



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

**TUESDAY, FEBRUARY 20, 2018  
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  
Michael Schrader

CHIEF COUNSEL  
Gary Crockett

CLERK OF THE BOARD  
Suzanne Turf

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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](http://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 November 15, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

## **REPORTS**

2. Consider Recommending Board of Directors' Ratification of CalOptima's Pharmacy Management Residency Program and Approval of Related Policy
3. Receive and File the CalOptima 2017 Quality Improvement Program Evaluation
4. Consider Recommending Board of Directors' Approval of the CalOptima 2018 Quality Improvement (QI) Program and 2018 QI Work Plan
5. Consider Recommending Board of Directors' Approval of the 2018 CalOptima Utilization Management Program
6. Receive and File the 2017 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance Performance Improvement Plan Annual Evaluation
7. Consider Recommending Board of Directors' Approval of the 2018 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan
8. Consider Recommending Board of Directors' Ratification of Increased Payment to Primary Care Physicians for the Depression Screening Incentive Program Funded by Intergovernmental Transfer (IGT) 1
9. Consider Recommending Board of Directors' Approval of CalOptima Policy GG.1656, Conflict of Interest

## **INFORMATION ITEMS**

10. PACE Member Advisory Committee Update
11. Quarterly Reports to the Board of Directors' Quality Assurance Committee
  - a. Quality Improvement Committee Fourth Quarter 2017 Update
  - b. Member Trend Report – Third Quarter 2017

## **COMMITTEE MEMBER COMMENTS**

## **ADJOURNMENT**

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

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

**November 15, 2017**

**CALL TO ORDER**

Chair Paul Yost called the meeting to order at 3:01 p.m. Director Nguyen led the pledge of Allegiance.

**Members Present:** Paul Yost, M.D., Chair; Ria Berger, Alexander Nguyen M.D.

**Members Absent:** Dr. Nikan Khatibi

**Others Present:** Michael Schrader, Chief Executive Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Tracy Hitzeman, Executive Director, Clinical Operations; Diana Hoffman, Deputy Chief Counsel, Ladan Khamseh, Chief Operating Officer; Suzanne Turf, Clerk of the Board

**PUBLIC COMMENTS**

There were no requests for public comment.

**CONSENT CALENDAR**

1. Approve the Minutes of the September 20, 2017 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

***Action: On motion of Director Berger, seconded and carried, the Committee approved the Minutes of the September 20, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Director Khatibi absent)***

**REPORTS**

2. Consider Recommending Board of Directors' Ratification and Amendment of Contract with Housecall Doctors Medical Group

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend that the Board of Directors ratify contract with Housecall Doctors Medical Group, and authorize the Chief

Executive Officer, with the assistance of legal counsel, to amend the existing OneCare contract with Housecall Doctors Medical Group to include OneCare Connect line of business for members in the CalOptima Community Network.

***Action: On motion of Director Berger, seconded and carried, the Committee recommended the Board of Directors ratify the contract with Housecall Doctors Medical Group, and authorize the Chief Executive Officer, with the assistance of legal counsel, to amend existing OneCare contract with Housecall Doctors Medical Group to include OneCare Connect line of business for members in the CalOptima Community Network. (Motion carried 3-0-0; Director Khatibi absent)***

### **INFORMATION ITEMS**

#### **3. PACE Member Advisory Committee Update**

This item was accepted as presented.

#### **4. Behavioral Health Integration Update**

Donald Sharps, M.D., Medical Director, presented a brief update on the transition of Medi-Cal behavioral health services including the status of the behavioral health provider network, staff recruitment, the development of internal workflow procedures, and member communication. Dr. Sharps also provided an update on the implementation of the Drug Medi-Cal Organized Delivery System, which is anticipated to begin on March 1, 2018.

#### **5. Palliative Care Update**

Tracy Hitzeman RN CCM, Executive Director, Clinical Operations, provided an overview of Senate Bill 1004, which requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance for Medi-Cal managed care plans to ensure the delivery of palliative care services effective January 1, 2018. It was noted health networks will be responsible for all palliative care services for their assigned members, and CalOptima plans to contract with providers for service delivery and care coordination for eligible CalOptima Direct and CalOptima Community Network members; reporting will be based on DHCS and plan requirements. CalOptima anticipates receiving guidance from DHCS regarding reporting requirements and approval for CalOptima policies and procedures.

#### **6. Over/Under Utilization Report**

Ms. Hitzeman presented a brief update on over/under utilization reporting and monitoring, and reviewed physician specific metrics related to unused authorizations, pharmacy utilization, and the frequency of selected procedures utilization.

#### **7. Quarterly Reports to the Quality Assurance Committee**

The following Quarterly Reports were accepted as presented:

- a. Quality Improvement Report
- b. Member Trend Report

**ADJOURNMENT**

Hearing no further business, Chair Yost adjourned the meeting at 3:41 p.m.

/s/ Suzanne Turf  
Suzanne Turf  
Clerk of the Board

*Approved: February 20, 2018*

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken February 20, 2018** **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

#### **Report Item**

2. Consider Recommending Board of Directors' Ratification of CalOptima's Pharmacy Management Residency Program and Approval of Related Policy

#### **Contact**

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

Kris Gericke, Pharm.D, Director, Pharmacy Management, (714) 246-8400

#### **Recommended Action**

Recommend that the Board of Directors ratify CalOptima's Pharmacy Management Residency Program, and approve Policy GG.1426: Residency Program, Pharmacy Management.

#### **Background**

CalOptima's Pharmacy Management Residency Program (Residency Program) was started in 2010 by staff. At this time, staff is requesting ratification of the existing program and approval of a policy formalizing program requirements and responsibilities.

Residency Programs are intended to provide organized, systematic, directed postgraduate training that centers on developing the knowledge, skills, and abilities needed to achieve professional competence in the delivery of patient-centered care and in pharmacy operational services in managed care organizations (MCOs) and settings.

Residents are licensed pharmacists who provide several contributions to CalOptima at a much-reduced direct cost. By the roles they can assume, residents can facilitate the redeployment of existing pharmacists to other areas, tasks, or projects, thereby expanding the capabilities of pharmacist roles in other parts of the organization. The residents play an integral role in embodying CalOptima's mission as an organization. Their contributions over the years to our members and the health system include some of the following: reduction of opioid overutilization, promotion of opioid rescue therapy in high risk members, medication reviews aimed to decrease high risk medication use in the elderly, and implementation of clinical training programs for CalOptima staff. These contributions have direct impacts on safe, effective, and rational use of medications which leads to improved outcomes for our members and reduced cost.

Due to the robust nature of the Residency Program training, past Pharmacy Residents are ideal candidates to transition into vacant full-time staff positions with minimal training required. To date, the pharmacy department employs four prior residents: two managers and two staff.

As detailed in the proposed policy, in conjunction with HR, Pharmacy Management Department serves as the designated point of contact to coordinate and administer the Residency Program. The Resident position is full time for a one-year period beginning in July. As proposed, CalOptima may offer two

paid one-year Pharmacy Resident positions at the discretion of the Human Resources and Pharmacy Management Departments to provide licensed practitioners with training and experience in essential areas of managed care pharmacy's responsibilities and functions that would be characterized as part of a managed care pharmacist generalist's practice.

A number of other Medi-Cal Managed Care Plans also have pharmacy residency programs, including Inland Empire Health Plan, LA Care, San Francisco Health Plan, and Health Plan of San Joaquin.

The Pharmacy Resident Program is included in the 2017 CalOptima Utilization Management Program.

### **Discussion**

Pharmacy Residents rotate through various areas in Pharmacy Management as well as complete a longitudinal drug utilization review (DUR) project that contributes to CMS and DHCS DUR requirements. The Residency Program year includes the following experiences:

- Interdisciplinary Care Team (ICT) participation as lead Clinical Pharmacist
- Comprehensive and Targeted Medication Reviews; Medication Therapy Management (MTM) Program
- Quarterly opioid prescribing summary creation and distribution
- Monthly Provider Newsletters aimed at educating providers in various clinical topics
- Medicare coverage determination and Medi-Cal prior authorization reviews
- PACE medication profile reviews

### *Projects and Assignments*

- Drug Monograph completion and presentation at quarterly Pharmacy and Therapeutics Meeting
- Prior authorization criteria development
- Updating clinical guidelines
- Drug Information projects
- MTM member education newsletters
- In-service interdepartmental clinical trainings for CalOptima staff
- Part D formulary submissions
- Pharmacy Benefits Manager (PBM) oversight

Through the experiences outlined above, the Pharmacy Residents have consistently engaged in quality improvement and assessment activities, assisted in staff development, and have supported innovative approaches to care that have positively impacted our members in a cost-effective and compassionate manner.

In addition to contributions Residents make to organizations through staffing and projects, staff pharmacists involved with Residency Programs have been found to experience a greater degree of job satisfaction and higher employee retention rates. CalOptima's Residency Program is intended to increase the number of well-trained pharmacists prepared to work in expanding patient care roles, and

also provides opportunities to recruit well-trained pharmacists. CalOptima has hired four of our past residents as clinical pharmacists over the past seven years.

The Residency Program is currently not accredited, but Pharmacy Management is evaluating whether to seek accreditation by the American Society of Hospital Pharmacists (ASHP). If a decision to seek accreditation is made in the future, staff will return to your Board with the necessary policy changes and costs associated with such a decision.

### **Fiscal Impact**

The two resident positions are budgeted items in the CalOptima Fiscal Year 2017-18 Operating Budget approved by the CalOptima Board of Directors on June 1, 2017. The annual salary and benefit cost for both residents is estimated at \$191,436.

### **Rationale for Recommendation**

Staff recommends ratification of CalOptima's Pharmacy Management Residency Program, and approval of the related Policy GG.1426, Residency Program, Pharmacy Management to provide training opportunities for new pharmacists and ensure continued staffing of critical areas.

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachments**

1. CalOptima Policy GG.1426: Residency Program, Pharmacy Management
2. PowerPoint Presentation: Pharmacy Residency Program

/s/ Michael Schrader  
**Authorized Signature**

2/12/2018  
**Date**

Policy #: GG.1426PP  
Title: **Pharmacy Management Residency Program**  
Department: Medical Affairs  
Section: Pharmacy Management

CEO Approval: Michael Schrader \_\_\_\_\_

Effective Date: TBD  
Last Review Date: Not Applicable  
Last Revised Date: Not Applicable

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**I. PURPOSE**

This policy describes CalOptima's Pharmacy Management Residency Program, an organized, systematic, directed postgraduate training program that centers on developing the knowledge, skills, and abilities needed to achieve professional competence in the delivery of patient-centered care and in pharmacy operational services in managed care organizations (MCOs) and settings.

**II. POLICY**

- A. CalOptima may offer paid Pharmacy Resident positions at the discretion of the Human Resources and Pharmacy Management Departments, and in accordance with U.S. Department of Labor (DOL) Fair Labor Standards Act (FLSA) guidelines, to provide licensed practitioners with training and experience in those essential areas of managed care pharmacy's responsibilities and functions that would be characterized as part of a managed care pharmacist generalist's practice.
- B. The CalOptima Pharmacy Management Residency Program is not accredited.
- C. The Pharmacy Management Department shall be responsible for administering the Residency Program and ensuring that the following Residency Program guidelines are followed:
1. The Pharmacy Management Department may provide Resident positions to qualified candidates meeting the education, qualifications, and experience required by the Pharmacy Management Department.
  2. The Resident position is full-time for a one (1) year period beginning in July of the current calendar year unless otherwise terminated by either CalOptima or the Resident.
- D. Residents will be required to:
1. Pass a background investigation, including, but not limited to, a criminal investigation, a review of the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration's (GSA) System for Award Management (SAM) OIG/SAM, and the Medi-Cal Suspended & Ineligible ("S&I") Website;
  2. Meet the CalOptima requirements for the Residency program, including proof of California Board of Pharmacy Pharmacist Licensure within ninety (90) calendar days of entering the Residency Program;
  3. Submit an application, resume and letter of intent to CalOptima;

4. Submit letters of recommendation to the Residency Coordinator;
  5. Submit official pharmacy school transcripts to the Residency Coordinator;
  6. Submit a signed acknowledgment confirming the Resident understands:
    - a. The expectations;
    - b. That the Resident is not entitled to a job at the conclusion of the Residency;
    - c. That the Resident is in a voluntary, at-will relationship, which can be terminated at any time; and
    - d. The Resident agrees to comply with all CalOptima Policies and Procedures and understands that CalOptima may prohibit a Resident from continuing in the program, regardless of whether the individual has completed personal objectives.
  7. Complete HIPAA and compliance training programs, along with tuberculosis (TB) or health screening requirements for the position, where applicable; and
  8. Sign CalOptima's confidentiality agreement.
- E. Residency Program Oversight
1. The Pharmacy Management Department shall be the designated point of contact to address questions, maintain consistency, and coordinate and administer the Residency Program.
  2. The Pharmacy Management Department shall be responsible for coordinating with the Human Resources Department and designating a Pharmacy Management Department contact to serve as the Residency Coordinator.
  3. The designated Residency Coordinator should be someone who possesses expertise in the area in which the Resident will work; has the time to invest in the Resident; and will oversee and assign the Resident's work.
  4. Weekly meetings between the Resident and the Residency Coordinator should be held to discuss what has been learned the prior week and what is expected the next week. The Residency Coordinator shall document such meetings. The Residency Coordinator or department manager shall sign the department Resident evaluations.
  5. At the conclusion of the Residency, the designated Resident supervisor shall submit a Department Resident Evaluation Form and provide a copy to the Resident.

### III. PROCEDURE

Responsible Party	Action
<b>Resident</b>	<ol style="list-style-type: none"> <li>1. The Resident is responsible for reviewing the Pharmacy Resident job description and ensuring that he or she meets the qualifications and minimum requirements for the position before submitting an application.</li> <li>2. Apply for a Pharmacy Resident position through CalOptima's applicant tracking system online.</li> <li>3. Submit degree verification for Pharm.D. from an accredited college of pharmacy.</li> <li>4. Submit licensure confirmation within ninety (90) calendar days of commencing the Pharmacy Residency Program.</li> <li>5. Participate in an interview.</li> <li>6. If accepted, complete a background check and health screening, and submit a signed Offer Letter and complete other documents, or tests, as required.</li> </ol>
<b>Sponsoring Department</b>	<ol style="list-style-type: none"> <li>1. Administer and coordinate all Pharmacy Resident activities.</li> <li>2. Coordinate with Facilities for space considerations.</li> <li>3. Submit a request to fill (RTF) for the Pharmacy Resident position to the Human Resources Department, including details of the position requirements and period of time.</li> <li>4. Review applications and notify the Human Resources Department to schedule an interview if applicant is qualified.</li> <li>5. Interview Pharmacy Resident applicants.</li> <li>6. Once a qualified Pharmacy Resident applicant has been identified and the Sponsoring Department is interested in selecting that applicant to fill the position, coordinate with the Human Resources Department to provide an Offer Letter and complete the Pharmacy Resident on-boarding process, including but not limited to, background checks.</li> <li>7. Designate a contact to serve as the supervisor of Pharmacy Resident.</li> <li>8. Ensure the Pharmacy Resident's activities are within the scope of practice applicable to their license and that they perform within this scope if applicable.</li> <li>9. Notify and collaborate with the Human Resources Department if the Pharmacy Resident is not adhering to the programs or agency's policies or procedures.</li> <li>10. Complete reviews and evaluations consistent with the Residency Manual and provide timely feedback to Pharmacy Resident.</li> <li>11. Update the Residency Manual and Pharmacy Resident Job Description on an annual basis.</li> </ol>
<b>Human Resources Department</b>	<ol style="list-style-type: none"> <li>1. Receive RTF for Pharmacy Resident positions from the Sponsoring Department and verify all necessary approvals, including budgeted positions, have been obtained.</li> <li>2. Receive and review Pharmacy Resident applications.</li> <li>3. Coordinate Pharmacy Resident interviews and on-boarding process, including but not limited to, background, reference, and review of OIG LEIE, the GSA OIG/SAM, Medi-Cal S&amp;I Website exclusion checks, preparation of offer letters, coordinate health screening, where applicable, and coordinate the Resident's start date with the Sponsoring Department.</li> <li>4. Coordinate on-boarding activities, off-boarding activities, and all training requirements.</li> </ol>

Responsible Party	Action
	5. Maintain all Pharmacy Resident's records, including, but not limited to, all performance evaluations. 6. Monitor and support the Pharmacy Residency program activities and outcomes.

**IV. ATTACHMENTS**

Not Applicable

**V. REFERENCES**

- A. CalOptima Policy GA.8018: Paid Time Off (PTO)
- B. CalOptima Policy GA.5003: Budget and Operations Forecasting
- C. Department Resident Evaluation Form
- D. Resident Agreement
- E. Resident Offer Letter
- F. Resident Program Guidelines
- G. U.S. Department of Labor (DOL) Fair Labor Standards Act (FLSA) Guidelines
- H. Title 29, Code of Federal Regulations (CFR), §553.101
- I. Title 45, Code of Federal Regulations (CFR), §160.103

**VI. REGULATORY AGENCY APPROVALS**

None to Date

**VII. BOARD ACTIONS**

None to Date

**VIII. REVIEW/REVISION HISTORY**

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	TBD	GG.1426PP	Pharmacy Management Residency Program	Administrative

**IX. GLOSSARY**

Term	Definition
Job Description	A document that describes the requirements, qualifications, essential functions and responsibilities for the position.
Pharmacy Management Department	A department within CalOptima requesting a Pharmacy Resident and overseeing the management and work of the Pharmacy Resident pursuant to this policy.
Pharmacy Residency Program	A post-graduate training program offered by CalOptima which allows the Pharmacy Resident to perform as a licensed practitioner specializing in Managed Care and to train under the supervision of other experienced pharmacists.
Pharmacy Resident	The Pharmacy Resident is an employee completing a post graduate training specializing in managed care for one (1) year.
Residency Coordinator	The Clinical Pharmacist Manager responsible for direct supervision of Pharmacy Residents and the Residency Program. The Residency Coordinator will work with Pharmacy Management staff to achieve residency goals and objectives.
Residency Manual	A document outlining the purpose, program goals, program structure, core learning experiences, and project expectations for the Pharmacy Resident.



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# Pharmacy Residency Program

**Board of Directors' Quality Assurance Committee Meeting  
February 20, 2018**

**Nicki Ghazanfarpour, PharmD, BCGP, Manager, Pharmacy Clinical Programs  
Richard Bock, MD, Deputy Chief Medical Officer**

# Report Item

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- Consider Ratification of CalOptima's Pharmacy Management Residency Program and Approval of Related Policy.
- CalOptima's Pharmacy Management Residency Program (Residency Program) was started in 2010.
- At this time, staff is requesting ratification of the existing program and approval of a policy formalizing program requirements and responsibilities.

# Background

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- The Pharmacy Residency Program is included in the 2017 Utilization Management Program.
- Residents are required to possess a doctor of pharmacy (PharmD) degree and have graduated from an accredited school of pharmacy.
- Residents are full-time CalOptima employees and are required to meet all employment requirements.
- Pharmacy Residents are licensed pharmacists who provide several contributions to CalOptima at a much-reduced direct cost.

# Background

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- The Pharmacy Resident position is a 12-month duration and consists of structured rotations through different areas in Pharmacy Management.
- A number of other Medi-Cal Managed Care Plans also have Pharmacy Residency programs, including Inland Empire Health Plan, LA Care, San Francisco Health Plan, and Health Plan of San Joaquin.

# Discussion

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- As licensed pharmacists, Pharmacy Residents rotate in various areas within Pharmacy Management.
- The Residency Program year includes the following:
  - Interdisciplinary Care Team (ICT) participation as lead Clinical Pharmacist
  - Comprehensive and Targeted Medication Reviews; Medication Therapy Management (MTM) Program
  - Quarterly opioid prescribing summary creation and distribution
  - Monthly Provider Newsletters aimed at educating providers in various clinical topics
  - Medicare coverage determination and Medi-Cal prior authorization reviews
  - PACE medication profile reviews

# Discussion

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- Residents are required to complete a longitudinal drug utilization review (DUR) project that contributes to CMS and DHCS DUR requirements.
- Other Pharmacy Resident contributions include:
  - Drug monographs
  - Prior authorization criteria
  - Clinical guidelines
  - Drug Information
  - MTM member education newsletters
  - In-service clinical trainings
  - Part D formulary submissions
  - Pharmacy Benefits Manager (PBM) oversight

# Discussion

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- In addition to contributions Residents make to organizations through staffing and projects, staff pharmacists involved with residency programs have been found to experience a greater degree of job satisfaction and higher employee retention rates.
- CalOptima's Residency Program is intended to increase the number of well-trained pharmacists prepared to work in expanding patient care roles and also provides opportunities to recruit well-trained pharmacists.
- CalOptima has hired four of our past residents as clinical pharmacists over the past seven years.

# Fiscal Impact

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- Two Pharmacy Resident positions were included in the final fiscal year 17/18 budget.
- The Pharmacy Resident position is included in the CalOptima Annual Base Salary Schedule under Pay Grade K (range from \$47,112 to \$75,504 with a mid-range salary of \$61,360).
- The annual salary and benefits cost for two Pharmacy Residents is \$191,000, approximately half the salary of a clinical pharmacist position.

# Rationale for Recommendation

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- CalOptima's Pharmacy Residency Program provides extensive postgraduate training that centers on developing the knowledge, skills, and abilities needed to achieve professional competence in the delivery of patient care and managed care pharmacy operations.
- Pharmacy Residents provide many valuable contributions to CalOptima at approximately half the salary of a full-time clinical pharmacist.
- Past residents are ideal candidates to transition into vacant full-time staff positions with minimal training required.

# Rationale for Recommendation

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- Staff recommends ratification of CalOptima's Pharmacy Management Residency Program and approval of related Policy GG.1426: Residency Program, Pharmacy Management.



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# **2017 Quality Improvement Program Evaluation**

**Board of Directors' Quality Assurance Committee Meeting  
February 20, 2018**

**Kelly Rex-Kimmet  
Interim Director, Quality and Analytics**

# 2017 QI Program Evaluation

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- Represents the analysis of the core clinical and service indicators to determine if the Quality Improvement (QI) Program has achieved its key performance goals during the year
- Is based on the data through Q3 of the 2017 QI Work Plan
- Provided guidance for the 2018 QI Program

# 2017 QI Accomplishments

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- For the fourth year in a row, CalOptima was recognized for top quality care for Medi-Cal members in California, by NCQA.
- Maintained “Commendable” NCQA accreditation status
- Revised Health Network P4V program which demonstrated improvement in performance of P4V measures for adults and children
- CCN P4V Distribution Methodology approved by Board
- 6 QIP/PIP pilot initiatives required by DHCS, CMS launched

# QI 2017 Accomplishments

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- Implemented 8 Targeted Quality Initiatives with member and/or provider incentives to improve HEDIS scores
- Behavioral Health transition to in-house administration by CalOptima for its Medicaid network
- Provider coaching RFP results in selection of partner to provide targeted provider and office coaching (staff trainings, shadowing and follow-up)
- Provided access to members by credentialing and re-credentialing of 639 CCN providers, and added 820 BH providers to CCN, including ABA organizations
- Ensured patient safety by conducting over 700 FSR/MRR/PARS

# 2017 QI Accomplishments

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- Monitored Quality of Care and Service to members through clinical review of 1680 cases of potential quality issues
- Redesign/geographic expansion of *Shape Your Life* childhood obesity program and *Bright Steps* perinatal program
- Leveraged IVR calls to support member reminder campaigns (i.e., flu, IHA, future Medicare Diabetes Preventive Program–MDPP benefit)

# QI Opportunities for 2018

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- Continue to maintain demonstration of quality of care excellence via achievement of NCQA accreditation and top Medicaid health plan rating.
- Implement CCN provider P4V program
- Implement provider and office staff coaching program
- Increase focus on network adequacy/Access and Availability (AA) in order to improve performance on AA standards.
  - Several AA standards did not meet MPL including timely access to PCP's and specialists, and telephone triage.

