.67% | 85.00% |
| AMVI/Prospect | 99.40% | 100.00% | 97.70% |
| Arta Western | 100.00% | 100.00% | 0.00% |
| Monarch | 99.29% | 99.38% | 99.29% |
| Noble | 0%* | 0%* | 100.00% |
| Talbert | 100.00% | 100.00% | 97.33% |
| UCMG | 0%* | 100.00% | 100.00% |
| *** No bundles due or returned** | | | |
| **Indicates payment Modifier <80%** | | | |

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# Member Trend Report
# 1st Quarter 2017

**Board of Directors' Quality Assurance Committee Meeting**
**September 20, 2017**

**Janine Kodama**
**Director, Grievance and Appeals**

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# Overview

- Trend of the rate of complaints (appeals/grievances) per thousand members for all CalOptima programs for the first quarter in 2017.
  - Appeal — A request by the member for review of any decision to deny, modify or discontinue a covered service
  - Grievance — An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program
- Breakdown of the complaints by type
- Interventions based on trends, as appropriate

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# Quality of Service and Quality of Care

- Quality of Service (QOS) are issues resulting in inconvenience or dissatisfaction to the member.
- Quality of Care (QOC) concerns occur if the member feels there was a problem with the care they received or that they did not receive enough care.

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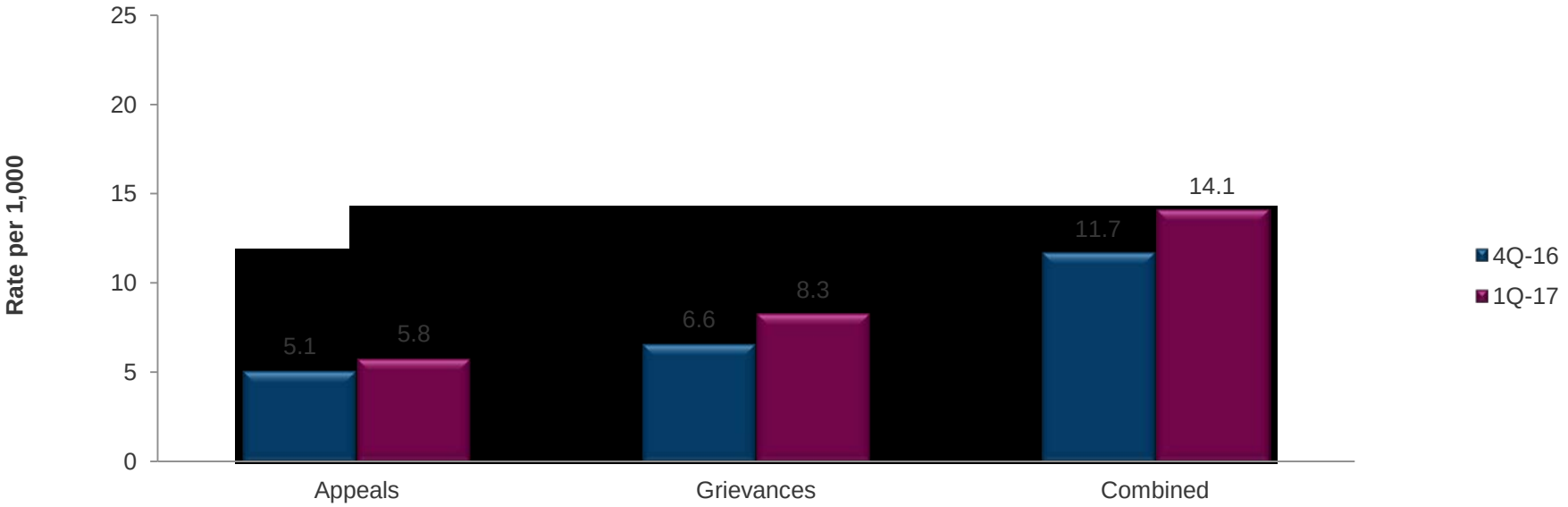
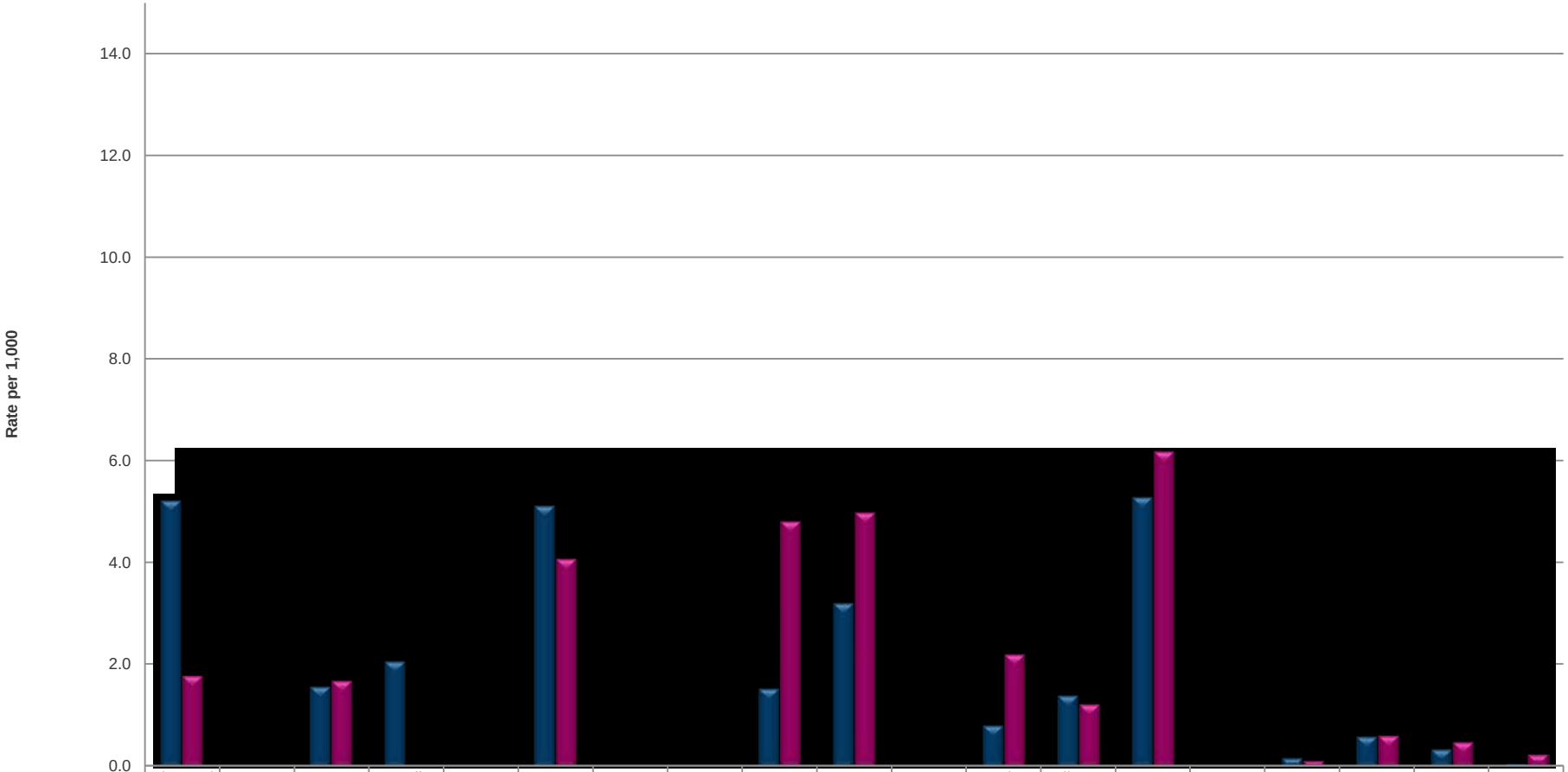
# Overall OneCare Connect (OCC) Member Complaints




| | Total Complaints | Appeals | Grievances | Membership |
|---|---|---|---|---|
| 4Q-2016 | 201 | 88 | 113 | 17,122 |
| 1Q-2017 | 230 | 95 | 135 | 16,297 |