# QI Opportunities for 2018

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- Improve performance on Behavioral Health HEDIS metrics; partner with Magellan and BHQI to achieve goals
- Improve analysis of effectiveness/ROI of internally developed Quality Initiatives
- Customer Service: Achieve KPI targets for average speed of answer (ASA) and abandonment rate
- Implement newly redesigned *Shape Your Life* and *Bright Steps* programs

# Summary of QI Evaluation

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- An effective quality improvement program is resource intensive and requires resources from multiple functional areas to collaborate, implement and assess effectiveness of quality initiatives and programs.
- Staffing resources and budget must support the scope of the QI program's goals.
  - Current resources (especially in BH and RX) are minimal to support quality initiatives.
  - Due to the expectation of no change in existing resources (staff and budget) for 2018, QI work plan tasks related to number of HEDIS measures to improve were reduced.
- Priority given to strategic goals of NCQA accreditation, health plan rating, DHCS EAS, OCC Quality Withhold and Member Experience and Access and Availability.

# Recommended Action

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Receive and file the 2017 CalOptima Quality Improvement Program Evaluation



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2017

# QUALITY IMPROVEMENT EVALUATION





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## **2017 QUALITY IMPROVEMENT EVALUATION**

### **SIGNATURE PAGE**

*Quality Improvement Committee Chair:*

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**Richard Bock, M.D.**  
**Deputy Chief Medical Officer**

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**Date**

*Board of Directors' Quality Assurance Committee Chair:*

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**Paul Yost, M.D.**

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**Date**

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# 2017 QUALITY IMPROVEMENT EVALUATION OF OVERALL PROGRAM EFFECTIVENESS

## EXECUTIVE SUMMARY

Activities in the 2017 Quality Improvement (QI) Program and associated Work Plan activities focused on refining the structure and process of care delivery, with the emphasis on member centric activity and consistency with regulatory and accreditation standards. All activities were undertaken in direct support of the Mission, Vision and Strategic Initiatives of the Board.

The 2017 Annual QI Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. This evaluation focuses on quality activities undertaken during the first three quarters of the calendar year 2017 to improve the health care and service available to members of CalOptima. The final 2017 QI Work Plan with the full calendar year results will be presented as a separate document in Q1 2018 to the QI Committee. The 2017 QI Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2018 QI Program and its Work Plan.

## PROGRAM STRUCTURE

In 2017, CalOptima sustained the development of its QI Program and infrastructure that included:

- A written Evaluation of the 2016 QI Program reviewed and approved by the QI Committee (QIC) on May 1, 2017, and the Board of Director's Quality Assurance Committee (QAC) on May 22, 2017.
- A written QI Program Description for 2017 included structure, scope, and process which was reviewed and approved by the QIC on February 1, 2017 and the Board of Director's Quality Assurance Committee (QAC) on March 2, 2017.
- A written Work Plan for 2017 that included clinical, patient safety and service monitors to evaluate quality activities, and that were reviewed and approved by the QIC on February 1, 2017 and the Board of Director's QAC on March 2, 2017.
  - The CalOptima Medical Directors provided direction and supervision of QI activities at the direction of the Chief Medical Officer (CMO). Overall oversight of the QI Program was provided by the Board of Directors.

## 2017 QI PROGRAM GOALS ACCOMPLISHMENTS

In 2017, CalOptima sustained the considerable and major steps in the development of its QI infrastructure, which included the achievement of National Committee for Quality Assurance (NCQA) Commendable Status. The QI Program incorporates continuous QI methodology of

Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies):

- It was organized to identify and analyze significant opportunities for improvement in care and service.
  - Accomplished as evidenced by the following summaries by area.
- It fostered the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress toward established benchmarks or goals.
  - Accomplished as evidenced by multidisciplinary committees, participation by practicing network providers, company-wide subcommittees and collaboration with delegated entities.
- It focused on QI activities carried out on an ongoing basis to promote efforts that support the identification and correction of quality of care issues.
- Accomplished as evidenced by the following summaries by area.
- Maintained a functional and viable QIC structure to oversee all lines of business.
- Developed a new format for the 2017 QI Work Plan.
  - This format allowed the organization to evaluate and track the effectiveness of the QI Program throughout the year.
  - Quarterly status updates to subcommittees were documented, tracked, and presented in a dashboard to the QIC.
- Continued activities in preparation for the 2018 NCQA accreditation survey.

**QI goals and objectives are to monitor, evaluate and improve:**

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
  - Accomplished as evidenced by QI reviews of Facility Site Reviews, follow up with potential quality issues with practitioners and facilities, monitoring of member grievances and complaints, and review of delegated entities review processes.
  - Collaboration with the Compliance department for identification of potential quality issues that may have involved fraud, waste, abuse, confidentiality, security, etc.
  - Accomplished as evidenced by the Measures Worksheet (Attachment A) progress on various Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Medicare STARS metrics.
- The important clinical and service issues facing the Medi-Cal population relevant to its demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care.
  - Aligned with Clinical Practice Guidelines.
  - Includes Medical and Behavioral Health population management activities.
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually acting on at least three identified opportunities.
  - Accomplished as evidenced by the strong increase in interdisciplinary care team

meetings, which include primary care, specialty and behavioral health practitioners.

- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
  - Accomplished as evidenced by the access and availability studies and summary of activities from the Access and Availability Subcommittee.
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
  - Accomplished as evidenced by a solid credentialing and peer review process.
- Member and provider satisfaction, including the timely resolution of complaints and grievances.
  - Accomplished as evidenced by Member Experience Surveys and Reports, the Primary Care Provider (PCP) Satisfaction Survey and the summary of the Grievance & Appeals Resolution Services (GARS) activities.
- Risk prevention and risk management processes.
  - Accomplished as evidenced by sound Potential Quality Issue (PQI) process to identify and address high-risk practitioners.
- Compliance with regulatory agencies and accreditation standards.
  - Accomplished through participation in mock and regulatory audits.
- Annual review and acceptance of the Utilization Management (UM) Program Description and UM Work Plan.
  - Accomplished as evidenced by the acceptance of the UM Program Description and Work Plan at QIC on April 11, 2017, and the QAC on May 22, 2017.
- The effectiveness and efficiency of internal operations and operations associated with functions delegated to the contracted medical groups.
  - Accomplished as evidenced by progress reports by individual departments and quarterly delegation reports.
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values.
  - Accomplished as evidenced by achievements in cross-departmental activities to improve member experience, expansion of the pay-for-value program, and further focus on opioid epidemic.
- Compliance with Clinical Practice Guidelines (CPG) and evidence-based medicine
  - Accomplished as evidenced by the annual review and acceptance of updated CPGs for medical and behavioral guidelines.
- Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
  - Accomplished as evidenced by Audit & Oversight (A&O) department quarterly reports of functions delegated to the Health Networks or conducted by internal departments.
- Promote patient safety and minimize risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and work with appropriate committees, departments, staff, practitioners, provider medical

groups, and other related health care delivery organizations (HDO) to assure that steps are taken to resolve and prevent recurrences.

- Accomplished as evidenced by summary of the QI Work teams' activities and the Quality Improvement Projects (QIP), Performance Improvement Projects (PIP) Chronic Care Improvement Programs (CCIP) and PDSA.
- Accomplished by ongoing monitoring and implementation of pharmacy initiatives including over/under utilization and specialty drug utilization.
- Accomplished by Community-Based Adult Services (CBAS), Skilled Nursing Facility (SNF) Long-Term Care (LTC), Multipurpose Senior Services Program (MSSP) and In-Home Supportive Services (IHSS) ongoing monitoring and reporting of Critical Incidents.

## QI PROGRAM RESOURCES AND COMMITTEE STRUCTURE

CalOptima has developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Ongoing data analysis across multiple areas provides the basis for identifying over/under utilization of services. Our approach also uses support systems for our members with vulnerabilities, disabilities and chronic illnesses.

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's QAC. Table 1 shows the frequency of the QIC and QAC meetings during 2017.

Table 1:

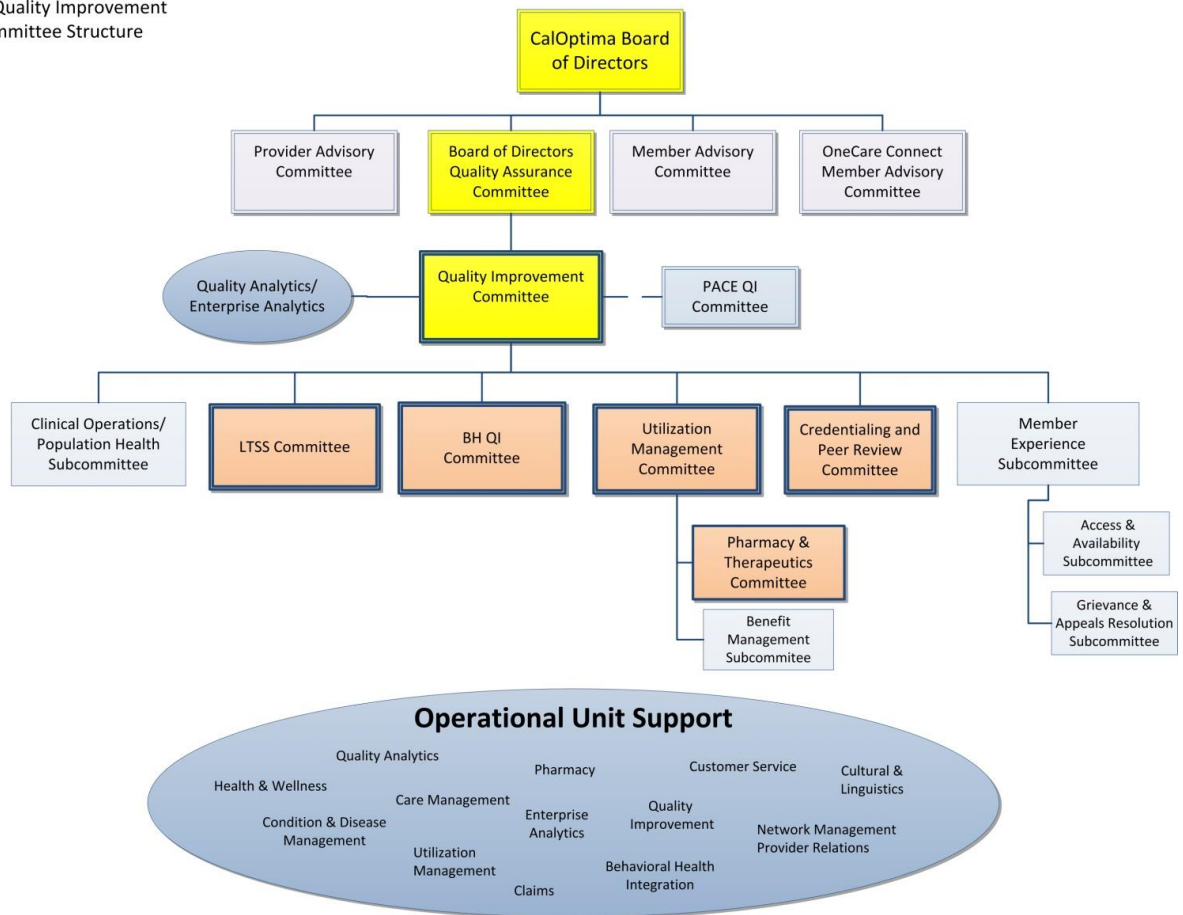
Committee Meeting Dates				
<b>QAC (Quarterly)</b>	2/15/2017	5/22/2017	9/20/2017	11/15/2017
<b>QIC (Monthly or at least 8 times/year)</b>	01/12/2017	04/11/2017	07/19/2017	10/11/2017
	02/01/2017	05/01/2017	08/08/2017	11/18/2017
	03/08/2017	06/14/2017	09/13/17	12/12/2017

### Committee and Subcommittee Reports:

Six committees and subcommittees support CalOptima's QI Program and report to QIC at least quarterly.

## 2017 Committee Organization Structure — Diagram

2017 Quality Improvement  
Committee Structure



As seen in the above reporting structure diagram, these committees are:

### 1. Credentialing Peer Review Committee (CPRC):

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ensure that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC, chaired by the Deputy CMO, reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all CalOptima practitioners. In addition, the CPRC reviews Potential Quality Issue cases that impact the quality of care of CalOptima members. In 2017, CPRC met 13 times.

### 2. Behavioral Health Quality Improvement Committee (BHQIC):

The Behavioral Health Integration (BHI) department manages the BHQI committee, which reports up to the QIC. The BHQI meets quarterly to: monitor and identify improvement areas of member and provider 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 members internal and external to CalOptima including delegated networks, 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 2017 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.

**3. Utilization Management Committee (UMC):**

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC, chaired by the UM Medical Director, monitors the utilization of health care services by CalOptima Direct and Medi-Cal overall through the delegated Health Networks to identify areas of under or over utilization that may adversely impact member care. In 2017, the UMC met quarterly; it monitored medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. The UMC also reviewed and approved the 2017 Utilization Management Program and Work Plan on 05/22/17.

**4. Pharmacy & Therapeutics (P&T) Subcommittee**

P&T subcommittee reports to the UMC, and is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all CalOptima members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. In 2017, the P&T met quarterly and addressed key pharmacy issues facing our providers and members.

**5. Member Experience (MEMX) Subcommittee:**

The MEMX focuses on the issues and factors that influence the member's experience with the health plan. The MEMX subcommittee is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members experience with the health plan. In 2017 MEMX subcommittee met bi-monthly to review survey results, and develop action plans to address member experience concerns.

**6. Grievance & Appeals Resolution Services (GARS) Subcommittee**

The GARS subcommittee reports up to the MEMX and met quarterly. GARS protects the rights of our members, and to promote the provision of quality health care services, and enforces that the policies and procedures of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. Quarterly, the GARS subcommittee reviews the member trend report, which includes rate of complaints (appeals/grievances), a breakdown of complaint by type and interventions based on trends.

**7. Long-Term Services and Supports QI Subcommittee (LTSS QISC):**

The LTSS QISC met on a quarterly basis in 2017, and addressed key components of regulatory, safety, quality and clinical initiatives. The LTSS/Case Management Medical Director chairs the LTSS QISC meetings, whose members also include administrators and clinical leaders from the following groups: CBAS providers, Orange County Social Services Agency (OC SSA) IHSS, OC Public Authority (PA) IHSS, nursing facility (NF), MSSP, delegated Health Networks and other CalOptima clinical and operational staff. In 2017, LTSS reviewed progress on the LTSS PIP, IHSS and CBAS staffing and utilization measures, and NF quality measures.

**8. Clinical Operations/Population Health Subcommittee (COPHS)**

The Clinical Operations/Population Health subcommittee, also known as Medical Affairs, exists to oversee, guide and ensure the integration and coordination of functions across the continuum of care, including but not limited to population health, disease management, care management, complex case management, UM, LTC, pharmacy, and behavioral health services. This subcommittee monitors the progress of the established program goals and metrics defined for CalOptima's disease management, complex case management programs and Model of Care. These programs are reviewed at monthly meetings and updated through the QI workplan updates which is reflected in the QI Work Plan dashboard quarterly.

Each committee reported quarterly to QIC; minutes were submitted and approved. Presentations from each committee focused on the QI or UM Work Plans and included reports on progress-to-date, issues and/or barriers identified collaboration across functional areas, and any operational concerns.

The QI committee structure allowed for adequate program resources to be allocated in each of the subcommittees, as evidenced by Medical Director and external practitioner involvement as well as CalOptima's senior leadership involvement at various subcommittees and at the QIC. This reporting structure was new in 2017, and provided a sound infrastructure for tracking quality program results as evidenced by the QI Work Plan updates and dashboard. Towards the end of 2017, it was determined that the GARS subcommittee needed more visibility directly to the QIC and QAC, therefore, starting in 2018, the GARS subcommittee will report directly to QIC and also to MEMX.

## **SUMMARY EVALUATION AND OPPORTUNITIES FOR IMPROVEMENT IN 2018**

For CalOptima 2017, was a year of quality achievement. For the fourth year in a row, CalOptima was named the top rated Medicaid plan in California according to the NCQA's Medicaid Health Insurance Plan Ratings 2017-2018. Additionally, CalOptima maintained NCQA "Commendable" health plan accreditation status. Both achievements reflect CalOptima's dedication to Quality Care for our members in accordance with our mission statement and CORE values.

In 2017, we noted improvement in several clinical HEDIS measures. Some of this improvement can be attributed to our pay for value program (P4V) which was significantly revamped in 2016.

Measures incentivized through our pay for value program did perform better than other measures that were not incentivized.

Eight quality initiatives were implemented in 2017 to improve performance in breast and cervical cancer screenings, postpartum care and diabetes A1C testing and control. Both member and provider incentives were newly implemented to test member and provider response to monetary incentives. Response to the member and provider incentives reflects a low response rate through November, 2017. Final results and analysis of impact will be available after Q1 2018, once data collection is considered complete. In addition to internally developed quality initiatives, six regulatory required and highly prescribed PIPs and QIPs were initiated. One Chronic Care Improvement project (CCIP) concluded. Due to the highly prescribed methodology outlined by the regulators, it was challenging to leverage staff resources across the spectrum of clinical measures targeted for improvement.

Improving the “Member Experience” continued to be a major focus in 2017. CalOptima’s member experience scores lag behind other county organized health system (COHS) model Medicaid plans and California lags behind the rest of the nation in member experience scores. (our Medicaid reimbursement rate lags behind the rest of the country as well). Member pain points such as timely access to PCP’s and specialists, referrals for coordination of care, member communications, customer service and potential quality indicators (PQIs) were reviewed and evaluated for actions needed. A request for proposal (RFP) was issued in 2017 for targeted provider and office staff coaching services. A contract award was made. The provider and office staff coaching program will be implemented in 2018 and is expected to have a material impact on individual provider member experience scores which will be reflected in improved member experience scores for CalOptima.

Member programs for childhood obesity such as “Shape your Life” and Perinatal Care were redesigned and expanded in 2017. The new programs will be implemented in 2018.

Behavioral health implemented a major change by bringing administration of the Medicaid network for mild to moderate services in-house on January 1, 2018. This was a major lift for the behavioral health team as well as for other departments that supported the transition.

QI opportunities in 2018 include the following:

- Continue to maintain demonstration of quality of care excellence via achievement of NCQA accreditation and top Medicaid health plan rating.
- Implement CCN provider P4V program
- Implement Targeted Provider and Office Staff Coaching program
- Increase focus on network adequacy/Access and Availability (AA) in order to improve performance on AA standards. Several AA standards did not meet minimum performance level (MPL) including timely access to PCP’s, specialists and telephone triage. Revamp AA team participants.

- Credentialing-Implementation of CPRC policies ensuring consistency across CalOptima and HN including communication and enforcement of quality findings.
- Improve performance on Behavioral Health HEDIS metrics; partner with Magellan and BHQI to achieve goals.
- Improve analysis of effectiveness/return on investment of internally developed Quality Initiatives
- Customer Service: Achieve key performance indicators (KPI) targets quarterly including PCP termination notification. Collaborate with provider relations to ensure HN PCP term notifications are received timely.
- Implement newly redesigned Shape Your Life and Bright Steps programs

## BEHAVIORAL HEALTH INTEGRATION

### **Implementation of new managed behavioral health organization (MBHO) vendor/partner:**

On January 1, 2017, CalOptima successfully implemented Magellan Healthcare as its new MBHO partner. The Behavioral Health Integration (BHI) department worked closely with multiple CalOptima business units to ensure adequate provider network for behavioral health and Applied Behavioral Analysis (ABA) services; oversight of BH call center; approval of member materials; development of process flows for continuity of care; coordination with Finance, Accounting, Regulatory, and interface with County Specialty Mental Health Services were all functional by the go-live date of January 1, 2017.

In September 2017, the CalOptima Board of Directors approved integrating Medi-Cal covered Behavioral Health Services within CalOptima internal operations effective January 1, 2018. The BHI department worked diligently with Project Management and other departments to ensure a smooth transition from Magellan. Magellan will continue to manage behavioral health benefits for OneCare (HMO Special Needs Population) (OC) and OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) (OCC) members through 2018.

### **Quality of Clinical Care: Behavioral Health HEDIS Measures**

This year the BHI department continued to work on BH HEDIS measures by developing and implementing activities that improved quality and service for members receiving BH and medical services. The focus continues to be monitoring on Antidepressant Medication Management (AMM) and attention-deficit/ hyperactivity disorder (ADHD) “Follow-up Care for Children Prescribed ADHD Medication” (ADD) HEDIS measures for 2017. AMM for HEDIS measures monitors treatment and progress of members on antidepressant medication. ADD for HEDIS measures and monitors the appropriate use of medications and follow up care for children prescribed ADHD Medication. The goal was to meet the 50th percentile or higher for both parts of the interventions.

In 2015, CalOptima met the HEDIS AMM goal of 75th percentile; in 2016 the goal was raised to the 90th percentile. In 2017, the goal was lowered to fall between the 75th and 90th percentile because achieving the 90th percentile was evaluated to be unrealistic due to a number of factors. Both rates dropped slightly from previous year's performance and did not meet our target goal but met the 50th percentile and was close to reaching our goal.

HEDIS Measure AMM	HEDIS 2016 Final Rate	HEDIS 2017 Final Rate	Goal	NCQA National Medicaid Percentiles 2016		
				50th	75th	90th
Effective acute phase treatment	55.92%	55.90%	59.52%	50.51%	56.15%	62.56%
Effective continuation phase treatment	41.02%	39.61%	43.39%	34.02%	40.48%	48.39%

For 2017 ADD HEDIS rates improved but still did not meet the 50th percentile. The 2016 HEDIS rates for ADD Initiation Phase and Continuation and Maintenance Phase were 34.96% and 38.86% respectively. Because CalOptima did not reach the 2015 HEDIS ADD goal of 50<sup>th</sup> percentile, the goal for 2016 remained the same. The 2016 HEDIS ADD final rates did not reach the target goals; however, they surpassed the 2014 and 2015 rates. It is important to note that the NCQA National Medicaid percentiles for ADD have increased each year for the past three years, indicating an upward trend in performance at a national level. For this reason, we continue to work on improvement to these rates.

HEDIS Measure ADD	HEDIS 2016 Final Rate	HEDIS 2017 Final Rate	Goal	Quality Compass Percentiles 2016		
				50th	75th	90th
Initiation phase	34.96%	38.95%	49.55%	42.19%	49.55%	55.48%
Continuation phase	38.86%	43.07%	62.50%	52.47%	62.50%	67.23%

During 2017 HEDIS rates for AMM and ADD were monitored as a QI activity. The BHQI team reviewed progress towards goals for both measures at their quarterly meeting. We continue to show improvement for the continuation rates for AMM. For acute phase, the rates remain steady. Each year the national average increased and we are just shy of meeting the goal. We have met 50th percentile which is important towards our goal of maintaining NCQA accreditation

The BH department holds a monthly focused work group meeting that includes quality, pharmacy and BH staff that delves into HEDIS results for analysis and recommendations to the quarterly steering committee meeting. Data is reviewed month to date in comparison to the previous year rates during that same month and in comparison to progress towards goals. If a downward trend is noted, the group reviews the data to look at potential reasons for drops in rates. The BHQI workgroup was tasked with exploring other best practices to help improve performance when it was noted that we may not meet the 50th percentile. Additionally, we received provider feedback that the targeted brochure and letters for AMM and ADD respectively, are not the most effective way of reminding providers and members about ADD and AMM prescription adherence. In 2018, the BH workgroup will explore other strategies for more effectively meeting the established goals.

## QUALITY OF CLINICAL CARE - BH INTERDISCIPLINARY CARE TEAM PARTICIPATION

BHI chose to continue to monitor and identify opportunities to improve integration and coordination of care across settings and /or transitions of care through Interdisciplinary Care Team/Interdisciplinary Care Plan (ICT/ICP). The goal is to ensure members with BH services are able to participate in their care planning, that their medical doctor is aware and able to participate as well, and that the BH team they are working with can coordinate that care with their PCP and those providers exchange information regularly.

The member centric approach of care for Medi-Cal Seniors and Persons with Disabilities (SPD) population continues to be a focus for CalOptima. Since July 2015, one of the components of this model — ICTs — remains a priority of integration of care. We first reported on this measure for 2016, using a formula that would track the participation rate of BH providers in ICT meetings. It was determined that 2016 would provide the baseline measurement year for assessing improvement in this process. Through analysis, we realized the proposed formula for measurement in 2016 was not optimal for tracking the process in its current design. Therefore, we changed the formula for reporting year 2017.

ICT Coordination of Care M/C 2017		
A — Total of ICTs Participated	B — Total ICTs invitations to MBHO for member in BH services	x 100%
173	186	95%

ICT Coordination of Care M/C 2016		
A — Total ICTs	B — ICTs completed with BH	x 100%
102	35	34%

Measuring Participation in ICTs has evolved several times since its inception. For the 2017 measurement year, we revised the formula. Participation in ICTs for 2017 met the goal of achieving a 10% increase in participation in ICTs over prior year's performance — in fact there was a 95 % participation rate during 2017, compared to 34% during 2016.

The goal that BHI set out to accomplish was to gain a 10% improvement over last year's provider/BH liaison participation rates.

There are several challenges to expanding the tracking of BH ICT participations to all Health Networks (HN).

1. First, there is limited ability for the HNs to identify members who are currently receiving BH services. This is primarily due to the fact that outpatient BH benefit is carved out from the HNs. To address this problem, BHI has developed a monthly report that lists all members with BH claims in the past 6 months. The list is shared with the HNs for the purpose of care coordination including ICT invitation.
2. A second barrier is the lack of a centralized ICT invitation system for BH. HNs are responsible for and conduct ICTs on their end, but they did not have a standardized

mechanism to invite BH providers to attend the meeting. On occasion, invitations would be sent to CalOptima BHI and staff would need to check multiple databases (e.g. pharmacy, claims etc.) to determine if the members are receiving BH services. The process is both time consuming and ineffective.

3. As a result, the BH team developed a new system to track all HN ICTs that require BH participation. HNs are now sending all ICT invitations to the Managed Behavioral Health Organization (MBHO). The MBHO is responsible for contacting the BH provider and obtaining all the relevant clinical information.

In 2018, BH will continue to calculate ICT participation rate, the same as in 2017. With CalOptima directly managing Medi-Cal BH benefits, BHI will actively participate in ICTs for Medi-Cal members while Magellan continues to provide ICT support for OC and OCC members.

## QUALITY AND PERFORMANCE IMPROVEMENT PROJECTS

Annually, CalOptima participates in Quality Improvement Projects (QIP), Performance Improvement Projects (PIP), and Chronic Care Improvement Projects (CCIP) as directed by our regulatory entities; the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). Quality and PIP may also include PDSA rapid cycle improvement projects.

Quality and PIP measure performance on important clinical and/or non-clinical focus areas with the aim of improving health outcomes and member satisfaction. Quality and PIP are recommended and prioritized for the annual QI Work Plan and calendar for CalOptima's three lines of business; Medi-Cal (Medicaid), OC and OCC. CalOptima has fulfilled the requirement of completing all regulatory required Quality/PIP for DHCS and CMS for the 2017 year.

### Quality Improvement Projects (QIPs):

#### OC Diabetes QIP to Improve HbA1c Testing Rates (Year 2):

OC members diagnosed with diabetes and who have not received a HbA1c test (based on our monthly 2017 reports) were targeted to receive a mailing to promote testing. In addition, all contracted OC Health Networks were sent monthly prospective rates along with member-level information to utilize for targeted interventions to increase HbA1c testing for their OC members. In 2015, CalOptima's OC population has decrease significantly due to the transition of most of the members to the OCC program. The total OC population now stands at 1,378 members as of November 2017. The total eligible OC diabetic population based on HEDIS specifications in 2017 is 188 members.

#### Preliminary results of the OC QIP:

Intervention	Numerator	Denominator	Rate
Number of members who received the mailing intervention	105	188	55.9%

<b>HEDIS Measure</b>	<b>HEDIS November 2016 Prospective Rates</b>	<b>HEDIS November 2017 Prospective Rates</b>	<b>2016 Quality Compass Goal</b>	<b>Goal Met/Not Met</b>	
<b>Comprehensive Diabetes Care – HbA1c Testing</b>		85.09%	85.11%	93.90%	Not Met

Preliminary results indicate that 105 out of 188 members (55.9%) received educational outreach via mail. Although there was a slight increase in the rate compared to last year, CalOptima did not meet the goal of 93.90% by 8.79% percentage points. It does not appear that the mailing intervention had an impact on the prospective rates. It should be noted that the measurement period for the QIP runs from January 1, 2017 to December 31, 2017, and CalOptima has not received all claims/encounter data for the HbA1c measure as there is a 90-day lag. In addition, the Comprehensive Diabetes Care measure is a hybrid measure which HEDIS medical chart reviews have not been conducted to give a full assessment of the results.

CalOptima encountered some barriers while implementing this QIP which included data retrieval of reports and staffing resources. To mitigate the data retrieval reports, Quality Analytics worked closely with our Information Systems department to ensure reports are accurate and could be obtained in a timely manner so that mailings are dropped consistently. Due to competing priorities, health education staff could not conduct telephonic outreach to the OC members for this QIP project. Therefore, CalOptima continued to focus our efforts on the mailing intervention for this reporting period.

CalOptima will continue with outreach efforts to OC members and look for opportunities for program improvement. The Quality Analytics department will work closely with the Health Education and Disease Management department to assess staffing resources and opportunities for conducting telephonic outreach to members to increase HbA1c testing for the OC population.

#### **OCC QIP to Improve 30-day Readmission Rate (Year 2):**

OCC members admitted to either Fountain Valley Regional Hospital or Anaheim Regional Medical Center with any diagnosis (excluding pregnancy and severe mental health) are outreached by a health coach to receive home visits and follow-ups after discharge as part of the Transition of Care (TOC) program. The second intervention for this QIP project was sending discharge mailing kits to OCC members with information on self-management to prevent future readmissions. CalOptima identified unexpected reporting errors for the mailing intervention during this measurement period. This reporting error limited the mailing to Medi-Cal and OC line of businesses only and excluded the OCC population from receiving the mailing. Due to this limitation, CalOptima is unable to provide outcome results for the mailing intervention however, outcomes for the coaching intervention remain unaffected.

**Preliminary results for the OCC QIP:**

***Outreach and Participation (Table 1)***

<b>Health Coaching at the 2 targeted hospitals</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Rate</b>
Number of members who were outreached to by health coach	31	1064	2.9%
Number of OCC members who were outreached to and received the health coaching.	5	31	16.1%

***Readmission Rates for OCC members who RECEIVED coaching***

<b>Eligible members who RECEIVED coaching</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Percent</b>
<b>Readmission</b>	3	5	60.0%
<b>No Readmission</b>	2	5	40.0%

***Readmission Rates for OCC members who RECEIVED Coaching***

<b>Total readmission rates for eligible OCC members</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Percent</b>
<b>Readmission</b>	410	1064	38.4%
<b>No Readmission</b>	651	1064	61.2%

***Readmission Rates for those who DID NOT receive coaching***

<b>Eligible members who <u>DID NOT</u> receive coaching</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Percent</b>
<b>Readmission</b>	407	1059	38.4%
<b>No Readmission</b>	649	1059	61.3%

Preliminary results for the OCC QIP show that of the 1064 eligible members for the TOC program, only 5 members received the coaching intervention and 1059 did not receive the coaching intervention. When analyzing readmission rates, 60% of the members receiving coaching were readmitted to the hospital within 30 days of discharge compared to the 38.4% of members who did not receive coaching. The number of members who received coaching (5) was very low and did not provide a representative sample of the coaching group. Therefore, it is difficult to assess if the intervention was effective currently with low participation rates. Follow-up visits with a PCP for the OCC population are currently be analyzed and will be updated in the OCC QIP report by Quarter 1, 2018. When looking at the total TOC eligible population, 38.5% of members were readmitted within 30 days of discharge. This is 21.7 percentage points higher than the goal set at 16.8%. CalOptima did not meet the overall goal for this submission.

While implementing the TOC program, CalOptima encountered barriers associated with real-time data retrieval, infrastructure changes, and staffing resources. The outreach to eligible OCC (MMP) members was initiated using eCEDA, a real-time web-based hospital census application. On July 1, 2017, the contract with this data source expired and was not renewed. As a result, a lower volume of CalOptima members was identified during the second half of the measurement period. This impacted the pool of potential members for outreach for both the coaching and mailing interventions. CalOptima also identified unexpected reporting errors for the mailing intervention was not able to implement the activity.

To address the data limitations, CalOptima assessed remaining data sources available and narrowed the target population to include only OCC CalOptima Community Network members discharged with any diagnosis, excluding pregnancy and severe mental health. The reporting error that prevented OCC members from receiving a discharge mailing kit led the TOC work team to actively improve internal coordination and communication regarding the daily activities of the TOC program. The team met more frequently to share status updates. Out of these discussions, the team decided to focus efforts on the health coaching intervention given that the eCeda data source was no longer available for the mailing intervention moving forward. The timeliness of the mailing intervention depended on the eCeda data source. To increase program participation, the health coach continued the efforts to improve member engagement by clarifying TOC program services and answering members' questions. Currently, there is only one health coach designated to this program.

CalOptima staff will continue efforts to enhance the TOC program to become a meaningful and successful service to OCC members while considering program resources. TOC team will conduct frequent process evaluations throughout the year to improve the program activities. The TOC team will continue improving internal communications and assess opportunities (i.e., additional staff resources and promotion activities) to improve participation rates for TOC program.

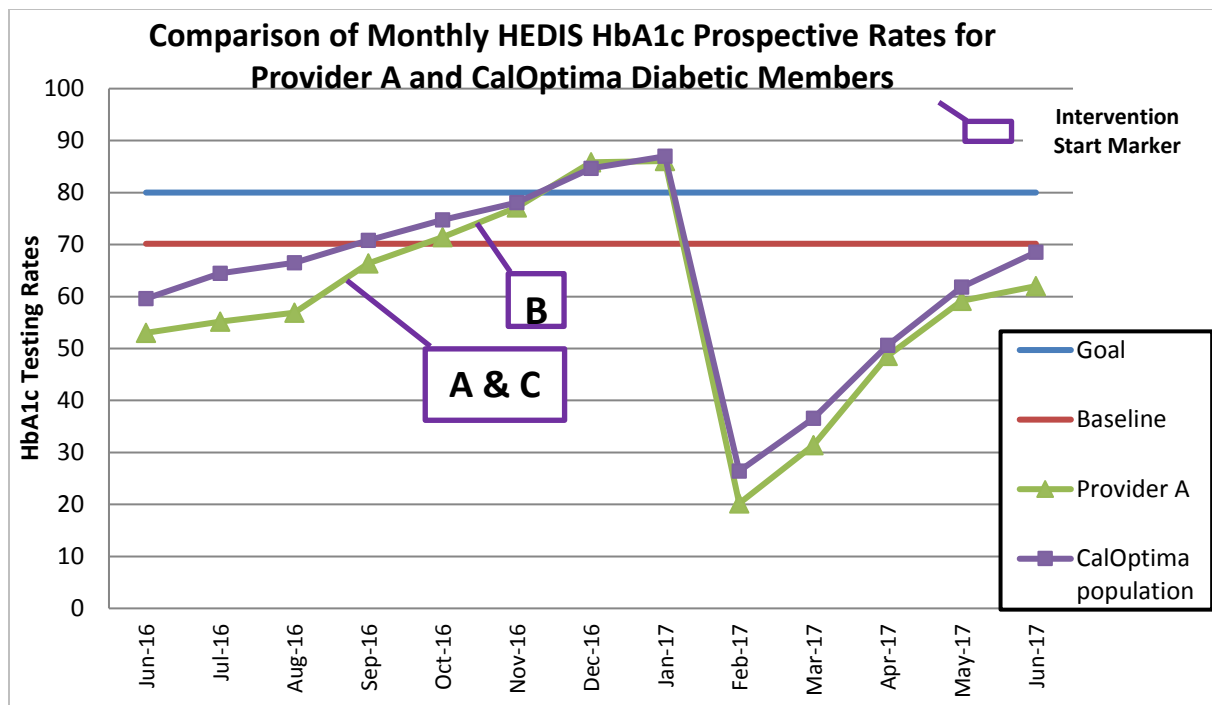
**PIPs:**

PIPs are rapid cycle improvement projects that are narrowed in focus to only target a small population to test interventions.

**Medi-Cal Diabetes PIP to Improve HbA1c Testing Rates:**

CalOptima completed the Medi-Cal Diabetes PIP project this year. As part of this PIP project, CalOptima worked with 1 targeted office (Provider A) to implement 3 interventions which included the following; **A)** implement better member educational outreach for HbA1c testing, **B)** generate bi-monthly reports for Provider A to identify members who are due for a HbA1c test and conduct outreach, and **C)** create a resource document to identify convenient lab locations and hours to distribute to Provider A members.

CalOptima met all requirements and achieved complete validation of the **Medi-Cal (MC) Diabetes PIP Findings:**



Based on the results of the PIP, the Specific Measurable Acceptable Realistic Timely (SMART) Aim goal of completing 80% of HbA1c testing at the targeted provider offices was achieved for two months throughout the PIP cycle. Results could not be directly linked to the interventions conducted. CalOptima met all requirements and achieved complete validation of the MC Diabetes PIP. Health Services Advisory Group (HSAG), the External Quality Review Organization (EQRO) for DHCS, provides quality review services for states that operate Medicaid managed care programs. HSAG assigned the PIP a *Low Confidence* but mentioned that the methodology was sound.

Lessons learned from the tested interventions are helpful on how the QI team will be outreaching to members, involving providers and keeping the providers engaged. Member feedback on tested interventions would have been very helpful in adjusting the interventions from the start of the PIP cycle. Although the interventions had no real direct impact with the SMART Aim, there was a positive impact on both member engagement and provider awareness from the PIP cycle. During discussion and follow-up with the provider office, the QI team received positive feedback on the office being able to provide up-to-date educational information and resources for members that was in their spoken language. The member data file shared with the office was documented as being helpful for the office to outreach to specific members on services needed. Office staff shared that the member list was extremely helpful to outreach to members for services needed and to be able to note which members are new to their office for additional follow-up.

### Recommendations:

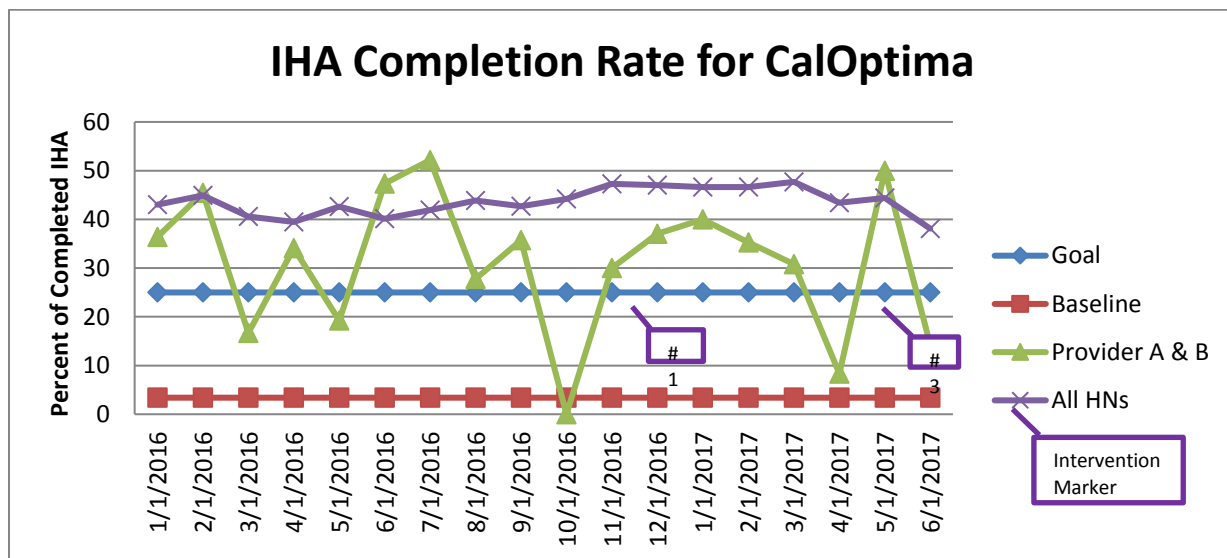
- 1) **Intervention A** will be adapted to fit other office needs in the best approach for outreach. The QI work team would also like to be able to gather member information on barriers to obtaining their HbA1c testing and what would help them obtain the test.

- 2) **Intervention B** will be adopted. Provider awareness of members needing testing was a big factor on how to start outreach to members. The provider was not always aware of which members needed testing, especially if they are a new member. Data that is received at the office level is different from what the MCO may have; this information is helpful to share with providers in ensuring their members obtain the care they need for any health management.
- 3) **Intervention C** will be abandoned as providing lab information to members needing their testing ended up not being a strong intervention to affect change for members. This intervention can be added with providing members with updated resources to receive their HbA1c testing.

### MC PIP to Improve Initial Health Assessment Rates (IHA):

CalOptima completed the MC PIP to IHA this year. As part of this PIP project, CalOptima worked with 2 targeted Provider offices (Provider A and Provider B) to implement 3 interventions which included the following; 1) Conduct in-services at provider office A and B to educate office staff on IHA requirements; 2) Follow-up after IHA missed appointments (discontinued due to staffing resources) and 3) Conduct IHA phone call reminders to Provider A and B members.

### MC IHA PIP Findings:



The IHA completion rate increased from baseline each month (with the exception of October, 2016) for Provider Offices A and B. Additionally, both offices had at least 13 months show the IHA completion rate above the PIP SMART Aim goal of 25%. In addition, Provider Office A and B exceeded the CalOptima overall IHA completion rate for all Health Networks 4 times during the measurement period. We could conclude our efforts to be successful and directly related to the PIP. There may be other confounding effects that may have impacted the IHA completion rates. During the PIP cycle, CalOptima was also responding to a Corrective Action Plan (CAP) issued by the DHCS on the IHA. The CAP required the organization to add additional activities focused on IHA awareness for physician and member, and regular

monitoring/reporting strategies. The team believes the efforts supporting the CAP and PIP both directly contributed to the increase in the IHA completion rate. The additional activities achieved during the time of the PIP included; 1) creation of an IHA Task Force with participation from the delegated Health Networks; 2) refinement of the IHA report logic; 3) adding the IHA completion rate as a display measure with monthly Pay for Value reports to our HN. Using interactive voice recognition (IVR) technology for IHA reminder campaigns.

CalOptima met all requirements and achieved complete validation from HSAG for the IHA PIP. The SMART Aim goal of completing 25% IHA appointments for targeted providers was also achieved. The HSAG assigned the PIP a *Confidence* rating for this performance improvement project.

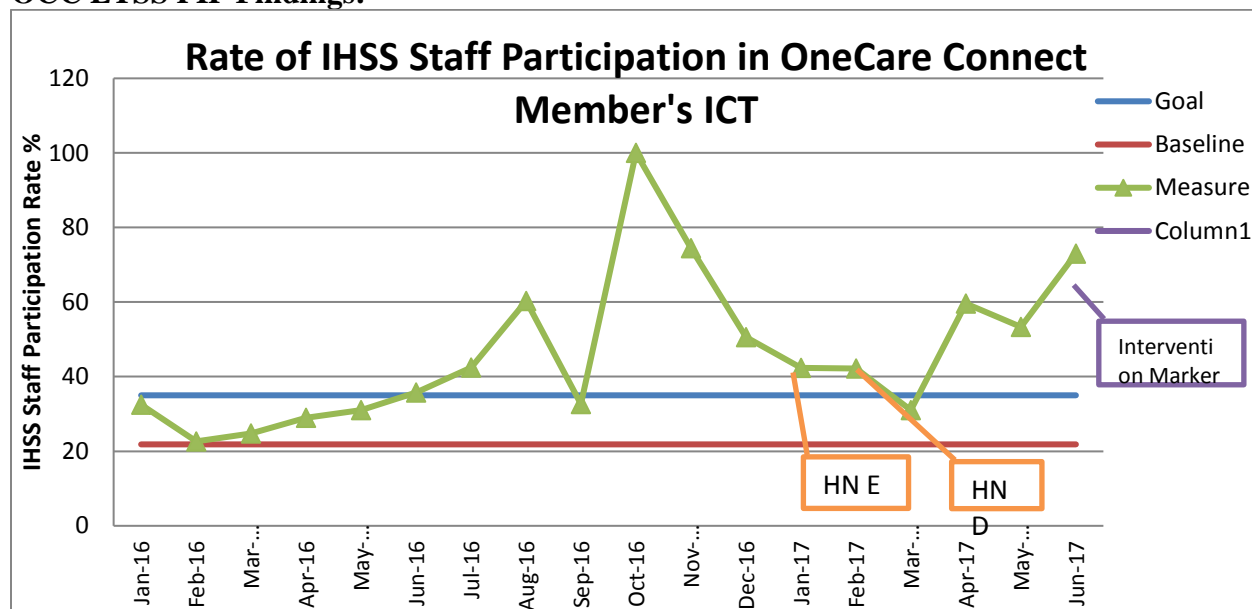
**Lessons Learned:** The success of our office interventions required a commitment from provider office staff the full duration of the PIP. This did not happen. The office staff have limited resources and they do not understand the value of PIP. In the future, CalOptima should be thoughtful about how we leverage the provider community and develop the interventions accordingly. CalOptima will continue our efforts in increasing the IHA completion rate among our membership.