# OCC Member Grievances Quarterly Rate/1,000




| | Alta Med Health (558) | AMVI Care (569) | Arta (590) | Family Choice (1,909) | Heritage (249) | Monarch (5,157) | Noble (439) | OC Adv (114) | Prospect (3,121) | Talbert (1,205) | UCMG (605) | American Logis ics (16,297) | Liberty Dental (16,297) | CCN (1,781) | MLTSS (16,297) | Magellan (16,297) | OCC Prog (16,297) | OCC Pharm (16,297) | VSP (16,297) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4Q-16 (17,122) | 5.2 | 0.0 | 1.6 | 2.1 | 0.0 | 5.1 | 0.0 | 0.0 | 1.5 | 3.2 | 0.0 | 0.8 | 1.4 | 5.3 | 0 0 | 0.2 | 0.6 | 0.4 | 0.1 |
| 1Q-17 (16,297) | 1.8 | 0.0 | 1.7 | 0 0 | 0.0 | 4.1 | 0.0 | 0.0 | 4.8 | 5.0 | 0.0 | 2.2 | 1.2 | 6.2 | 0 0 | 0.1 | 0.6 | 0.5 | 0.2 |

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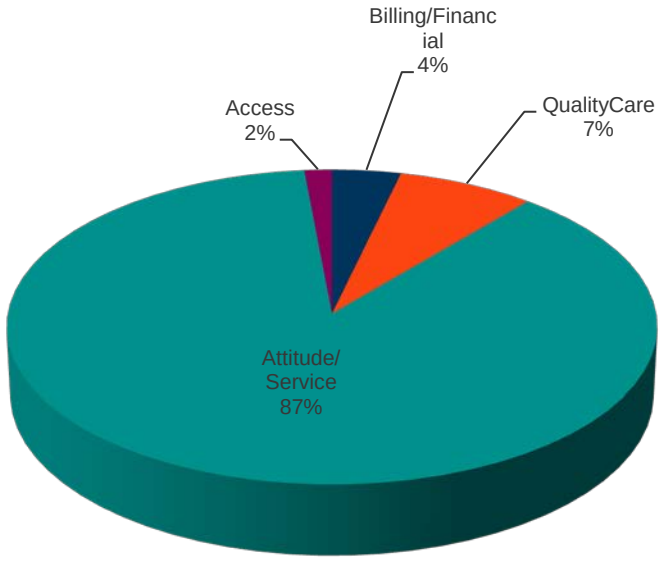
CalOptima A Public Agency Better. Together.

# OCC Grievances by Category

- Total of 135 grievances filed by 106 unique members in Q1 2017.
  - Of these, 118 grievances (87%) were related to QOS, and 10 grievances (7%) were related to QOC concerns.
  - Note: The percentage by categories represents the historic trend.
- The Quality Improvement (QI) department continues to review for QOC issues and potential trending.

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# Common QOS and QOC Concerns

- Delay in service (QOS)
  - Referral delays
  - Appointments
- Dental (QOS)
  - Referral delays
  - MD/Staff Unprofessional
- Transportation vendor (QOS)
  - Late/no show
  - Unprofessional/rude
- Question diagnosis/treatment (QOC)
  - Concerns not being addressed
  - Medication issues

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# Summary

- Talbert and Prospect report a higher quarterly rate/1,000 grievances compared to Q4 2016
  - Talbert — Six (6) grievances received out of 1, 205 members and filed by 4 unique members
  - Prospect — Fifteen (15) grievance received out of 3,121 members and filed by 12 unique members
- American Logistics grievances continue to increase, going from14 in Q4 2016 to 36 in Q1 2017. American Logistics made up 27% of all grievances filed in Q1. The complaints were related to no show, early/late pickups and rudeness. Customer Service continues to work with American Logistics, Provider Network Relations and Quality Improvement departments for next steps.
- All quality of care concerns are referred to Quality Improvement department for investigation.

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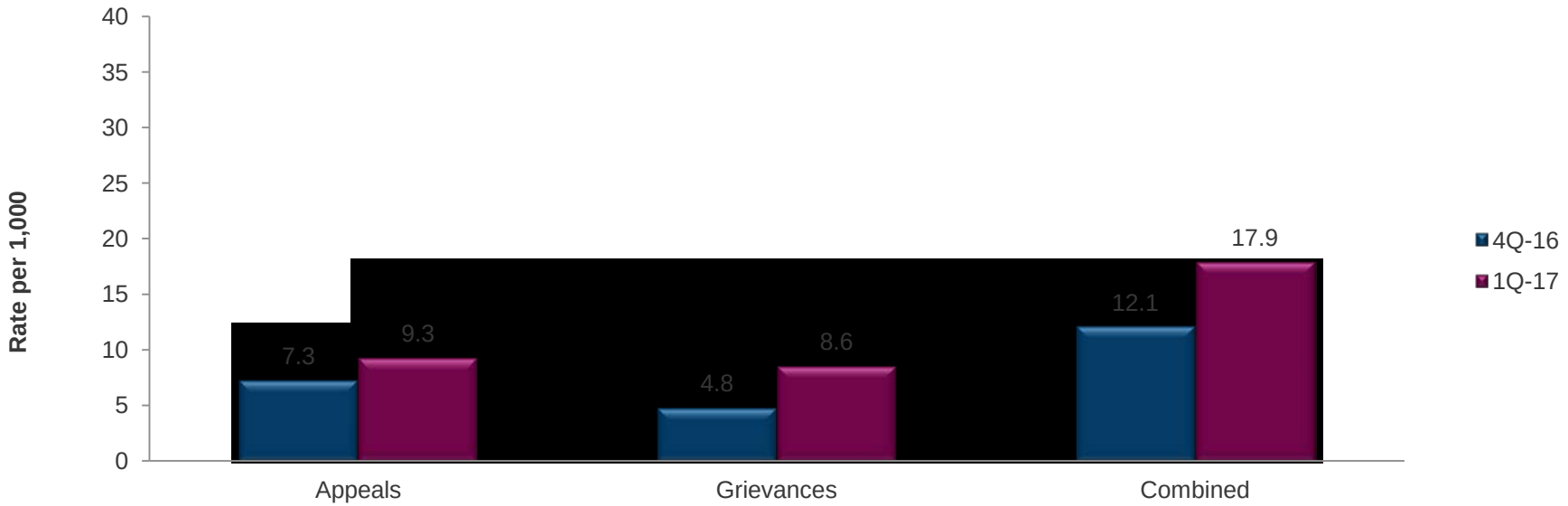
# Overall OneCare (OC) Member Complaints




| | Total Complaints | Appeals | Grievances | Membership |
|---|---|---|---|---|
| 4Q-2016 | 16 | 10 | 6 | 1,232 |
| 1Q-2017 | 18 | 12 | 11 | 1,285 |