**Recommendations:** The interventions identified for the PIP are not sustainable, nor do they support expanding beyond the scope of this project. Interventions 1, 2 and 3 are all resource intensive, costly, and did not demonstrate any immediate return on investment. Intervention 1 and Intervention 2 will be abandoned. Intervention 3 is recommended to be adapted to IVR reminder campaigns. The organization needs to identify cost effective strategies to increase IHA awareness and improve completion rates. While the results are very preliminary, it appears there could be value in continuing strategies like IVR reminder campaigns (used to support our CAP). We will continue to explore these and other initiatives in the future.

### **OCC LTSS PIP to Improve IHSS Care Coordination:**

CalOptima completed the OCC LTSS PIP to Improve IHSS Care Coordination project this year. As part of this PIP project, CalOptima worked with 2 targeted Health Networks to implement 1 intervention. The intervention, providing education to the Health Networks regarding the IHSS ICT processes and the value of IHSS staff participation in ICTs, was implemented with Health Network E and D. In addition, CalOptima engaged HNs to send invitations to increase participate in ICT meetings.

## OCC LTSS PIP Findings:



One intervention was tested during the life of the PIP with two different Health Networks. The intervention, providing education to the Health Networks regarding the IHSS ICT processes and the value of IHSS staff participation in ICTs, was implemented with Health Network E on January 18, 2017 and Health Network D on February 21, 2017. The goal was to increase the rate of invitations submitted to CalOptima IHSS staff for IHSS members' ICTs. The prediction was an increase in invitations received would result in an increase in IHSS staff participation in ICTs. The intervention does not appear to have a positive effect on the SMART Aim. The SMART Aim showed no change from January to February 2017 (implementation months), and shows a decline below goal in March 2017. Furthermore, when looking at the specific data set for Health Network Network D and E in Module 4, we know IHSS staff participation in ICTs rose around the time of intervention, then fell below baseline, despite an overall increase in ICT invitations submitted to CalOptima IHSS Social Worker Liaison by Health Network D and E.

The IHSS PIP team defined success for intervention 1 as an increase of 25% or more in participation rate from baseline (21.84%) of the two selected networks, testing over a two month period. This goal was not achieved by Health Network E, which logged an average rate of participation of 18.18% for January and February 2017. The goal was achieved by Health Network D, which logged an average rate of participation of 52.75% for February and March 2017. However, the rate of participation in ICTs for Health Network D was not maintained beyond the first two months. Participation at Health Network D fell significantly to 9.09% in April, with an average participation rate of 20.16% for April, May and June 2017.

CalOptima met all requirements and achieved complete validation for the LTSS PIP. The SMART Aim goal of 35% rate if IHSS staff participation in member's ICT meetings was achieved. However, the results cannot be directly attributed to the intervention as numbers showed improvement prior to the start of the intervention. Improvement could have some other confounding effect. HSAG assigned the PIP a *Low Confidence* but mentioned that the methodology was sound.

**Lessons learned:** There are several factors influencing IHSS staff participation in IHSS members' ICTs.

- 1) Staffing constraints at SSA, CalOptima and Health Networks. In some cases, staff called in sick on a scheduled ICT day and there is no one available to stand in on their behalf. In other cases, there were multiple ICTs scheduled at the same time and not enough staff to attend all ICT meetings. Sometimes the member's primary care physician or specialty doctor was not available at the time of the scheduled meeting and the meeting was rescheduled at the last minute, again limiting IHSS staff's availability to participate.
- 2) Last minute cancelations/reschedules of ICT meetings. Continue with open lines of communication with staff to reduce last minute cancellations.
- 3) Some Health Networks continue to send ICT invitations late (less than five days before the scheduled ICT). When an invitation is received a day or two in advance, it is difficult for already busy IHSS staff to make room in their schedules to participate in the meeting. When this happens, the best option is to submit the member's IHSS information to the ICT team via fax. This helped mitigate the barrier and the ICT would have the information available to them in the meeting.
- 4) Some Health Networks prefer and request that the IHSS information is provided to the ICT team via fax instead of IHSS staff participating in the meeting. Expanding the method of delivery would accommodate HNs requests and reduce barriers.

### **Recommendations:**

Based on these results, it is recommended by the team to abandon this intervention. In addition, the coordination of IHSS services has transitioned back to the County.

Overall, CalOptima gained valuable tools and experiences throughout the QIP/PIPs processes. Although these PIPs may be challenging at times, it was helpful in identifying opportunities to focus on areas where improvements were needed. Lessons learned can be applied to future interventions. CalOptima intends to continue a good working relationship with our provider partners and continue our efforts in improving the quality of care for our members. CalOptima will continue to participate in QIP/PIPs as directed by our regulatory entities (DHCS and CMS) per contract requirements.

### **Chronic Care Improvement Projects (CCIP) Update:**

**OC Controlling Blood Pressure CCIP** finished its last year. OC members with a diagnosis of hypertension were offered a no-cost home blood pressure monitor if they opted into the program and agreed to follow-up telephonic sessions with health coaches to track blood pressure control. Due to a high percentage of members with disabilities or special needs, remaining in this SNP plan, many members were unable to contact or participate. Despite extensive efforts to contact members through telephonic outreach, only a total of 24 eligible OC members enrolled in the program. Of those, only 3 members participated actively and received 2 or more health coach sessions. These members seemed to already have controlled hypertension, and did not maximally benefit from the program offerings.

**OCC Heart Health CCIP** completed its second year. After extensive efforts to collaborate and try to re-engineer the existing piecemeal TOC program being operated through Case

Management and Quality Analytics, current plans entail developing a completely independent data report and process between Disease Management and Pharmacy, to identify, contact and counsel all OCC members who have had a hospitalization for heart failure, and initiate telephone counseling within 2-3 days of discharge, to assist the member with medical decisions and self-management to prevent an unplanned readmission within 30 days. The criteria, data report and health coach counseling process are currently being finalized.

### **PDSA Rapid Cycle Improvement Projects:**

#### **OCC Long-Term Care (LTC) PDSA project:**

CalOptima engaged in the OCC LTC this year in March, 2017 as directed by the CMS. As part of this PSDA project, CalOptima has the global aim to reduce potentially avoidable hospitalizations and other adverse events for nursing facility residents in the CalOptima OCC program. CalOptima targeted 10 long term care facilities contracted with the OCC program to reduce avoidable hospitalizations by implementing the Treatment in Place (TIP) services. The purpose of the TIP service is to prevent CCN-OCC member hospitalization when they could be safely treated at the LTC/SNF. Furthermore, it would allow LTC/SNFs to safely treat patients at a higher intensity level for patients who may otherwise be hospitalized upon an acute change in condition and reduce the negative health impact of transitioning a patient to a different setting at his/her fragile state or condition. The benefit of the TIP service is LTC/SNFs would be compensated at a higher rate for providing these services.

**SMART Objective 1:** By September 30, 2017, CalOptima will provide TIP services education to staff of 10 LTC/SNF with the highest volume of CCN-OCC members and/or highest number of avoidable hospitalizations using the AHRQ guide and HEDIS Hospitalization for Potentially Preventable Complications (HPC) measure as a guideline for identifying specific avoidable diagnoses.

**SMART Objective 2:** By September 30, 2017, at least 90% of the surveyed CCN-OCC contracted LTC/SNF staff will score 80% or higher on a post-test after receiving training to measure knowledge and understanding of the TIP services.

**SMART Objective 3:** By December 31, 2017, increase the utilization of TIP services within contracted LTC/SNF by 33% from baseline (3 authorizations in 2016).

**Interventions:** As part of the Long Term Connect Program, CalOptima will provide enhanced education and training sessions to targeted LTC/SNF staff on how to access and provide TIP services to CalOptima CCN-OCC LTC/SNF members. These trainings will be conducted from August 1, 2017 to September 30, 2017 by CalOptima staff. CalOptima will document those who participated in the training through sign-in sheets. Staff education will include the following;

- 1) Enhanced training on the Cal MediConnect Policy CMC.1818 “Treatment in Place (TIP) for CalOptima Community Network (CCN) Members Residing in Long Term Care Facilities”
- 2) A review of the TIP authorization process and
- 3) Supplementary educational documents/reference sheets to help identify what are considered avoidable admissions.

CalOptima will quantitatively measure staff knowledge about TIP services by utilizing a 10-question quiz to assess knowledge immediately after the training (post-test). In addition, the post-test will include questions to assess the following: LTC/SNF staff capacity, current facility resources, and facility best practices for preventing avoidable hospitalizations and other adverse events. One month after the site training, CalOptima staff will conduct a follow-up visit with each participating site to discuss their successes with providing TIP services, conduct follow-up qualitative interviews, and address questions and challenges that facilities may have encountered. CalOptima staff will collect qualitative data by documenting in a tracking log (for each participating site) the TIP implementation history, barriers, feedback, and questions. CalOptima will track TIP utilization through December 31, 2017.

Outcomes data regarding reducing avoidable hospitalizations for the CCN-OCC LTC/SNF population will be available during Cycle 2 and 3 of this PDSA project. CalOptima will continue to review and assess data on avoidable hospitalizations in the CCN-OCC LTC/SNF population throughout this PDSA. Additional criteria may be included in Cycle 2, such as procedure codes coupled with diagnosis, which will yield a better assessment of what hospitalizations would be deemed “appropriate” versus “avoidable.” Preliminary results are currently in process.

## **PATIENT SAFETY PROGRAM**

Member (patient) safety is a very important part of CalOptima’s quality program, and aligns with CalOptima’s mission statement to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

As monitored in the 2017 QI Work Plan, the success of the patient safety program was measured by ensuring the following:

1. Timely completion of facility site reviews
2. Review and Follow-up of Quality of Care complaints
3. Review of Pharmacy Management
4. Review of Specialty Drug Utilization
5. Review and Assessment of CBAS and SNF quality monitoring
6. Review of PBM performance monitoring

### **SAFETY OF CLINICAL CARE — TIMELY COMPLETION OF FACILITY SITE REVIEWS (FSR)**

In 2017 CalOptima continued to provide safety to its members by conducting FSR at all PCP offices. CalOptima’s team of 3 QI nurses, and two Physical Accessibility Review Survey (PARS) reviewers conducted:

- 45 Educational sessions
- 64 Initial Full Scope reviews
- 183 Periodic Full Scope visits
- 574 PARS

***The goal for this measure is to ensure that all sites pass their review with at least 80% total score on their FSR & Medical Record Review (MRR).*** The table below shows that the majority of the sites met the 80% goal for FSR and MRR with the exception of Adult Preventative Medical Record Review which achieved at only 76.8% overall.

<b>AVERAGE SCORE: FSR</b>		<b>&lt;80%</b>	<b>&gt;80%</b>
Access & Safety	97%	0	56
Personnel	96%	3	56
Office Management	99%	0	55
Clinical Services	95%	2	54
Preventive Services	97%	0	53
Infection Control	96%	4	52

<b>AVERAGE SCORE: MRR</b>		<b>&lt;80%</b>	<b>&gt;80%</b>
Format	98%	1	103
Documentation	92%	0	104
Continuity & Coordination	95%	1	103
Pediatric Preventive	90%	10	44
Adult Preventive	76.8%	8	17
OB/CPSP Preventive	0.0%	0	0

In addition, for physical accessibility and ADA compliance of the 574 sites surveyed in 2017, 58% achieved Basic Access, meeting the required 29 elements. The remaining 42% did not meet at least 1 of the 29 PARS elements, resulting in Limited Access. Deficiencies were provided to the sites; however, many sites were reluctant to make changes mainly due to cost constraints.

Corrective Action Plans (CAP) were issued to sites that scored below 80%, and the nurses worked with the sites until the CAPS were resolved. If a critical element CAP was issued, a site had 10 days to respond with their action plan. For a regular CAP the site had 45 days to respond. Of the CAPS issued, 85% were closed within the required timeframes. There are many reasons for the delays; however, the delays results in extra staff time and follow-up to ensure the CAPS are completed. In 2018, the team will continue work with provider offices to ensure CAP closure within appropriate timeframes, and as necessary will work with Provider Relations and Health Network Operations to ensure proper closure of CAPs for the safety of our members.

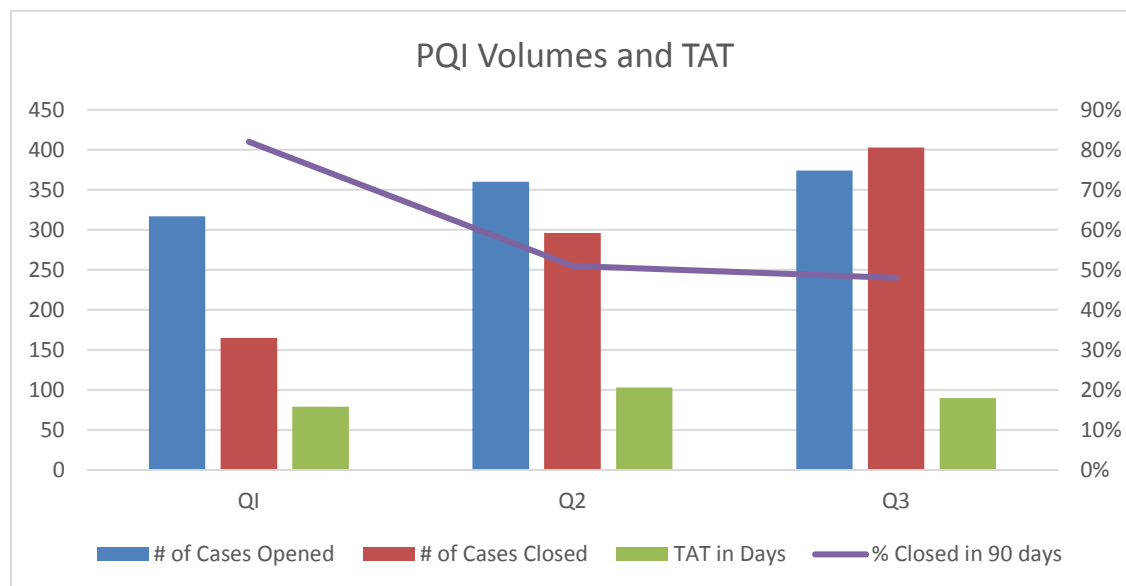
#### **SAFETY OF CLINICAL CARE — REVIEW AND FOLLOW-UP ON POTENTIAL QUALITY OF CARE ISSUES**

Monthly, we have been monitoring the number of open cases, closed cases, and the turn-around-time (TAT) to close cases. We have seen a rise in the TAT as the number of cases referred for review has also increased. It was determined in December 2017, the reports used to determine TAT in days were miscalculating the data. The reports have since been fixed, so the new results are below.

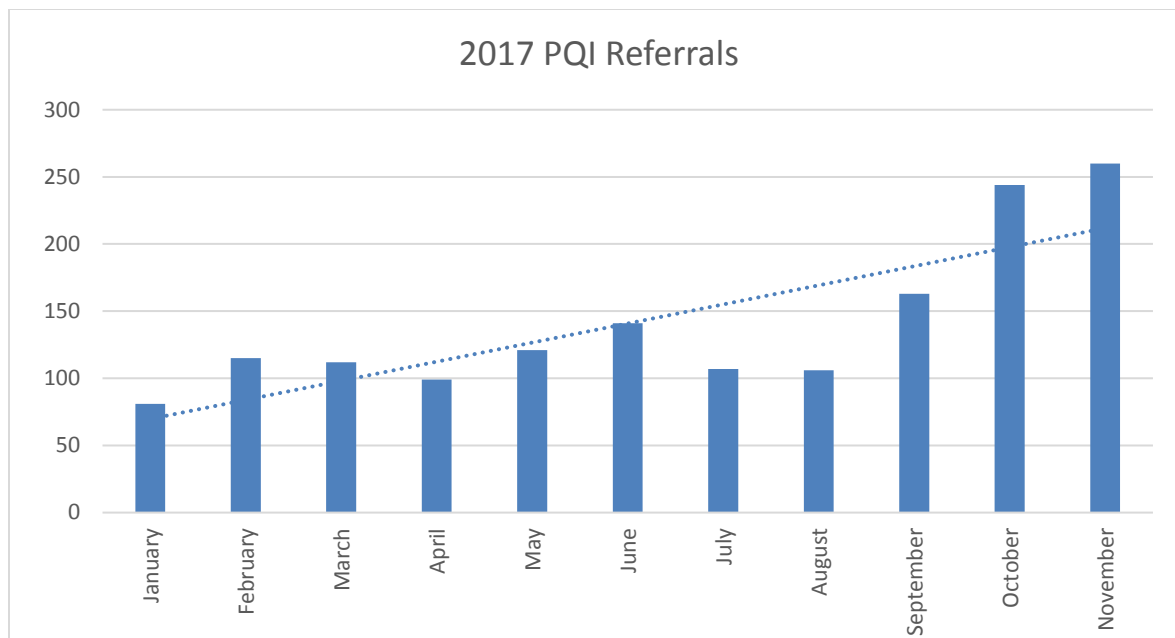
In February 2017, the Department of Managed Health Care (DMHC) was concerned about care for the member while the investigation was occurring since the investigations sometimes took upwards of six months to complete. As a result of the CAP we received in July, we began performing an “Initial Review” on all cases by the nurse in 3-5 business days of receipt to determine and follow-up on any care coordination needed by the member. This added process helps us identify any member’s clinical needs are met in a timely fashion.

In order to improve the number of Quality of Care (QOC) referrals and reduce the number of Quality of Service (QOS) referrals, multiple communications were initiated. This is to ensure that cases requiring nurse and physician review are appropriately handled. In April, an email was sent to all directors, managers and supervisors at CalOptima encouraging QOC referrals, and providing directions how to make the referrals. In April and September, in-person training and a new tip sheet was provided to the Medi-Cal Customer Service department. Disease Management received training in November. The OC and OCC Customer Service departments received training in December.

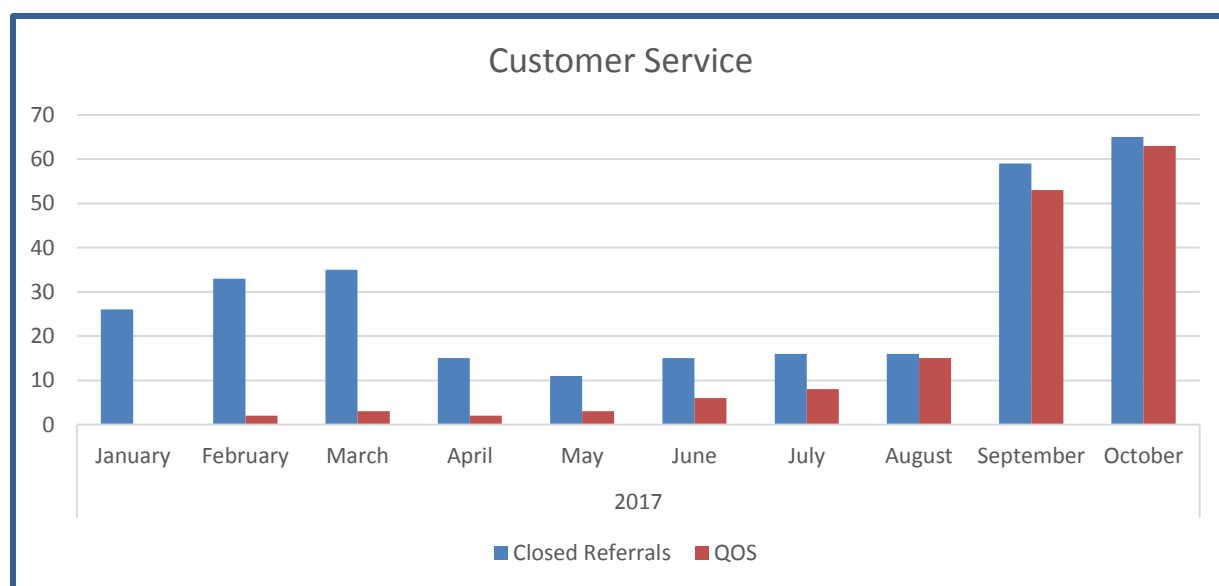
We have a goal of closing 90% of the cases in 90 days. In Quarter 1 (Q1), the average TAT for cases was 79 days. Of the cases, 82% were closed in 90 days. In Quarter 2 (Q2), 51% of the cases were closed in 90 days, with an average TAT of 103 days. In Quarter 3 (Q3), 48% of the cases were closed in 90 days, with an average TAT of 90 days.



The number of referrals of PQIs have increased in 2017, with a significant increase beginning in Q4.



The average TAT and cases closing in 90 days has risen in relation to the increase in the number of cases. Most of the cases are referred by Customer Service and GARS. Because of the CAP Customer Service received from DMHC from the audit in February 2017, in Q3, Customer Service began auditing their calls from Q2, and referred significantly more cases in Q3. However, most of the cases were Quality of Service, not Quality of Care, as shown in the chart below. In November 2017, Customer Service began directing most of referrals to GARS so the influx of referrals from Customer Service has declined while the number of referrals from GARS has risen.



The TAT has risen also because of the additional work of performing an Initial Review within the first 3-5 days of receipt of the PQI. This review for care for the member has added additional work for the nurses, lengthened the case review, and increased the overall TAT of the case. In

2018, the team continues to work with GARS and Customer Service, to determine the optimal work flow that ensures timely closure of PQI's and serves the members' needs.

#### **SAFETY OF CLINICAL CARE AND QUALITY OF CLINICAL CARE — REVIEWED THROUGH PHARMACY MANAGEMENT**

Monitor for underutilization of pharmaceuticals and provide education to providers:

- Underutilization of osteoporosis therapies for members receiving corticosteroids
- Underutilization of calcium for members with a diagnosis of osteoporosis
- Underutilization of statins for members with diabetes

Programs to prevent overutilization include:

- Pharmacy Home Program
- Prescriber Restriction Program

<b>Underutilization Measures</b>	<b>3Q 2017</b>	<b>2Q 2017</b>	<b>1Q 2017</b>	<b>4Q 2016</b>	<b>3Q 2016</b>	<b>2Q 2016</b>
Diabetes with Hypertension without an ACE, ARB, or DRI	2,017	1,933	1,966	1,955	1,917	2,008
Bisphosphonate without calcium	1,427	1,434	1,376	1,339	1,265	1,269
Prednisone 5mg (or equivalent) without a Bisphosphonate	1,032	1,056	1,039	1,065	1,070	1,071

Members are locked into a Pharmacy Home if they fill prescriptions at four or more pharmacies in a two-month period.

<b>Pharmacy Home</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>
<b># of Members</b>	118	140	137	152	149	124	133	142	172	151	108	98

Members were identified for the Prescriber Restriction Program for controlled substances starting in January with a program effective date of 3/15/17.