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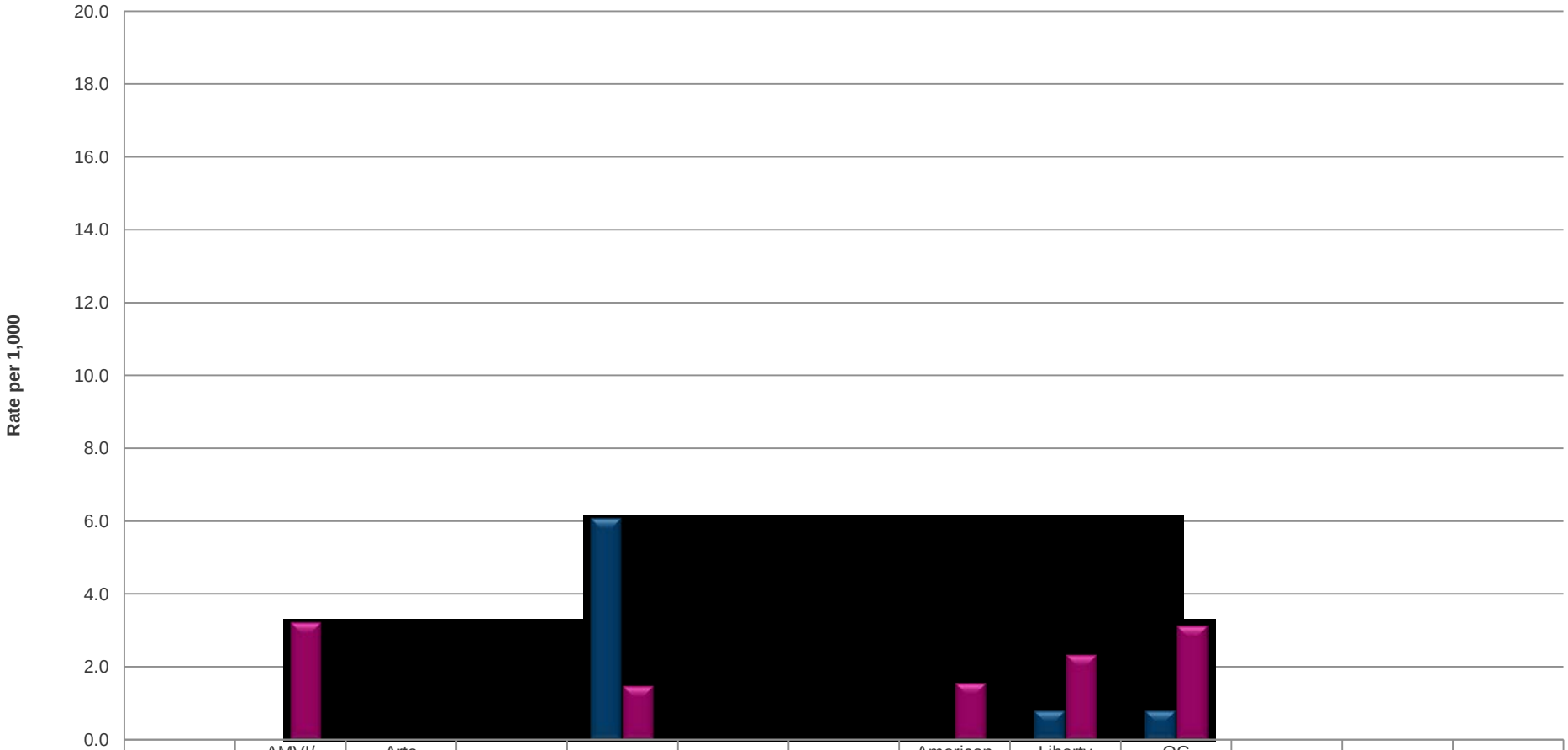
# OC Member Grievances Quarterly Rate/1,000




| | Alta Med Health (35) | AMVI/ Prospect (311) | Arta Western (43) | Family Choice (78) | Monarch (677) | Talbert (110) | UCMG (23) | American Logistics (1,285) | Liberty Dental (1,285) | OC Operations (1,285) | OC Pharm (1,285) | VSP (1,285) | Magellan (1,285) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4Q-16 (6) | 0.00 | 0.00 | 0.00 | 0.00 | 6.08 | 0.00 | 0.00 | 0.00 | 0.81 | 0.81 | 0.00 | 0.00 | 0.00 |
| 1Q-17 (11) | 0.0 | 3.2 | 0.0 | 0.0 | 1.5 | 0.0 | 0.0 | 1.6 | 2.3 | 3.1 | 0.0 | 0.0 | 0.0 |

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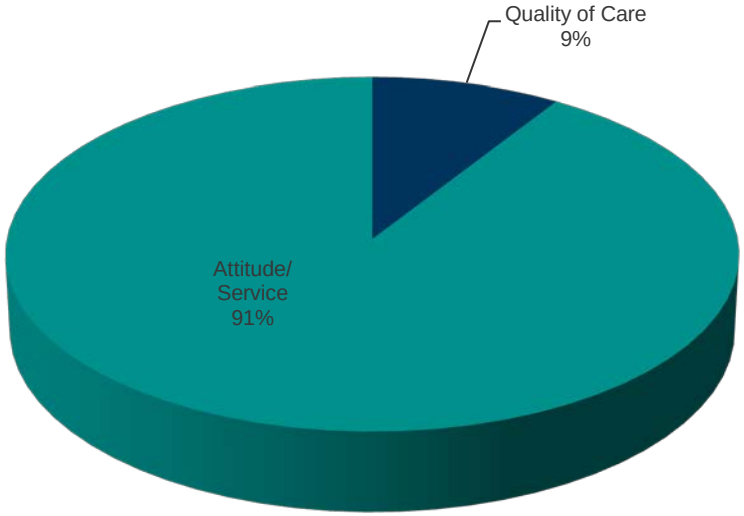
# OC Grievances by Category