<b>Prescriber Restriction</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>
<b># of Members</b>	40	3	10	8	10	7	10	46	33	14	26	29

**Underutilization:**

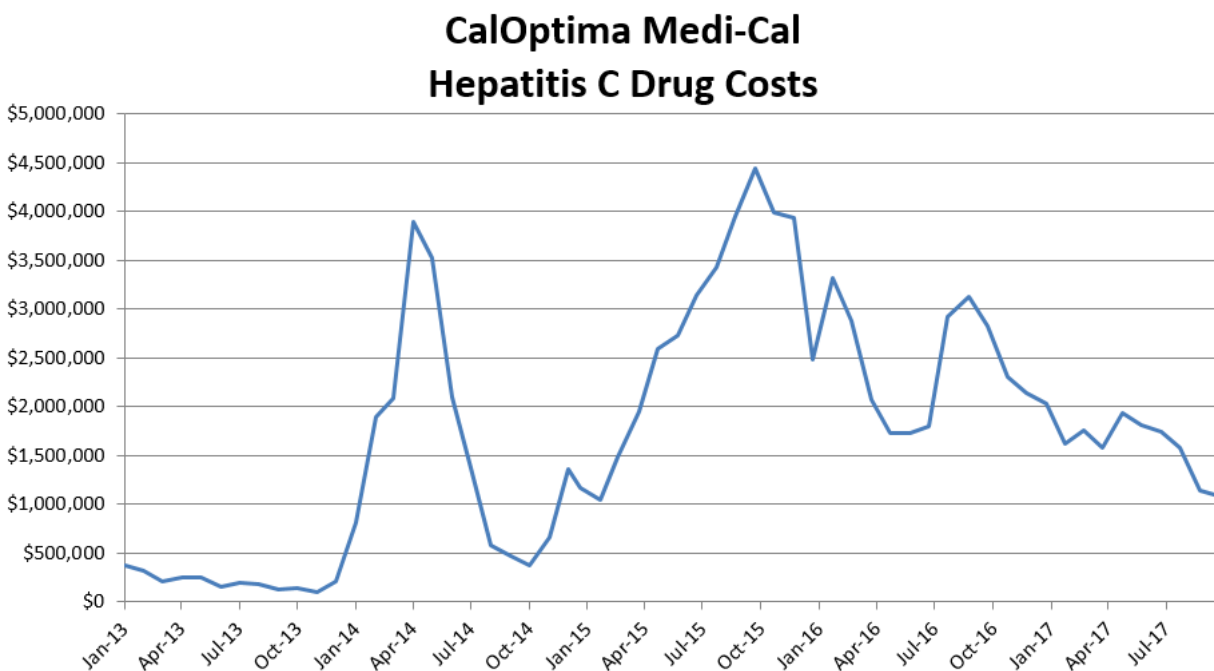
For 2017, there was a slight increase in potential underutilization of pharmaceuticals for bisphosphonate without calcium as compared to 4Q16. There were no changes to the underutilization rate for members on a corticosteroid without a bisphosphonate and diabetes with hypertension without an ACE, ARB, or DRI.

For members locked into pharmacy home, the total number peaked in September at 172, and decreased to 98 in December.

Members were identified for the Prescriber Restriction Program starting in January with a program effective date of 3/15/17. There have been on average 26 members identified per month over the past 6 months.

**SAFETY OF CLINICAL CARE AND QUALITY OF CLINICAL CARE — REVIEW OF SPECIALTY DRUG UTILIZATION**

Reviewed and reported of Specialty Drug trends, with a focus on hepatitis C treatments.



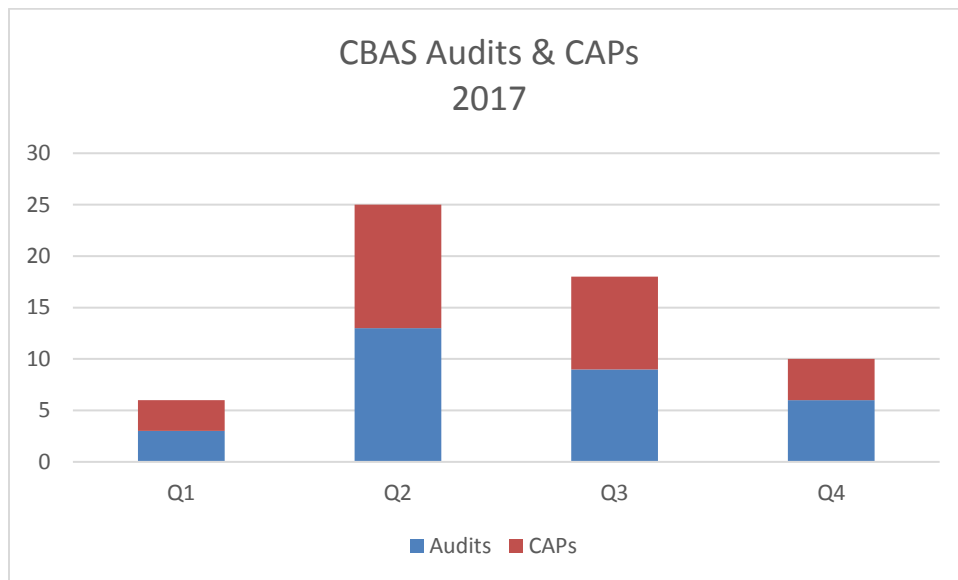
By revising and maintaining updated Hepatitis C Treatment Guidelines based on the American Association for the Study of Liver Diseases (AASLD) Guidelines and promoting the use of the most cost-effective agents, costs for hepatitis C treatment decreased by over \$3 million from October 2015 to October 2017.

**PATIENT SAFETY — REVIEW AND ASSESSMENT OF CBAS QUALITY MONITORING**

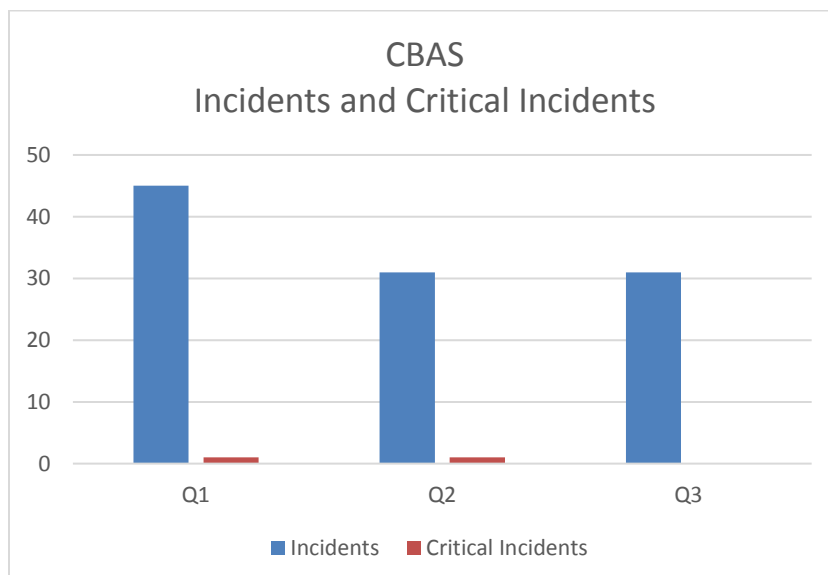
The CBAS centers were audited to assess compliance with California Department of Aging (CDA) regulations. CAP were initiated on those facilities that were not in compliance. The individual CAPs were reviewed upon audit with any previous CAPs.

The CBAS centers submitted Incident reports and Critical Incident reports which were reviewed for Quality of Care issues. A revised Incident Form was provided to all of the CBAS centers this year, and the form was reviewed at the CBAS Workshop provided in October 2017.

In Q1, 3 centers were audited. Three CAPs were initiated and all were returned. In Q2, 13 Centers were audited. And 12 centers received CAPs, and all of the CAPs were returned. In Q3, 9 sites were audited. All sites received a CAP, and all were returned. In Q4, 2016, 6 sites were audited, 4 received CAPs, and all were returned.



For Incident Reports, 45 were submitted in Q1, 31 in Q2 and 31 in Q3. One Critical Incident Report was submitted in Q1, 1 in Q2, and none in Q3.



We continue to evaluate the CBAS centers against the CAP issued by the CDA. All CBAS centers were audited in 2017. Of the centers audited, 93% had CAPs. All of the centers who received a CAP from CalOptima, provided documentation and resolution to the CAP.

We continually receive Incident and Critical Incident Reports from the CBAS Centers. The majority of the incidents are related to falls. None of the Critical Incidents results in QOC issues.

The goal was that 100% of the CBAS centers would be audited for review of CDA audit. We achieved this goal as all 30 of the Centers were audited.

#### **PATIENT SAFETY — REVIEW AND ASSESSMENT OF SNF QUALITY MONITORING**

The SNF/LTC centers were audited to assess compliance of contracted with DHCS regulations. CAP were initiated on those facilities that were not in compliance. The individual CAPs were reviewed upon audit with any previous CAPs.

The SNF/LTC Facilities submitted Critical Incident reports which were reviewed for QOC issues. A revised Incident Form was provided to all of the SNF/LTC Facilities this year. The form was reviewed and training was provided on Critical Incidents at the LTC Workshop in June 2017.

In Q1, 17 facilities were audited; no CAPs were initiated. In Q2, 14 were audited; no facilities received CAPs. In Q3, 16 facilities were audited; of which zero received a CAP. In Q4, 19 facilities were audited; and none received a CAP.

For Critical Incident Reports, zero were submitted in Q1, two in Q2 and zero in Q3.

We continue to evaluate the SNF/LTC facilities against the CAPs issued by the DHCS. And 66 facilities were audited Q1-Q3 2017. Of the Facilities audited, zero had CAPs, but most received recommendations, which the facilities received with appreciation.

We continually receive Critical Incident Reports from the SNF/LTC facilities. One of the SNF/LTC facilities reported falls on a continued basis, which is not a Critical Incident. The facility ceased submitting falls as a Critical Incident after attending the LTC Workshop. Of the two Critical Incidents reported, both were investigated for QOC.

We had a goal of auditing 100% of the SNF/LTC facilities annually. We met that goal as we have audited all of our contracted locations.

## PATIENT SAFETY — PHARMACY BENEFIT MANAGER (PBM) PERFORMANCE MONITORING

Review and report quarterly on clinical and service metrics for MedImpact as it relates to performance guarantees. As seen below Q1, Q2, Q3 performance guarantees were met.

Description	Performance Standard	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Customer Service													
Customer Service: Phone Abandonment Rate	4% or less	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	Provider Calls: Abandonment Rate (Excludes Medicare Line of Business)	0.40%	0.39%	0.26%	1.11%	1.02%	1.33%	1.48%	1.32%	1.45%	0.87%	0.69%	
	Provider Calls: Abandonment Rate (Medicare Line of Business)	0.29%	0.33%	0.26%	0.25%	0.28%	0.17%	0.44%	0.29%	0.48%	0.42%	0.73%	
Customer Service: Average Speed of Answer  (Excludes Medicare Line of Business)	85% or more	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	Provider Calls: % of Calls answered within 30 seconds	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Customer Service: Average Speed of Answer  (Medicare Line of Business)	In accordance with CMS five-star rating	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	Provider Calls: % of Calls answered within 30 seconds	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Customer Service: Average Hold Time  (Medicare Line of Business)	Within 2 minutes or less	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	Provider Calls: Average Hold Time (in seconds)	4.96	4.96	5.54	6.67	6.17	5.61	6.98	7.03	9.68	8.18	13.12	
Customer Service: CMS Star Rating  (Medicare Line of Business)	Greater than 98.3												
	Star Rating	5											

Description	Performance Standard	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Claims Processing													
Claims Processing: Claims Adjudication Accuracy	99.5% or more errors.	Y			Y			Y					
	Accuracy %	100%			100%			100%					
Reporting													
Reporting: PDE Reporting (Acceptance)	99.25% of PDE records submitted to CMS shall be accepted by CMS.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
(Medicare Line of Business)	PDE Acceptance Rate (CAT02)	100%	100%	100%	99.99%	99.99%	100%	99.99%	99.99%	99.97%	99.94%	99.93%	
	PDE Acceptance Rate (CAT04/05)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.98%	99.98%	

\* No attestation requested this quarter

Description	Performance Standard	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
System and Compliance													
Systems and Compliance: System Availability /Online Claims Processing System	99.962%	Y			Y			Y					
	Accuracy %	99.995%			99.996%			99.991%					
Systems and Compliance: System Availability /Reporting Tools	99%	Y			Y			Y					
Systems and Compliance: Benefit Plan Information Set-Up and Changes and Formulary Set- Up and Changes (Accuracy)	98%	Y			Y			Y					
	Medicaid and Part D Benefit Plan Set-Up												
	Benefit Plan Loading Accuracy (Non-Medicare)	99.60%			99.97%			100%					
	Benefit Plan Loading Accuracy (Part D)	98.33%			99.97%			99.81%					
	95% of Formulary Set-Up and Changes will be set up and loaded accurately within the System.	Y			Y			Y					
	Formulary Change Accuracy (Non-Medicare)	100%			100%			100%					
Formulary Change Accuracy (Part D)	98.33%			100%			99.67%						

Description	Performance Standard	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
System and Compliance													
Systems and Compliance: Benefit Plan Information Set-Up and Changes and Formulary Set-Up and Changes (Turn Around Times)	98%	Y	Y	Y	N/A*	Y	Y	Y	Y	Y			
	Percent of Benefits Loaded Timely	100%	100%	100%	N/A	100%	100%	100%	100%	100%			
	95%	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Percent of Formulary Set-up Loaded Timely												
	Percent of Formulary Changes Loaded Timely	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Systems and Compliance: Eligibility File Changes after initial Set- Up (Turn Around Times and Accuracy)	98%	Y			Y			Y					
	Eligibility Set-Up and Loading Accuracy	100%			100%			100%					
Systems and Compliance: Eligibility File Missing Data	Same Business Day	Y			Y			Y					
	% of Eligibility Files Without Missing Data	100%			100%			100%					
Systems and Compliance: Eligibility File Error Correction (Resolution)	Within twenty-four (24) hours	Y			Y			Y					

\* No BCRs during this time

Description	Performance Standard	JA N	FE B	MA R	AP R	MA Y	JU N	JU L	AU G	SE P	OCT	NOV	DEC
System and Compliance													
Systems and Compliance: Online System Claim Response Time	98% or more of Claims will be processed within 2 seconds or less	Y			Y			Y					
	Non-Part D Response Time (in seconds)	0.74			0.57			0.52					
	Part D Response Time (in seconds)	0.74			0.55			0.47					
Payment and Audit													
Payment and Audit: Pharmacy Reimbursement  (Excludes Medicare Part D Line of Business)	100% of pharmacy Claims will be paid in compliance with all state prompt pay requirements	Y			Y			Y					
	% of Pharmacy Claims Paid Timely	100%			100%			100%					
Payment and Audit: Pharmacy Reimbursement  (Medicare Line of Business)	100% of Medicare Part D Claims will be paid within CMS required timeframes	Y			Y			Y					
	% of Pharmacy Claims Paid Timely	100%			100%			100%					
Payment and Audit: Member Over/Under Payments  (Medicare Line of Business)	Within forty-five (45) calendar days.	Y			Y			Y					
	% of Claim Adjustments Reprocessed Timely	100%			100%			100%					
	% of Refunds or Recovery Notices Delivered Timely	100%			100%			100%					

Description	Performance Standard	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Pharmacy Network													
Pharmacy Network: Network Access(Non-Medicare)	CalOptima network adequacy requirements	Y			Y			Y					
	Urban Network Access	99.70%			99.60%			99.60%					
	Suburban Network Access	99.10%			99.10%			99.10%					
	Rural Network Access	99.50%			99.40%			99.50%					
	Retail Pharmacies for Extended Days Supplies	N/A - Does not have a 90-day network											
	LTC Pharmacies	100%			100%			100%					
	Network Access for HIT Pharmacies	100%			100%			100%					
Pharmacy Network: Network Access (Part D)	CalOptima network adequacy requirements	Y			Y			Y					
	Urban Network Access	99.80%			99.70%			99.70%					
	Suburban Network Access	99.10%			99.40%			99.50%					
	Rural Network Access	99.10%			99.10%			98.70%					
	Retail Pharmacies for Extended Days Supplies	N/A - Does not have a 90-day network											
	LTC Pharmacies	100%			100%			100%					
	Network Access for HIT Pharmacies	100%			100%			100%					

Description	Performance Standard	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
<b>Formulary</b>													
Performance Guarantees	Within 45 calendar days after the end of each quarter.	Y			Y			Y					
	Date PG Report Provided	5/18/2017			9/1/2017			11/13/2017					
Timeliness for providing Pharmacy Claims Encounter Data Files (Medi-Cal)	Monthly	Y			Y			Y					
	No. of Incidents Encounter Data not Submitted Timely	0			0			0					
	Comments	No incidents			04/07/2017 05/08/2017 06/08/2017			07/06/2017 08/06/2017 09/06/2017					
iPrescription Drug Event (PDE) Submission	Monthly	Y			Y			Y					
	Dates of Monthly Submissions of PDE records	01/6/17, 01/24/17, 02/9/17, 02/27/17, 03/13/17, 03/24/17			04/11/17, 04/24/17, 05/9/17, 05/23/17, 06/8/17, 06/22/17			07/11/17, 07/25/17, 08/9/17, 08/24/17, 09/25/17, 09/26/17					

Description	Performance Standard	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
<b>Formulary</b>													
Prescription Drug Event (PDE) error correction	PBM guarantees that it will correct immediately actionable PDE errors within timeframes specified by CMS	N/A - no incidents			Y			Y					
	Number of files not corrected timely				0			0					
Weekly Claims Payment Invoices	PBM guarantees that it will provide CalOptima with weekly invoices timely	Y			Y			Y					

## CARE MANAGEMENT

The CalOptima Case Management department had a successful 2017. The department's OCC HRA completion and collection continued with its positive trend for 2018. During this year, we instituted a new process for annual HRA calls for OCC, with a positive trend for completion. SPD and OC HRA collection consistently met goals. Coordination of BHI saw varied results, with some challenges as CalOptima changed from one MBHO to another. A positive trend in ICT participation by the MBHO and BHI persisted, with some modest success in County of Orange Behavioral Health participation. Member satisfaction with case management continued to be strong, although the number of returned surveys remained low. In response to low numbers, Case Management instituted an additional collection interval for surveys which boosted our

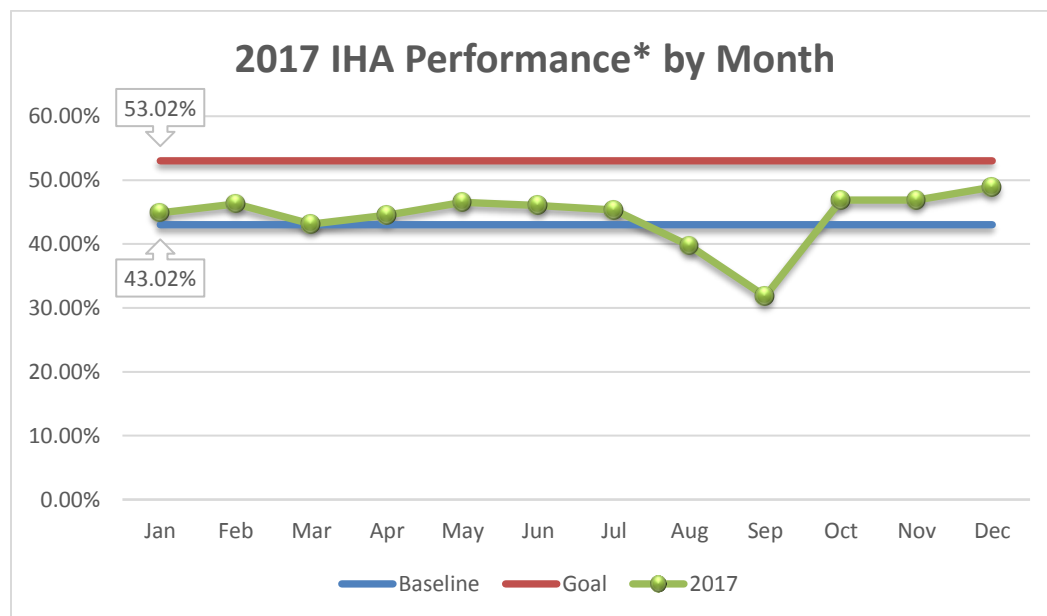
number of surveys received in fourth quarter. The Emergency Room (ER) high utilizers project enrolled 10 new members per quarter to Case Management, and the group began discovering common themes among the members who tend to use the ER as a primary source of health care. Utilization was reduced after just one quarter of program enrollment. Health Network MOC performance continued to be strong for most networks, with one network receiving a CAP. Complex case management audit results were mixed, with some networks achieving a high level of accuracy and one network receiving CAP for poor performance. Overall, the QI results showed improvement during 2017.

## HEALTH EDUCATION & DISEASE MANAGEMENT

Health Education & Disease Management (HE/DM) IHA interventions, such as Welcome Calls via IVR took place January–June 2017. Monitoring and tracking of Health Network complete IHAs was developed and maintained monthly. IHA IVR message, incorporating DHCS Health Information Form (HIF)/Member Evaluation Tool (MET) requirement began in September 2017 and will continue in 2018. Our area participated in the DHCS/HSAG PIP to increase IHA performance through June 2017. In response to a CAP, a Clinic Chart Audit at CalOptima community clinics was performed from June–August 2017 and yielded 83.92% on IHA Comprehensive history, Preventive Services 88.69%, Comprehensive Physical/Mental Status Exam 78.07%, Diagnoses Plan of Care 94.14% and the SHA 48.09%. The goal to improve IHA plan performance from 2016 (43.02%) by 10% was not met. The 2017 IHA Performance rate was 44.17%.

**IHA Performance\* by Year**

2016	2017
43.02%	44.17%



\*Data as of 12/21/17; IHA performance calculated as fully met + partially met

- Fully Met=Evidence of an IHA visit and SHA within 120 days of member effective date
- Partially Met=Evidence of an IHA visit or SHA within 120 days of member effective date

The results indicate a 1.15% increase from the previous year. Due to the delay of when claims are submitted and processed, the IHA rate is expected to increase slightly for 2017 than what is originally reported. As such, the data will need to be re-run in the following months to account for the data lag.

Efforts to improve IHA performance will continue into 2018.

**Medi-Cal Diabetes Incentive Initiative:** As a follow-up to an initial Diabetes A1C targeted member incentive program in 2016, Medi-Cal members with diabetes who were either

- 1) Missing an A1C test,
- 2) Had a last A1C value >9% or were missing a diabetic eye exam in the last two years, were sent a targeted incentive offer for a \$25 Target gift card, if they provided evidence of the tests or exams being completed, with verification by a provider.

The offer for missed A1C was sent to 5578 Medi-Cal members, 6252 members for A1C >9% who need to re-test and 8553 members who need an eye exam, totaling 20,383. As of January 9, 2018, 217 Eye Exam, 181 A1C and 336 A1C >9% reply forms were processed, totaling 734 valid reply forms and a 3% response rate to date.