- Total of 11 grievances filed by 10 unique members in Q1 2017.
  - Of these, 10 grievances (91%) were related to QOS, and 1 grievance (9%) was related to QOC concerns.
- The QI department continues to review for QOC issues and potential trending.

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# Common QOS and QOC Concerns

- Wrong information given (QOS)
- Transportation vendor (QOS)
- Question treatment (QOC)

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# Summary

- Although AMVI seem to report a higher quarterly rate/1,000 grievances, it's due to the overall low membership.
  - AMVI – One (1) grievance received out of 311 members.
- OC Operations reported a higher quarterly rate/1,000 grievances due to four complaints regarding internal operations
- No specific trending of issues or providers identified.

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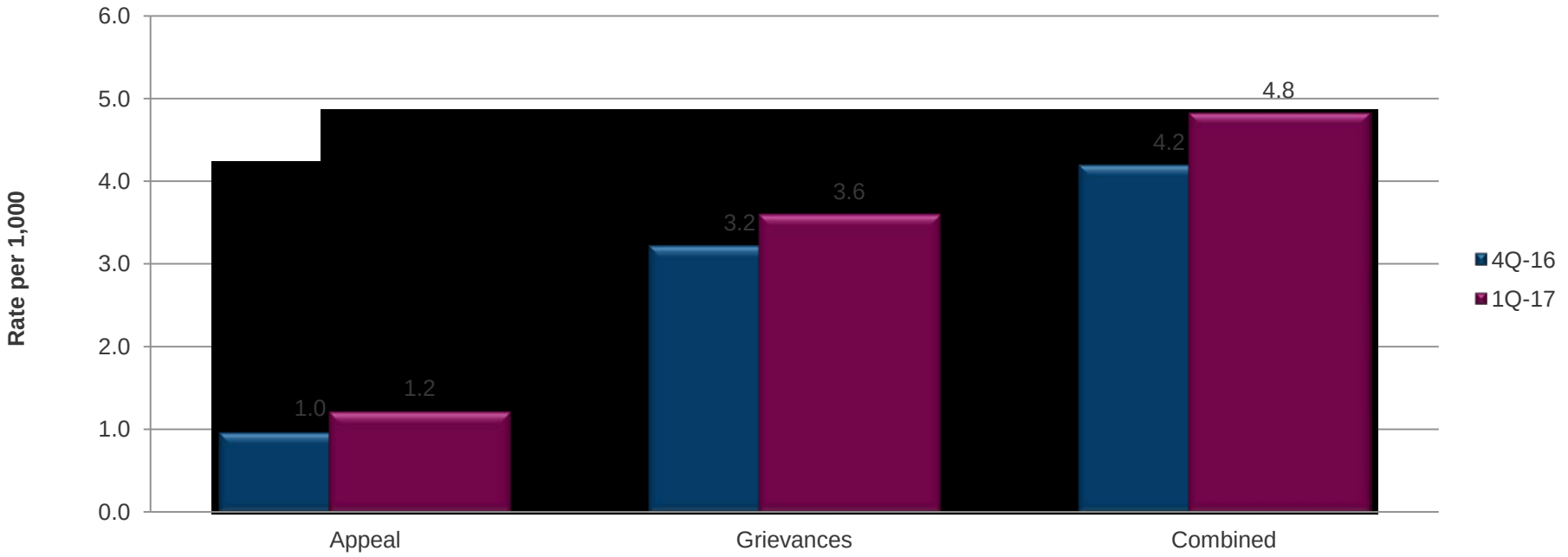
# Overall Medi-Cal (MC) Member Complaints




| | Total Complaints | Appeals | Grievances | Membership |
|---|---|---|---|---|
| 4Q-2016 | 826 | 192 | 634 | 774,869 |
| 1Q-2017 | 921 | 233 | 688 | 774, 750 |