**Asthma Aware, Heart Health and Diabetes Talk newsletters** were successfully mailed to all DM members with helpful and relevant information on how members can best manage their conditions. Two issues of the **Shape Your Life newsletter** were mailed in 2017.

Newsletters	Number Mailed	Mailed Date
Asthma Aware (Jan 17)	17,164	January 2017
Heart Health	1,412	April 2017
Diabetes Talk	41,646	June 2017
Shape Your Life Issue 1	60,235	June 2017
Shape Your Life Issue 2	69,058	August 2017

**Targeted Wellness Interventions:** Certain areas for targeted wellness mailing interventions were identified to fulfill the Mem7 requirements. HE/DM, fulfilled Medi-Cal member mailings intermittently throughout the year:

- 1) 331 adults and pediatric Medi-Cal members with **2 or more ED visits due to Asthma** (April and Nov 2017)
- 2) 23,788 Medi-Cal members with Diabetes received the **“Tests and Shots for Persons with Diabetes”** (September 2017)
- 3) 23,788 Medi-Cal members with Diabetes received the **Diabetes Incentive offer**,
- 4) An average of 240 **Tobacco Cessation Offers** (mailed monthly) and
- 5) 2430 Medi-Cal Members were identified with utilization for **lower back pain** and received educational material (mailed monthly).

**Continuing Education:** The HE/DM area coordinated and organized a total of 5 continuing education (CE) and 4 continuing medical education (CME) events in 2017. There was an average of 80 participants in attendance at each event.

**DM Member Experience Survey:** The 2017 DM Member Experience Survey was executed differently from the previous year. The 2017 DM satisfaction survey targeted English and Spanish-speaking members enrolled in a DM program who had at least two health coach interactions 3 months prior to the mailing date. The survey tool was developed to obtain feedback on member experience with DM programs regarding:

- 1) Overall program satisfaction
- 2) Helpfulness of program staff
- 3) Usefulness of the information disseminated, and
- 4) Members' experience in adhering to treatment plans.

This year's DM survey measured satisfaction of only DM members who received active DM telephonic Health Coaching throughout the year as opposed to the 2016 measurement year survey which took written and mailed materials into account and was mailed to the entire DM population. To ensure maximal interaction with health coaches, surveys were mailed 3 months after the IHA was completed, which suggested at least 2 interactions between member and health coach.

There were 945 surveys mailed between April and October 2017 to members who had a health coach interaction January through July 2017. Of the 945 surveys that were mailed, 133 were returned, a response rate of 14.1%. And 98.4% of members responded that they are overall satisfied with CalOptima's DM programs.

**Provider Health Management Programs Notification:** A provider notification report was created and mailed to all primary care physicians in all Health Networks (minus Kaiser) in December to provide primary care physicians a list of their CalOptima members in a DM program. The notification gave them a snapshot of key health indicators (lab results, missing exams and medication adherence ratio) to share information and partner to bring our member's conditions under better care management. The notification allowed a means for physicians to provide comments or feedback. Responses are just starting to return.

**Shape Your Life (SYL) Weight Management Program:** A Program Manager was hired to oversee the SYL program in 2017 which enabled us to have an individual employee focus specifically on this program. An RFP was re-issued, vendors have been selected and we are in the process of contract negotiations. The program continues to run under the historic model while decisions have been made to improve the program which will be implemented with the new contracts. Shape Your Life newsletters were mailed to members in March and July reaching 129,293 members. Unfortunately, Weight Watchers (the adult weight management program) was intended to launch but has not yet been implemented.

**Perinatal Support Services:** HE/DM inherited the program in 2017. A request for information (RFI) was released and we received 2 responses. With the information obtained through the RFI, an RFP was released. The RFP closed at the end of the year and we are currently in the vendor selection process. Historically, CalOptima has sent members prenatal and postpartum packets as part of this program and this project is being transitioned to HE/DM. We are in the process of determining what will be the most beneficial information to mail to members. We expect to implement the new packets in mid-2018. Staff are also participating in the OC Breastfeeding Coalition and the OC Perinatal Council.

**Projects and Opportunities in 2018:** While the HE/DM department accomplished many objectives and performance goals, there are still areas of opportunity in 2018. The department is still working to increase active member participation in DM programs through an improved Round-Robin identification and assignment process. In addition, current assessments are limited to high-risk members with telephonic interaction by a health coach. A low-risk IHA is being added to all new DM member welcome packets to help us obtain information from the lower risk population, to get a better feel for the entire population's needs. The redesign of the asthma program will include expanding interventions and services to adults with asthma. For heart failure, the redesign will incorporate inclusion of Medi-Cal members with more events and classes to link members with community resources, including CalOptima health coaches. The department is committed to aligning DM efforts to positively impact HEDIS rates, especially the Comprehensive Diabetes Care and Asthma Medication Ratio (AMR) measures. In addition, the Shape Your Life Childhood Obesity program, a more comprehensive Tobacco Cessation and Perinatal programs are being developed and or have already gone through the RFP and vendor selection process and are being scheduled for launch in 2018.

## **LONG-TERM SERVICES AND SUPPORTS (LTSS)**

### **QUALITY OF CLINICAL CARE — REVIEW AND ASSESS HOSPITAL ADMISSIONS**

LTSS measures and monitors hospital admissions of members enrolled in one or more of the following: CBAS, IHSS, LTC, and/or MSSP. The goal being to reduce the rate of hospital admissions among members enrolled in LTSS programs.

To reduce hospital admissions LTSS will continue to work with Data Analytics to identify specific LTSS members who are high utilizers of hospital services.

CBAS organized a workgroup of LTSS staff and CBAS center directors and administrators to examine the hospital admissions/readmissions data and developed a plan for CBAS center staff to address specific symptoms of high cost diagnoses. The CBAS workgroup will continue to meet quarterly through 2018.

LTC began reviewing hospital admissions data in Q3 2017 with LTC Administrators. LTC will organize a workgroup in Q1 2018. The workgroup will be responsible for developing a plan to be utilized in LTC facilities to reduce unnecessary hospitalizations.

LTSS measures hospital admissions by program. There is overlap and duplication as some members are enrolled in multiple programs. All data is reported as Per Thousand Members Per Year (PTMPY). Data includes all lines of business, excluding PACE and COD Medi-Medi.

Green represents goal met. Red represents goal not met.

Program	Goals	Quarter 1 Updated	Quarter 2 Updated	Quarter 3
CBAS	254	318	313	248
IHSS	263	340	311	206
LTC	768	908	983	537
MSSP	310	639	545	319

#### SAFETY AND QUALITY OF CLINICAL CARE — REVIEW AND ASSESS EMERGENCY DEPARTMENT VISITS

LTSS measures and monitors emergency department visits of members enrolled in one or more of the following: CBAS, IHSS, LTC, and/or MSSP. The goal being to reduce the rate of emergency department visits among members enrolled in LTSS programs.

LTC introduced Treatment in Place (TIP) in 2016, a program designed to compensate LTC facilities for providing treatment in the LTC facilities when appropriate to reduce avoidable emergency department visits and hospitalizations among CalOptima Community Network (CCN) OCC members. In 2017, LTC completed in-person TIP training updates to select LTC facilities. This program will continue in 2018.

LTSS measures emergency department visits by program. There is overlap and duplication between programs as some members are enrolled in multiple LTSS programs. All data is reported as PTMPY. Data includes all lines of business, excluding PACE and COD Medi-Medi.

Green represents goal met. Red represents goal not met.

Program	Goals	Quarter 1 Updated	Quarter 2 Updated	Quarter 3
CBAS	491	614	575	227
IHSS	625	671	682	341
LTC	521	512	527	385
MSSP	867	714	1,038	254

## SAFETY AND QUALITY OF CLINICAL CARE — REVIEW AND ASSESS HOSPITAL READMISSIONS FOR LTSS

LTSS measures and monitors hospital readmissions of members enrolled in one or more of the following: CBAS, IHSS, LTC, and/or MSSP. The goal being to reduce the rate of hospital readmissions among members enrolled in LTSS programs.

To reduce hospital re-admissions LTSS will continue to work with Data Analytics to identify specific LTSS members who are high utilizers of hospital services. LTSS will also review the costliest diagnoses at the time of readmission.

CBAS organized a workgroup of LTSS staff and CBAS center directors and administrators to examine the hospital admissions, with a focus on readmissions data, and developed a plan for CBAS center staff to address specific symptoms of high cost diagnoses. The CBAS workgroup will continue to meet quarterly through 2018.

LTSS measures emergency department visits by program. There is overlap and duplication between programs as some members are enrolled in multiple programs. Data reported is based on readmissions 30 days post discharge. Data includes all lines of business, excluding PACE and COD Medi-Medi. **Green represents goal met. Red represents goal not met.**

Program	Goals	Quarter 1 Updated	Quarter 2 Updated	Quarter 3
CBAS	15%	18%	30%	11%
IHSS	16%	24%	22%	17%
LTC	24%	20%	24%	14%
MSSP	10%	26%	27%	8%

It's important to note several confounding variables:

- 1) LTSS is asked to report metrics within a couple weeks of quarter end.
- 2) Data is based on claims data.
- 3) It is challenging to account for claims lag as hospitals have up to one year from date of service to bill for the service.
- 4) As claims are submitted the LTSS census effectively changes which affects the metrics.
- 5) The majority of LTSS members are Medi-Medi, CalOptima does not have access to Medicare claims.

Consequently, the majority of LTSS members are excluded from the denominator. These LTSS measures are based on the early claims of the remaining population and reflect a very small percentage of the overall LTSS membership, subjecting the data to wider swings.

Reflecting on the confounding variables LTSS began measuring the data at quarters end and then again at the end of the subsequent quarter. If you look at the chart above, you can see this altered the data significantly.

LTC is the only program to consistently meet the goal for hospital readmissions.

Currently, it is impossible to know if the data is unreliable or if there has been a significant increase in hospital readmissions amongst LTSS Home and community based services (CBAS, IHSS and MSSP) members. LTSS will continue to evaluate areas of concern.

*Note: All administration and financial responsibility for IHSS will return to Orange County Social Services Agency as of January 1, 2018. Therefore, as of Quarter 1 2018, IHSS will not be included in CalOptima LTSS Quarterly reporting.*

#### **SAFETY AND QUALITY OF CLINICAL CARE — REVIEW AND ASSESS LTSS UTILIZATION OF HOME AND COMMUNITY BASED SERVICES**

LTSS measures and monitors utilization of LTC and home and community based services, which includes CBAS, IHSS, and/or MSSP. The goal being to maintain or increase utilization of home and community based services while decreasing LTC utilization.

This is a new goal that was introduced in Quarter 2 2017.

Planned activities include raising awareness about home and community based services and discharge planning for LTC.

LTSS program utilization trends for members age 65 and over is a percentage of all CalOptima members age 65 and over. **Green represents goal met. Red represents goal not met.**

Program	Goals	Quarter 1	Quarter 2	Quarter 3
LTC	3.9%	4.38%	4.32%	4.22%
HCBS	17%	17.0%	16.95%	17.01%

The LTC utilization goal of 3.9% was not met. However, the LTC utilization is trending down and consistently remained within 1% of the goal.

The HCBS goal of 17% was consistently met, with no apparent trends emerging.

The goal of LTSS is to maintain members in the least restrictive environment, living in the community. It is appropriate to see an increase in HCBS utilizations with the goal being to reduce LTC utilization.

*Note: All administration and financial responsibility for IHSS will return to Orange County Social Services Agency as of January 1, 2018. Therefore, as of quarter 1 2018, IHSS will not be included in CalOptima LTSS Quarterly reporting*

#### **QUALITY OF CLINICAL CARE — CBAS AND SNF/LTC SATISFACTION SURVEYS**

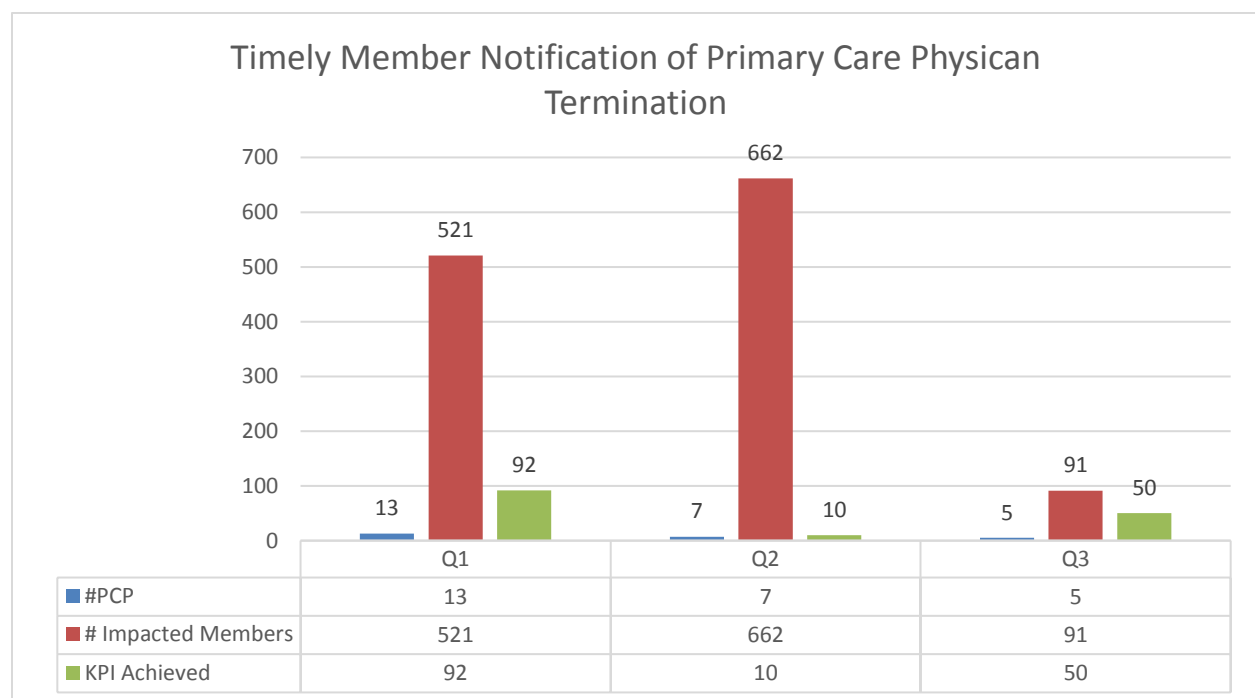
Critical to the evaluation of our LTSS services is measuring our member's satisfaction with their site of care. CBAS and SNF/LTC satisfaction surveys were completed at the end of 2017. There

were many changes to the tool and methodology of the survey mainly due to the learnings from the previous year's survey. Results are expected by Q1 2018, and will be reported to LTSS QISC.

## ACCESS & AVAILABILITY

### QUALITY OF SERVICE AND CLINICAL CARE – NOTIFICATION OF TERMINATION TO MEMBERS

Customer Services monitors and reports all member notification issued to a member whose primary care physician is terminated their contracted relationship with CalOptima Community Network (CNN) on a quarterly basis.



Key Performance Indicator – 85%

#### Measurement

- Member must receive written notification of their PCP termination from the network within 30 days from the date of the termination
  - Exception: CalOptima is notified in less than 30 days of termination then notification would be within three business days.

#### Data Source

- Provider Relations Add, Change & Termination (ACT) form

#### Analysis and Results

- KPI was not achieved in Q2 and Q3
  - Provider Relations ACT form failed to include a date of notification from the terminating PCP or Health Network.
    - ACT form updated to include date of notification field August 2017.

- Provider Relations failed to provide the ACT form in a timely manner to Customer Service Enrollment and Reconciliation unit to complete member notification
  - This is caused by providers who do not provide adequate notice to Provider Relations within 60 days from effective termination date.

## **ACCESS TO CARE — CREDENTIALING AND RE-CREDENTIALING OF PROVIDER NETWORK**

In 2017, the Credentialing department supported members' access to care by ensuring the quality of the provider through the credentialing and re-credentialing process. During the year, 639 Initial and Re-credentialed CalOptima Care Network providers were approved. CalOptima continues to credential provider types including physicians, non-physician medical practitioners (NMP), and health delivery organizations (HDO).

The Peer Review Committee met monthly for eleven months and had two ad-hoc committees. Also, clean file lists (i.e. no issues) were prepared and reviewed at committee, as well as files that were identified with potential issues or concerns. The committee took action in 1 case that resulted in the requirement to file an 805 and submit National Practitioner Data Bank (NPDB) reports.

The goal established for 2017 was to ensure that all initial credentialing files were processed within 180 days, and re-credentialing files did not exceed 36 months. In 2017, initial and re-credentialing files met the timeliness standard 99% of the time.

In 2017, 639 initial and re-credentialing files were processed compared with 817 in 2016. The number of initial files processes was less than the previous year, however re-credentialing files actually decreased from 2016.

The Credentialing department continues to work with Provider Relations to determine access needs for 2018. Starting 01/01/2018, CalOptima will assume credentialing of the BH Network, which will double the number of practitioners in CalOptima's network. Additional resources have been added to process the additional recredential files required in 2018.

## **ACCESSIBILITY: REVIEW OF ACCESS TO CARE (APPOINTMENT ACCESSIBILITY)**

CalOptima fielded a Timely Access Survey of providers in 2017 to determine if CalOptima and its Health Networks were in compliance with CalOptima's accessibility standards in GG.1600 and MA.7007. Data and results will be discussed at the Access and Availability Quality Improvement Workgroup and reported up to the Member Experience subcommittee. All Health Networks, including the CalOptima Community Network, will be provided and presented their Health Network specific results on accessibility. Health Networks who do not meet the availability standards will be issued a Quality Improvement Project (QIP) to improve their accessibility to CalOptima members.

For this areas/questions, CalOptima has set a 90% MPL. The following areas/question did not meet the MPL:

- Getting primary care non-urgent sick or acute appointment within 3 business days
- Getting urgent specialty appointments (NO authorization required) within 48 hours
- Getting urgent specialty appointments (authorization required) within 96 hours
- Getting non-urgent specialty appointment within 15 business days
- Getting urgent appointments for ancillary services with 96 hours
- Having telephone triage or screening services 24/7
- Having a telephone triage or screening service method
- Triage or screening service informing members of wait time for return call
- Medical professional returning urgent messages during business hours within 30 minutes
- Phone instructing members to dial 911 or go to the nearest emergency room if an emergency

Area/question with statistically significant improvement:

- Office offering patient the choice of waiting or rescheduling if wait exceeds 45 minutes
- Live person answering phone during business hours within 30 minutes

Areas/questions with statistically significant decrease in score

- Getting urgent appointments for ancillary services with 96 hours

The following will be areas of focus for CalOptima:

- Specialty appointments
- Telephone triage
- Medical professional returning call
- Phone instructing members to dial 911 or go to the nearest emergency room if an emergency

CalOptima will continue to monitor CalOptima and its Health Networks on accessibility of providers and to work with our provider relations department as well as the Health Networks to ensure that our members can appropriate access our providers.

#### **ACCESSIBILITY: REVIEW OF AVAILABILITY OF PRACTITIONERS**

Quality Analytic staff ran quarterly availability reports in 2017 to determine if CalOptima and its Health Networks were in compliance with CalOptima's availability standards in GG.1600 and MA.7007. Data and results were discussed at the Access and Availability Quality Improvement Workgroup and reported up to the Member Experience subcommittee. All Health Networks, including the CalOptima Community Network, were provided and presented their Health Network specific results on availability. Health Networks who did not meet the availability standards were issued a Quality Improvement Project (QIP) to improve their network adequacy.

CalOptima will continue to:

- Monitor availability data quarterly
- Present results to the Member Experience subcommittee
- Share results with the Health Networks
- Work with the Health Networks to obtain more complete provider and facility data

CalOptima monitors the following for primary care practitioners, high volume specialists, high impact specialists and certain health care facilities:

- Ratio of providers to members
- Distance/time between providers and members

(Note: standards vary by provider type)

Primary care practitioners and OB/GYNs met all plan level standards. The following specialty types did not meet standards:

- Dermatology (MC): Ratio
- Endocrinology (MC): Ratio
- Nephrology (MC): Ratio
- Cardiac Catheterization Services (OC/OCC): Distance

Further analysis was conducted at the Health Network level and most Health Networks did not meet the distance standards for Allergy and Immunology (OC/OCC).

Areas that did not meet standard include the following:

- Dermatology (MC): Ratio
- Endocrinology (MC): Ratio
- Nephrology (MC): Ratio
- Cardiac Catheterization Services (OC/OCC): Distance
- Allergy and Immunology (OC/OCC): Distance

CalOptima will continue to monitor CalOptima and its Health Networks on availability of providers and to work with our Provider Relations department as well as the Health Networks to ensure that we have appropriate network adequacy.

## **MEMBER EXPERIENCE**

### **QUALITY OF SERVICE — REVIEW OF MEMBER SATISFACTION**

CalOptima fielded CAHPS surveys in 2017 to monitor member experience for all lines of business. In addition, Health Network level CAHPS surveys were fielded for Medi-Cal Child, Medi-Cal Adult and OCC. CAHPS results, along with other member experience data (i.e. grievance and appeals, timelines access, network adequacy, customer service, etc.) were presented to the Member Experience subcommittee to help identify areas for improvement.

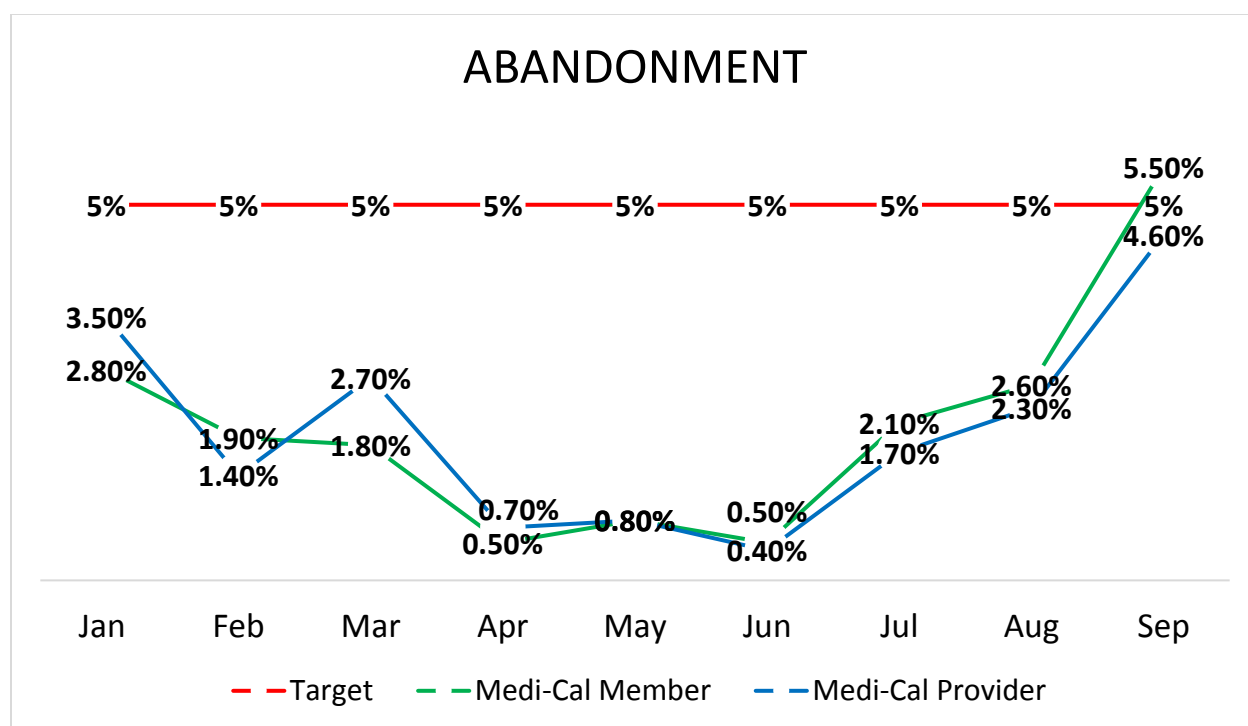
CalOptima fielded all CAHPS surveys planned for 2017. Surveys for 2017 included:

- Medi-Cal Child Plan Level Survey
- Medi-Cal Adult Plan Level Survey
- OC Plan Level Survey
- OCC Plan Level Survey
- Medi-Cal Child Health Network Level Survey
- Medi-Cal Adult Health Network Level Survey
- OCC Health Network Level Survey

Results were presented to the Member Experience subcommittee, QIC, as well as Provider Advisory Committee (PAC) and Member Advisory Committee (MAC). The Member Experience subcommittee has identified areas for improvement. While the goal of fielding all of the surveys listed above were met, there remain significant opportunities to improve our member experience scores. In 2018, a new initiative will be launched which focuses on provider coaching and shadowing. Providers will be invited to participate in this new initiative which will include customer service trainings for front office staff and providers, provider toolkits, shadowing and mystery calls to offices to assess initial customer service challenges and post training performance.

## QUALITY OF SERVICE — REVIEWED THROUGH CUSTOMER SERVICE STATS

Customer Service monitors and reports abandonment rate and service levels on a daily, weekly, monthly, quarterly and annually for both inbound member and provider calls.



Key Performance Indicator – 5%

Measurement

- Members calls must not exceed a 5% abandonment rate of total calls received per month.

Data Source

- Avaya phone system data is converted into CalOptima's CORE report CS0072-Call Statistic by Date Range.

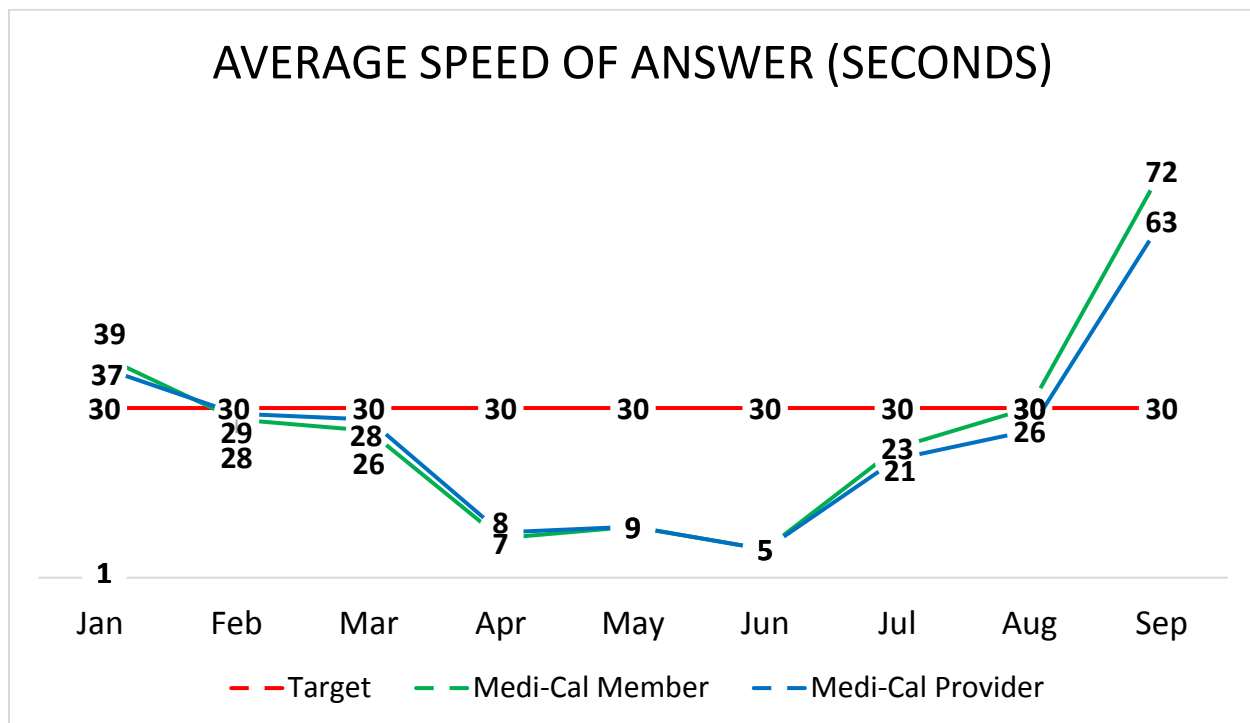
Results

- Q1 — 2.2%
- Q2 — 0.6%
- Q3 — 3.4%

Abandonment Rate

- KPIs achieved for Q1, Q2, Q3

- Continue to monitor daily, weekly, monthly abandonment rate and adjust staffing resource as appropriate if KPI is not being met



#### Key Performance Indicator

- Average Speed of Answer – 30 seconds

#### Data Source

- Avaya phone system data is converted into CalOptima's CORE report CS0072-Call Statistic by Date Range.

#### Results

- Q1 — 31 Seconds
- Q2 — 7 Seconds
- Q3 — 41 Seconds

#### Average Speed of Answer:

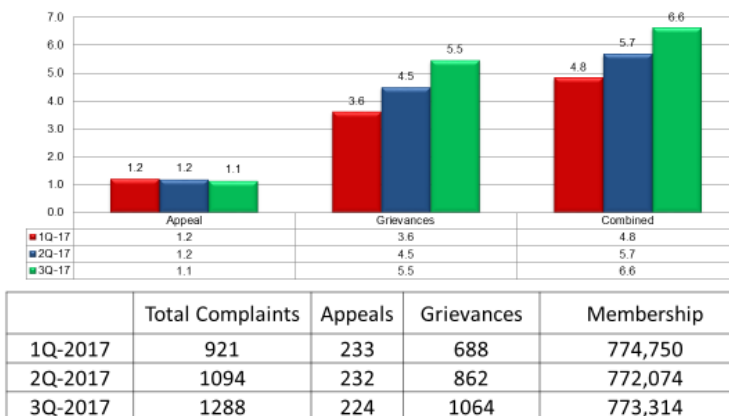
- KPIs achieved for Q1, Q2, Q3
- Continue to monitor daily, weekly, monthly average speed of answer rate and adjust staffing resource as appropriate if KPI is not being met

### QUALITY OF SERVICE – REVIEWED THROUGH GRIEVANCES AND APPEAL

CalOptima provided quarterly trend reports on the rate of complaints (appeals/grievances) for all programs during 2017. The tables below show the quarterly data for each population. In summary, for Medi-Cal, we saw member billing increase by 67% from Q2 and Q3 which impacted the overall grievances. Billing issues were previously resolved by Customer Service staff. Due to a Regulatory Audit finding, billing issues not resolved by the next business day are categorized as standard grievances, which are forward to the Grievance and Appeals Resolution

Services department for handling under the grievance process. Quality of Care concerns are referred to CalOptima's QI department for further investigation. Since GARS handles all appeal and grievances for CalOptima, data is shared with Health Networks at the Joint Operations Meetings (JOM). For OCC, we saw a continued decrease in OCC coverage appeals for Liberty Dental which was attributed to Liberty Dental's Provider Relations department educating their dental providers about benefit limitations and Denti-Cal covered services. American Logistics and Liberty dental account for the increased grievances seen in Q1 and Q2. However both are trending down from Q2 to Q3. This decline may be attributed to multi-departmental outreach and education provided to both vendors as well as monthly/ad-hoc meetings held with American Logistics to address any issues in order to better serve CalOptima's members. For OC, there was very low volume of complaints, thus no trends or outliers were identified.

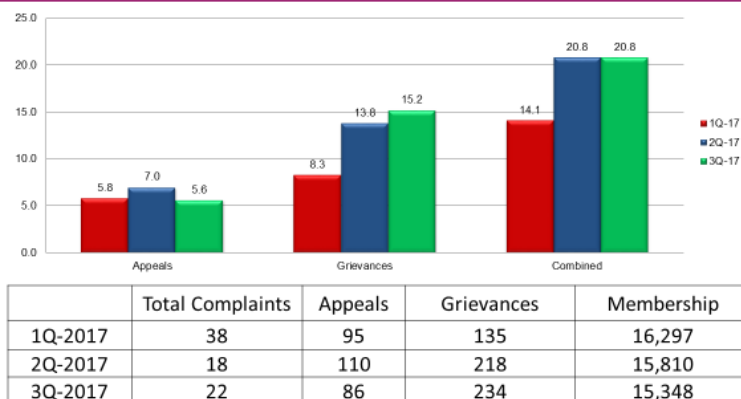
## Medi-Cal Member Complaints



0



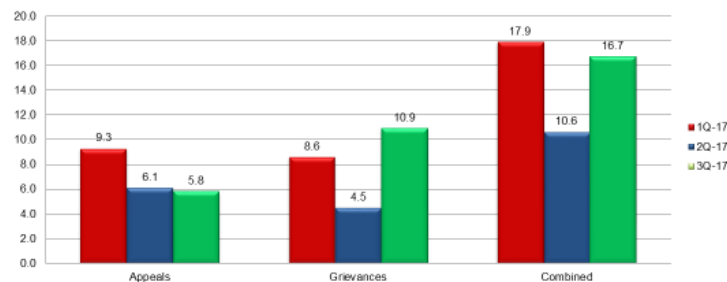
## OneCare Connect Member Complaints



3



## OneCare Member Complaints



	Total Complaints	Appeals	Grievances	Membership
1Q-2017	23	12	11	1,285
2Q-2017	14	8	6	1,320
3Q-2017	23	8	15	1,373

6



## HEDIS/STARS IMPROVEMENT

### *IMPROVE HEDIS MEASURES LISTED ON “MEASURES” WORKSHEET*

In 2017, CalOptima has conducted 9 new initiatives surrounding women’s health, particularly breast and cervical cancer and postpartum care. These initiatives included member and provider incentives. In addition, a new child/adolescent initiative was implemented to increase immunizations and well-care visits through our CalOptima Day health and wellness events. CalOptima continued to implement and sustain activities for all other HEDIS/STAR measures as indicated in the 2017 QI Work Plan. Please refer to HEDIS worksheet for more details on QI activities conducted for this year by measure.

#### **Medi-Cal Measures:**

This year, CalOptima focused on 17 measures for the Medi-Cal population. Compared to the same time last year, 12 out of the 17 targeted measures are performing better. Based on the data received at the end of quarter 3, 2017, CalOptima has met the goal for 2 measures. And 5 measures are on target to meet the goal and 10 measures are still pending final HEDIS results in 2018.

#### **2017 Medi-Cal Quality Initiatives:**

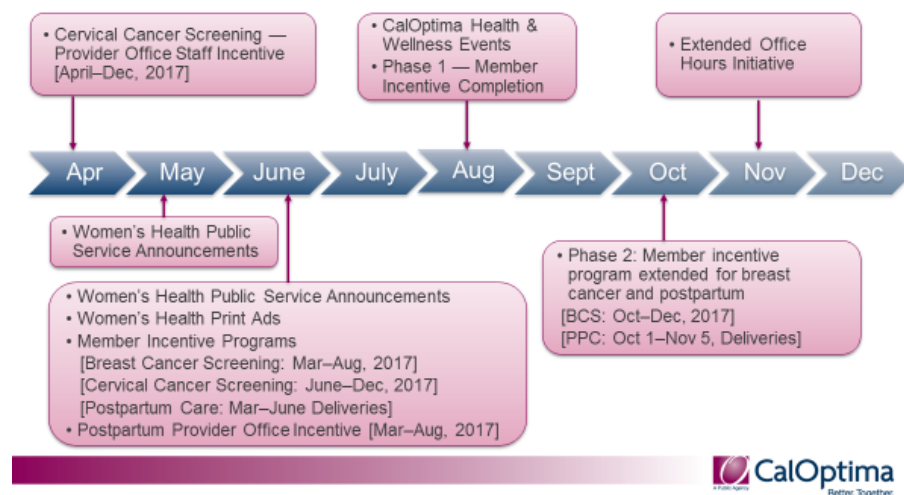
This year, CalOptima implemented several Medi-Cal quality improvement initiatives surrounding women’s health and child/adolescent well-care and immunizations. These initiatives were all pilot projects to test the effectiveness of new interventions. Initiatives were implemented by member and provider incentive programs. In addition, CalOptima launched several radio and print ads targeting ethnic communities to promote women’s health, particularly breast and cervical cancer screenings.

There were 3 member incentive programs offered to Medi-Cal members for the breast cancer screening, cervical cancer screening and postpartum check-ups. Provider initiatives included a

provider office staff incentive and extended office hours initiatives to promote cervical cancer screening and postpartum check-ups. In addition, there were health and wellness events (CalOptima Days) that promoted well-care visits and immunizations among the child and adolescent at targeted provider sites.

## Quality Initiatives Timeline:

### 2017 Quality Initiatives Timeline



2

## Member Initiatives:

Member Incentive	Description	Status
<b>Postpartum Member Incentive</b>  <b>Phase 1:</b> Deliveries from 3/30/17–6/30/17  <b>Phase 2:</b> Deliveries from 10/1/17–11/5/17	Eligible CalOptima Medi-Cal members can receive a \$25 gift card and be entered into a \$100 gift card opportunity drawing.	<b>Phase 1:</b> Mailed: 1,340 Forms received: 91 Eligible: 81 Response rate: 6.8% Approved: 89.0%  <b>Phase 2:</b> Rolling mailing: 531 Forms received: 7 Eligible: 5 Response rate: 1.3% Approved*: 71.4%  *CalOptima still accepting submissions through 01/31/18

<i>Member Incentive</i>	<i>Description</i>	<i>Status</i>
<b>Breast Cancer Screening Member Incentive</b>  <b>Phase 1:</b> 3/1/17–8/31/17  <b>Phase 2:</b> 10/1/17–12/31/17	Eligible CalOptima Medi-Cal members between the ages of 50 and 74 can receive a \$10 gift card and be entered into a \$100 gift card opportunity drawing.	<b>Phase 1:</b> Mailed: 18,031 Forms received: 472 Eligible: 368 Response rate: 2.9% Approved*: 78.0%  <b>Phase 2:</b> Mailed: 13,092 Forms received: 79 Eligible: 38 Response rate: <1% Approved*: 48.1%  *CalOptima still accepting submissions through 01/31/18
<b>Cervical Cancer Screening Member Incentive</b>  <b>Dates of Service:</b> June 1– December 31, 2017	Eligible CalOptima Medi-Cal members ages 21–64 are entered into a \$75 gift card opportunity drawing.	Mailed: 74,730 Forms received: 592 Eligible: 437 Response rate: <1% Approved*: 73.8%  *CalOptima still accepting submissions through 01/31/18

#### Provider Initiatives Description:

<i>Provider Incentive</i>	<i>Description</i>	<i>Status</i>
<b>PCP Office Staff Incentive:</b>  Scheduling Cervical Cancer Screenings (CCS)  Apr 1–Dec 31, 2017	<b>Pilot:</b> Provider office staff will receive \$10/member above their average monthly cervical cancer screening rate.	<b>Launch Date:</b> April 19, 2017  Initial participation from 9 clinics/PCP offices and 5 offices actively engaged.  <b>In Process:</b> Follow up with each office site to collect data and feedback. Reconcile data received and data reported by offices. Evaluation in process.

<i><b>Provider Incentive</b></i>	<i><b>Description</b></i>	<i><b>Status</b></i>
<b>Extended Office Hours Initiative:</b>  Cervical Cancer Screenings	<b>Pilot:</b> Target 1–2 high-volume PCP offices to extend office hours to conduct cervical cancer screenings for CalOptima members.  Each office may receive up to \$200/hour. (Maximum of 24 hours per/office)	Program extended through 12/31/17  Engaged 1 provider to participate in initiative. Launched on November 11, 2017.  Evaluation in process

## Postpartum

<i><b>Women's Health Campaign</b></i>	<i><b>Description</b></i>	<i><b>Status</b></i>
<b>Postpartum</b>  \$1,000 per provider office or clinic for participation in the program  \$1,000 per provider office for demonstrated improvement  May 1–August 31, 2017	<b>Pilot:</b> Target 3 primary care providers (PCPs), clinics or OB/GYN offices with the highest number of members who had a delivery between January and June, 2017.  Provide “just in time” trainings to office staff on medical records documentation and timeliness of postpartum visits  Targeted providers offices must submit sample of medical records to CalOptima for review (May–August)  CalOptima will conduct follow-up with provider offices and provide feedback on record documentation and timeliness.	Program has been completed. Results show that all 3 offices demonstrated meaningful improvement.

## CalOptima Day (Health and Wellness Events targeting children and adolescents)

<i><b>“CalOptima Day” Health and Wellness Event</b></i>	<i><b>Description — Offered at Health Network Participating Sites</b></i>	<i><b>Status</b></i>
<p><b>Child/Adolescent Immunizations and Well-Care Visits</b></p> <p>Providers can earn \$300/hr for hosting a health and wellness event at their location, up to \$2,400/event.</p> <p>Members will receive either a \$25 Stater Bros. gift card or 2 movie tickets</p> <p>Program launched August, 2017</p>	<p><b>Pilot:</b> Collaboration between CalOptima, participating Health Networks and their selected providers to conduct child and adolescent well-care visits and immunizations for targeted members.</p> <p>Participating providers/clinics had a dedicated staff to administer vaccinations and well-care visits for CalOptima Medi-Cal members only.</p>	<p><b>Round 1:</b> 4 Health Networks and their selected provider office participated:</p> <ol style="list-style-type: none"> <li>1) Monarch Family HealthCare</li> <li>2) CHOC Health Alliance</li> <li>3) Noble Mid-Orange County</li> <li>4) AMVI Care Health Network</li> </ol> <ul style="list-style-type: none"> <li>• Total of 130 CalOptima members received services</li> <li>• 165 HEDIS hits for the following measures [W15,W34, AWC, CIS, IMA]</li> </ul> <p><b>Round 2:</b> Expanded to community clinics and Health Networks. 4 provider sites participated.</p> <ol style="list-style-type: none"> <li>1) Monarch Family HealthCare</li> <li>2) Pediatrics and Neonatology</li> <li>3) Nhan Hoa Clinic</li> <li>4) AltaMed- Santa Ana Bristol</li> </ol> <ul style="list-style-type: none"> <li>• Total of 135 CalOptima members received services</li> <li>• 189 HEDIS hits for the following measures [W15,W34, AWC, CIS, IMA]</li> </ul>

## Public Service Announcements and Print Ads:

<i><b>Women’s Health Campaign</b></i>	<i><b>Description</b></i>	<i><b>Status</b></i>
<p><b>Public Service Announcement (PSA)</b></p>	<p><b>Promote:</b> Cervical cancer screenings with a focus on ethnic communities.</p>	<p><b>Completed in June, 2017</b></p> <p>PSA ran on local radio stations in Spanish, Vietnamese and Korean radio programs. Ads began Mother’s Day weekend.</p> <p>Developed the “<i>Good Health</i>” landing page on the CalOptima website.</p>

<b>Print Ads</b>	<b>Promote:</b> Women's health screenings (breast and cervical cancer screenings)	<b>Completed in June, 2017</b>  Print ads ran in local Orange County publications in English, Spanish, Vietnamese and Korean.
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## **Preliminary Assessment of All Quality Initiatives:**

### **Member Incentives:**

Preliminary assessment of the member incentive programs show that there were low participation rates for all 3 incentive programs based on initial outreach:

- Breast Cancer Screening <3%
- Cervical Cancer Screening <1%
- Postpartum Check Up <6%)

The Quality Analytics team is in the process of pulling data to assess the impact of the incentive programs compared to last year. Initial feedback from Health Networks and providers is that having member incentive programs is a good program to continue the effort in promoting preventive screenings for hard-to-reach populations.

**Recommendation:** To adapt the member incentive program and continue for the 2018 calendar year. Modifications would be:

- 1) To initiate the member incentive earlier in the year (beginning of the year) and
- 2) Have a year-round approach for these incentives to maintain consistent promotion throughout the year, which will reduce the barrier for staff to adjust the program materials in all seven threshold languages.
- 3) Guarantee a set amount that a member would receive for the incentive instead of entering recipients into an opportunity drawing.

Members may be more inclined to participate in the initiative if they know they would be guaranteed an incentive if they meet all requirements.

### **Provider Initiatives:**

#### **Provider Office Staff Incentive (Cervical Cancer Screening):**

Preliminary findings show that there is a discrepancy between administrative data received by CalOptima compared to what the offices have reported. There is tremendous amount of documentation from the offices on the efforts put in for this initiative. CalOptima is looking into working with these offices to assess what the problem areas are and how to address them. The incentive payout is based on claims/encounters received. Evaluation of program success is in process.

#### **Extended Office Hours (Cervical Cancer Screening):**

Preliminary findings show there were low participation for this initiative. The timing of the initiative may have impacted the results as it was launched towards the end of the year

(November 2017) right before the holidays. Office may not have enough prep time to promote the CalOptima focused event. Further evaluation of the program is still in process.

**Provider Office Incentive (Postpartum Check-ups):**

Findings show that there has been meaningful improvements for the 3 targeted provider offices in the areas of medical chart reviews. Office staff have a better understanding of the postpartum HEDIS measure and its requirements. This contributes to better medical chart documentation and promotion of timely postpartum care.

**Recommendation** is to continue postpartum outreach efforts and provide trainings to more provider office settings given resources available. In addition, continue communications with the participating offices to share best practices and engage other providers to improve their own processes.

**CalOptima Day (Health and Wellness Events targeting children and adolescents):**

Findings show that this initiative had very successful results. Overall participation of members was 59.09% for Round 1 and 67.69% for Round 2 of the initiatives. Participation in the CalOptima Day events totaled 265 members. The number of positive HEDIS hits [W15, W34, AWC, CIS, IMA] totaled 354.

**Recommendation:** Continue with the CalOptima Day events and possibly expand the program to include more measures (possibly preventive screening measures for adults).

**Public Service Announcements and Print Ads:**

CalOptima hired professional voice actors to create high quality public services announcements (PSA) to promote breast and cervical cancer screenings. In addition, our graphic design team created culturally appropriate and exceptional quality print ads to be published in ethnic publications. Although it may be difficult to assess the full impact of these publications since these PSAs were offered to all of Orange County readers, we have received some positive feedback on the quality of these publications. The Quality Analytics department will look into evaluating this project further by obtaining feedback from the participating vendors and assessing if there were any changes to the HEDIS measures rates during the time period these ads were launched compared to last year.