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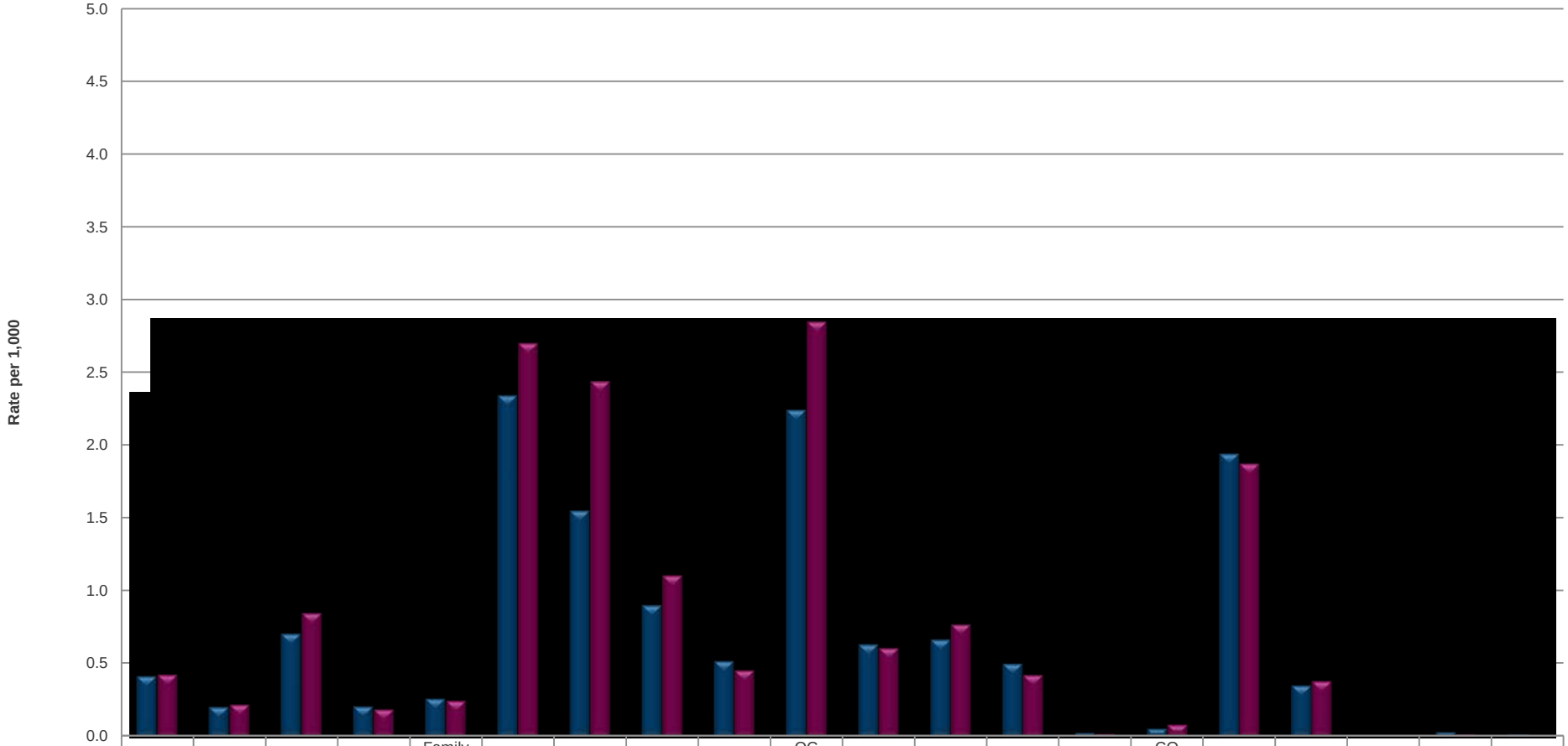
# MC Member Grievances Quarterly Rate/1,000




| | AltaMed (41,952) | AMVI (22,331) | Arta (74,380) | CHA (152,822) | Family Choice (48,026) | Heritage (4,078) | Kaiser (45,577) | Monarch (87,735) | Noble (32,795) | OC Advantage (1,054) | Prospect (34,386) | Talbert (24,697) | UCMG (35,130) | CO Prog (774,750) | CO Pharm (729,173) | CCN (70,945) | COD (98,842) | MLTSS (729,173) | Magellan (774,750) | VSP (729,173) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4Q-16 (634) | 0.42 | 0.21 | 0.71 | 0.21 | 0.26 | 2.34 | 1.55 | 0.90 | 0.52 | 2.24 | 0.63 | 0.67 | 0.50 | 0.03 | 0.06 | 1.94 | 0.35 | 0 00 | 0.03 | 0.02 |
| 1Q-17 (688) | 0.43 | 0.22 | 0.85 | 0.19 | 0.25 | 2.70 | 2.44 | 1.11 | 0.46 | 2.85 | 0.61 | 0.77 | 0.43 | 0.02 | 0.09 | 1.87 | 0.38 | 0 00 | 0.02 | 0.01 |

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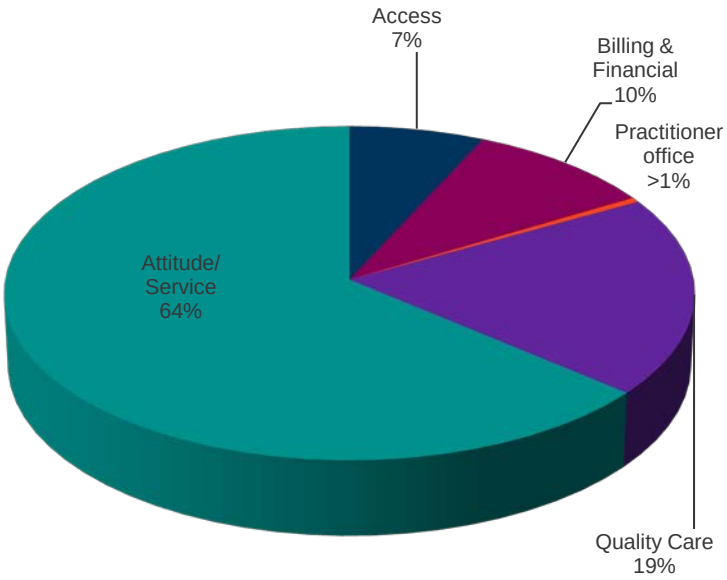
# Medi-Cal Grievances by Category

- Total of 688 grievances filed by 651 unique members in Q1 2017.
  - Of these, 439 grievances (64%) were related to QOS and 133 grievances (19%) were related to QOC concerns.
  - The percentage by categories represents the historic trend.
- The Quality Improvement (QI) department continues to review for QOC issues and potential trending.

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# Common QOS Concerns

- Delay in service
  - Referrals
  - Prescriptions
  - Test results
- Provider services
  - Dissatisfied with staff, doctor or program
- Rudeness
- Pharmacy
  - Vendor issues (i.e. Walgreens, CVS, Rite Aid)
  - PA Process

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# Common QOC Concerns

- Question diagnosis
- Question treatment
- Delay in treatment impacting member's care
- Refuse to treat

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# Summary

- OC Advantage reported a higher quarterly rate/1,000 grievances due to low membership. Three (3) grievances were received out of 1,054 members.
- Kaiser grievances increased from 71 in Q4 2016 to 111 in Q1 2017. The increases were found in the Quality of Service area in regards to Efficiency and Courtesy of both clinical and non-clinical staff.
- Review of the quality of service concerns for all heath networks did not identify specific trending for providers or staff.
- Overall grievances as a rate/1,000 members remained low at 3.6 in Q1 2017, a slight increase from 3.2 in Q4 2016.

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# Interventions

- All quality of care concerns are referred to the Quality Improvement department for investigation.
- CalOptima works with all our networks (by sharing the grievance and appeals data specific to each network) and providers to improve in these areas including QOS and QOC concerns.

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# CalOptima's Mission

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

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