**Recommendation:** The sustainability of these ads is difficult as both print and radio ads are very costly. It is recommended to continue to budget for print and radio ads in very targeted ethnic populations. There is benefit now that the radio ads have been recorded, we could focus our budget on running the existing ads as opposed to developing new ones. In addition, we would like to include the PSAs on our CalOptima hold message and include in other media platforms that are low or no cost.

**Medicare Measures:**

This year, CalOptima focused on 15 HEDIS/STARs/Health Outcomes Survey (HOS) measures in the 2017 QI work plan. The OC population has a significantly lower population due to the transition of members out of it and into the OCC line of business. Overall, OC had 7 measures performing better compared to the same time last year. And 2 out of 15 target measures have Met

goal thus far, with 2 measures approaching goal. And 11 of the measures are pending final HEDIS/STAR/HOS results for calendar year 2017.

For the OCC population, there are 7 measures that are performing better when compared to the same time last year, and 2 measures have met the goals and 1 measure approaching goal based on data received through September 30, 2017. There are 11 measures pending final HEDIS/STAR/HOS results.

The following measures for 2018 will be incorporated into the 2018 QI Work Plan. Some measures have been moved to monitoring status after consideration of past performance, importance to quality strategic goals and resources available to implement quality improvement initiatives

**Medi-Cal (Focus):**

- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
- Breast Cancer (BCS)
- Cervical Cancer (CCS)
- Comprehensive Diabetes Care (CDC)
- Hospital Readmissions (PCR)
- Prenatal/Postpartum Care (PPC)
- Childhood Immunization Status (CIS)
- Access to Preventive/Ambulatory Care (AAP)
- Children's Access to Primary Care Practitioners (CAP)
- Children with Pharyngitis (CWP)
- Review and assessment of ADHD medication (ADD) (MBHO focus measure)
- Review and assessment of Antidepressant Medication Management (AMM) (MBHO focus measure)
- Follow-up after Hospitalization for Mental Illness (FUH) (MBHO focus measure)

**Recommendations to Monitor:**

- Well-care visits
- Use of Imaging Studies for low back pain
- Appropriate Treatment of Upper Respiratory Infections (URI)

**Medicare (Focus):**

- Comprehensive Diabetes Care (CDC)
- All-cause readmissions (PCR)
- Adult Access to Preventive/Ambulatory Care (AAP)
- Breast Cancer Screening (BCS)
- Colorectal Cancer Screening (COL)
- Review and assessment of Antidepressant medication management (AMM) (MBHO focus measure)
- Follow-up after Hospitalization for Mental Illness (FUH) (MBHO focus measure)
- Review and assessment of Antidepressant medication management (AMM)
- Follow-up after Hospitalization for Mental Illness (FUH)

Benchmarks are set at either the 25th–90th percentile, depending on CalOptima’s performance and historical references. Goals are set by a team of internal staff who takes into consideration of setting goals based on quality strategic goals including health plan rating, DHCS minimum performance levels, NCQA accreditation, STAR measures and OCC quality withhold.

### ***IMPROVE CAHPS MEASURES LISTED ON “MEASURES” WORKSHEET***

CalOptima fielded CAHPS surveys in 2017 to monitor member experience. Survey results were presented to the Member Experience Sub-Committee and Health Network specific results were shared with our contracted Health Networks. The committee identified areas for improvement the following QI activities were implemented:

- Quality Analytic staff met with Health Networks to review their performance and identify opportunities for improvement
- Conduct Timely Access Survey to monitor appointment availability
- Monitor network adequacy for our members
- Issue Quality Improvement Plans to Health Networks who were out of compliance with CalOptima’s access and availability standards
- Issued a RFP for a Provider Coaching vendor
- Developed a Member Communications Workgroup to streamline all member mailings
  - Reviewed the new member packet and removed items that are no longer necessary as part of the mailing
  - Submit a waive to DHCS to stop sending member the hardcopy provider directory (directory is large and difficult to mailing and not user-friendly)

#### **Medi-Cal Child Results**

- Overall NCQA Plan Rating: 3.5 (from 4.0 in 2016)
- Consumer Satisfaction Rating: 1.5 (from 2.5 in 2016) – did not achieve the 3.0 NCQA CAHPS score
- Scores have decreased from the previous year, particularly in Rating of All Health Care

#### **Medi-Cal Adult Results**

- Scores generally increase from the previous year, particularly in the Customer Service Composite

#### **OC Results**

- Overall Star Rating: 3.5 (same as previous year) - did not achieve 4.0 CMS star score
- Member Experience with Health Plan: 2 star (from 1 star in 2016)
- Member Experience with Drug Plan: 2 star (remain the same from previous year)
- Scores have increased from previous year

#### **OCC Results**

- No Star scores available as it is considered a new plan

For CAHPS, scores for Medi-Cal Child decreased while scores for Medi-Cal Adult and OC increased. No scores were available for OCC. CalOptima also did not achieve the 3.0 CAHPS score nor attain the 4.0 CMS STAR rating.

## ***STARS IMPROVEMENT — MEDICATION ADHERENCE***

### Decrease utilization of high-risk medications

- Formulary controls
- Prior authorization criteria
- Prescriber education

### Antipsychotic use in members with dementia in nursing homes

- Prescriber education
- LTC quality incentive program

### Appropriate dosing of oral diabetes medications

- Formulary controls
- Prior authorization criteria
- Prescriber education

### Medication Adherence

- Comprehensive member and provider outreach to identified members who appear non-adherent with medication management (interventions based on unique member characteristics)
- Interventions include: Outreach; Pre-Assessment: Modified Morisky Scale (MMS) for knowledge, motivation and confidence; mailings with letter and member's action plan, Healthy You, and medication log; follow-up calls as needed
- Outcomes include: Pre and Post-PDC rates to measure program success; evaluate member's improvement in knowledge, motivation (MMS) and confidence; evaluate member survey results

<b>Patient Safety Measure</b>	<b>Contract</b>	<b>Contract Type</b>	<b>Report Month</b>	<b>Your Contract Current Rate</b>	<b>Contract Type Average Rate</b>	<b>Contract Performance Relative to Contract Type Average</b>
High Risk Medication	H5433 OneCare	MA-PD	11/2017	7.74 %	8.06 %	Equal or Better
High Risk Medication	H8016 OneCare Connect	MA-PD	11/2017	4.37 %	8.06 %	Equal or Better

<b>Patient Safety Measure</b>	<b>Contract</b>	<b>Contract Type</b>	<b>Report Month</b>	<b>Your Contract Current Rate</b>	<b>Contract Type Average Rate</b>	<b>Contract Performance Relative to Contract Type Average</b>
Antipsychotic Use in Persons with Dementia	H5433 OneCare	MA-PD	11/2017	8.13 %	11.72 %	Equal or Better
Antipsychotic Use in Persons with Dementia	H8016 OneCare Connect	MA-PD	11/2017	8.07 %	11.72 %	Equal or Better

<b>Patient Safety Measure</b>	<b>Contract</b>	<b>Contract Type</b>	<b>Report Month</b>	<b>Your Contract Current Rate</b>	<b>Contract Type Average Rate</b>	<b>Contract Performance Relative to Contract Type Average</b>
Diabetes Medication Dosing	H5433 OneCare	MA-PD	11/2017	0.00 %	0.40 %	Equal or Better
Diabetes Medication Dosing	H8016 OneCare Connect	MA-PD	11/2017	0.00 %	0.40 %	Equal or Better

<b>Patient Safety Measure</b>	<b>Contract</b>	<b>Contract Type</b>	<b>Report Month</b>	<b>Your Contract Current Rate</b>	<b>Contract Type Average Rate</b>	<b>Contract Performance Relative to Contract Type Average</b>
Diabetes Adherence	H5433 OneCare	MA-PD	11/2017	84.49 %	83.15 %	Equal or Better
Diabetes Adherence	H8016 OneCare Connect	MA-PD	11/2017	82.21 %	83.15 %	Worse

<b>Patient Safety Measure</b>	<b>Contract</b>	<b>Contract Type</b>	<b>Report Month</b>	<b>Your Contract Current Rate</b>	<b>Contract Type Average Rate</b>	<b>Contract Performance Relative to Contract Type Average</b>
RAS Antagonist Adherence	H5433 OneCare	MA-PD	11/2017	86.59 %	85.58 %	Equal or Better
RAS Antagonist Adherence	H8016 OneCare Connect	MA-PD	11/2017	82.54 %	85.58 %	Worse

<b>Patient Safety Measure</b>	<b>Contract</b>	<b>Contract Type</b>	<b>Report Month</b>	<b>Your Contract Current Rate</b>	<b>Contract Type Average Rate</b>	<b>Contract Performance Relative to Contract Type Average</b>
Statin Adherence	H5433 OneCare	MA-PD	11/2017	87.30 %	82.71 %	Equal or Better
Statin Adherence	H8016 OneCare Connect	MA-PD	11/2017	79.99 %	82.71 %	Worse

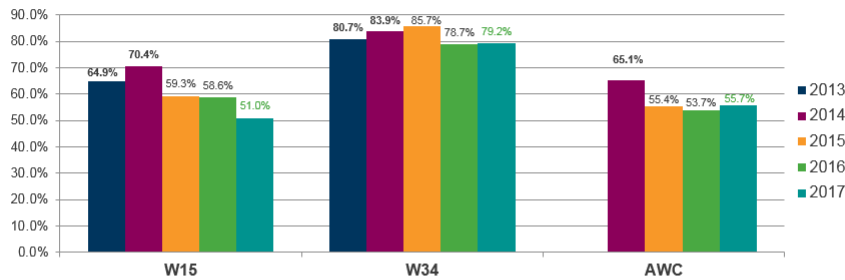
OC patient safety rates were equal or better than the MA-PD average for all measures. OCC patient safety rates were equal or better than the MA-PD average for all measures except adherence measures. We are continuing member outreach and are starting extended day supply programs with network pharmacies.

# HEDIS 2017 RESULTS

## MEDI-CAL RESULTS

### MEDI-CAL WELL CHILD VISITS

#### 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

Green= met goal, MPL met

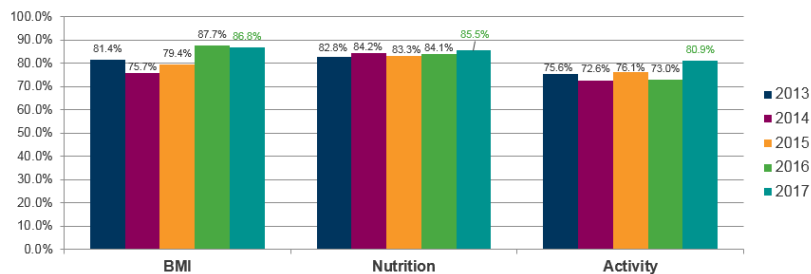
\*\*RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

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### MEDI-CAL WEIGHT ASSESSMENT AND COUNSELING

#### 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

Green= met goal, MPL met

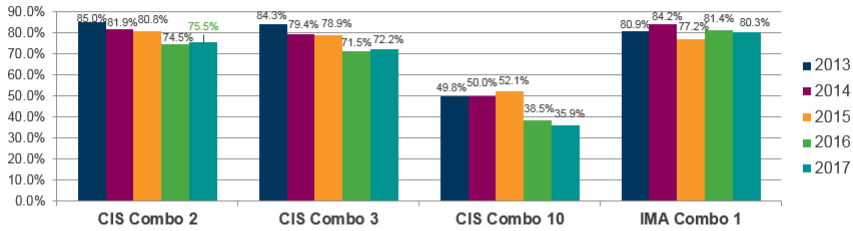
\*\*RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

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## MEDI-CAL IMMUNIZATIONS — CIS

### 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

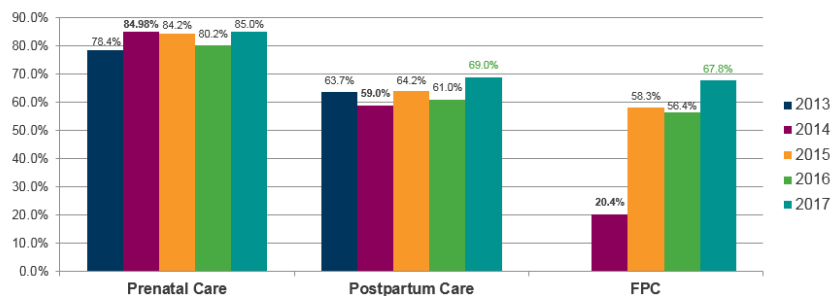
Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings \*\*RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value



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## MEDI-CAL WOMEN'S HEALTH — PPC

### 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

Green= met goal, MPL met

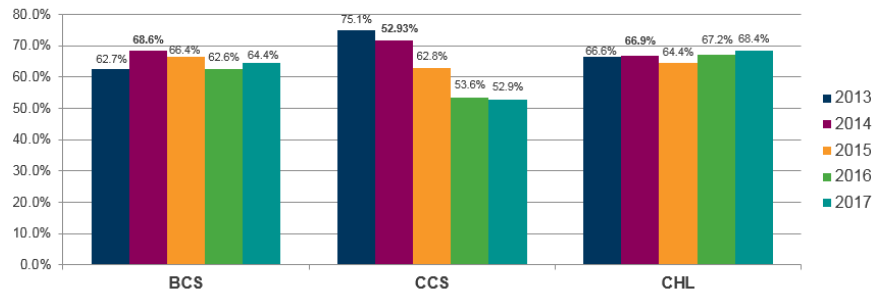
\*\*RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value



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## MEDI-CAL WOMEN'S HEALTH — BCS, CCS

### 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

Green= met goal, MPL met

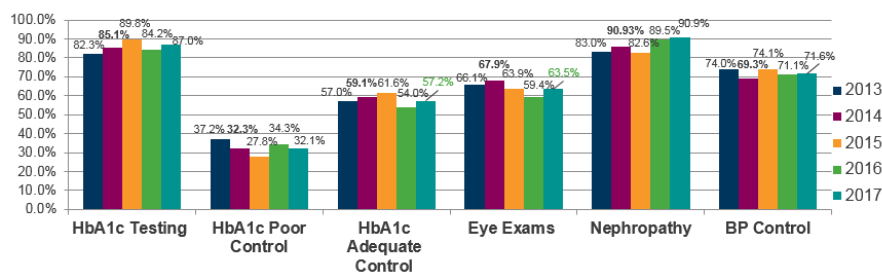
\*\*RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value



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## MEDI-CAL COMPREHENSIVE DIABETES CARE

### 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

Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings

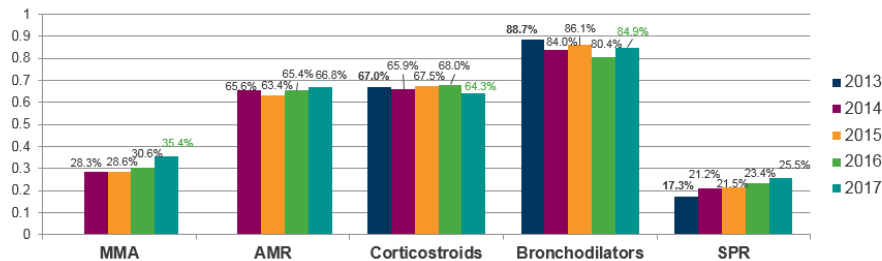
(RS), MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value



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## MEDI-CAL ASTHMA

### HEDIS 2017 Results: Medi-Cal Asthma and COPD



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Goal	Reporting Requirements*
Medication Management for People with Asthma (MMA) 5 to 64 years 75% Compliance	31.28%	37.50%	46.72%	35.31%	ACC, MPL, P4V, RS
Asthma Medication Ratio (AMR) 5 to 64 years > 50% Pharmacotherapy Management of COPD Exacerbation (PCE)	61.26%	65.36%	70.00%	67.68%	ACC, RS
1. Systemic Corticosteroids	70.39%	75.48%	79.07%	70.39%	ACC, RS
2. Bronchodilators	83.70%	86.75%	88.78%	83.70%	ACC, RS
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	30.26%	35.43%	40.54%	25.81%	ACC

Green= met goal, MPL met

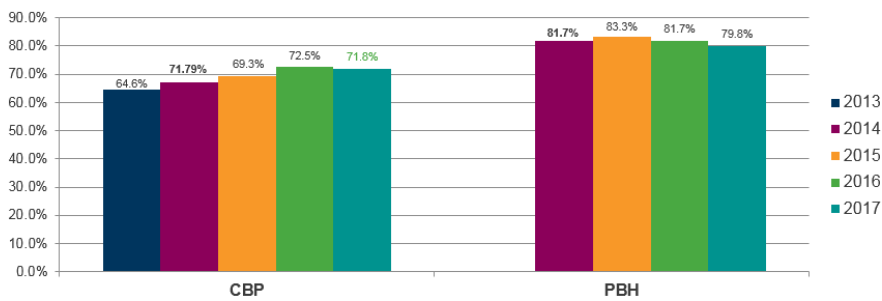
\*\*RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value



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## MEDI-CAL CARDIOVASCULAR CONDITIONS

### 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

Green= met goal, MPL met ++ measure triple weighted for Health Plan Ratings

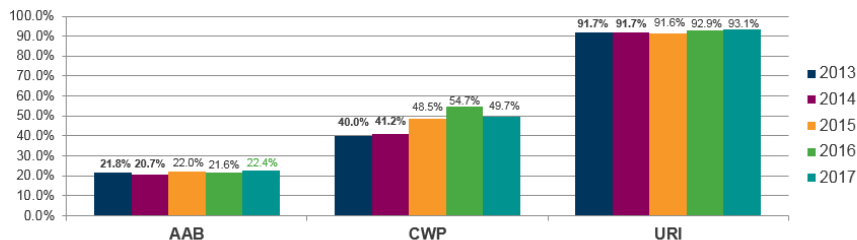
\*\*RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value



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## MEDI-CAL RESPIRATORY CONDITIONS

### 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

Green= met goal, MPL met

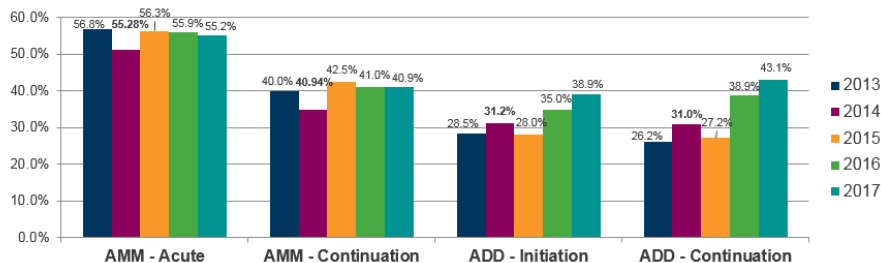
\*\*RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

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## MEDI-CAL BEHAVIORAL HEALTH

### 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

Green= met goal,

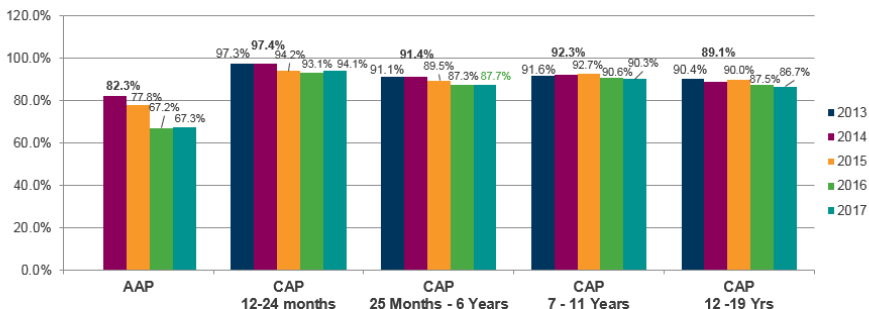
\*\*RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

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## MEDI-CAL ANNUAL VISITS

### HEDIS 2017 Results: Medi-Cal Annual Visits to PCP's



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

Green= met goal

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

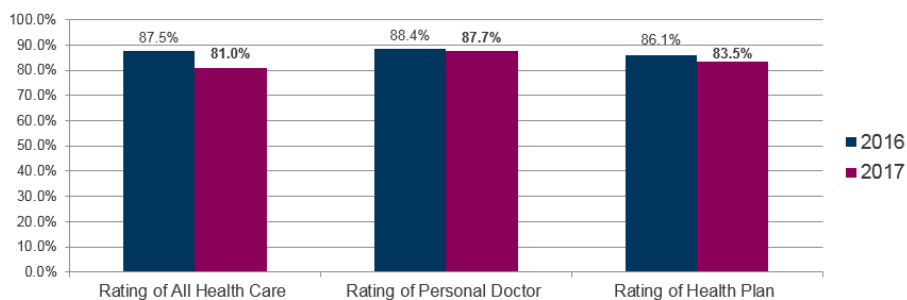


2

## CAHPS RESULTS

### CAHPS® 5.0H CHILD MEMBER SURVEY RESULTS (PARENT'S SATISFACTION WITH THEIR CHILD'S CARE)

#### CAHPS Child Member Survey Results (Parents Satisfaction with Their Child's Care)



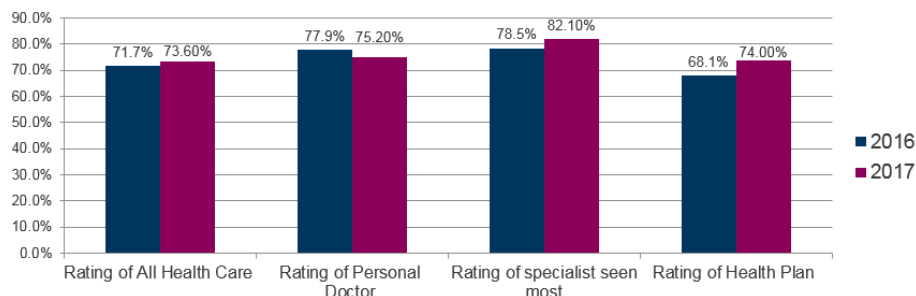
NCQA Accreditation 3-point score	CalOptima 2016	CalOptima 2017	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Rating of All Health Care	2.61	2.54	2.55	2.61	2.64	2.69
Rating of Personal Doctor	2.69	2.60	2.65	2.68	2.72	2.75
Rating of Health Plan	2.64	2.56	2.55	2.61	2.67	2.72

\*Red = less than 25<sup>th</sup> percentile, Yellow = 25<sup>th</sup> percentile, Pink = 50<sup>th</sup> percentile, Blue = 75<sup>th</sup> percentile, Green = 90<sup>th</sup> percentile



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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	2.29	2.32	2.38	2.43	2.46
Rating of Personal Doctor	2.44	2.48	2.53	2.57	2.62
Rating of Specialist Seen Most	2.50	2.49	2.54	2.58	2.63
Rating of Health Plan	2.35	2.35	2.43	2.48	2.53

\*Red = less than 25<sup>th</sup> percentile, Yellow = 25<sup>th</sup> percentile, Pink = 50<sup>th</sup> percentile, Blue = 75<sup>th</sup> percentile, Green = 90<sup>th</sup> percentile

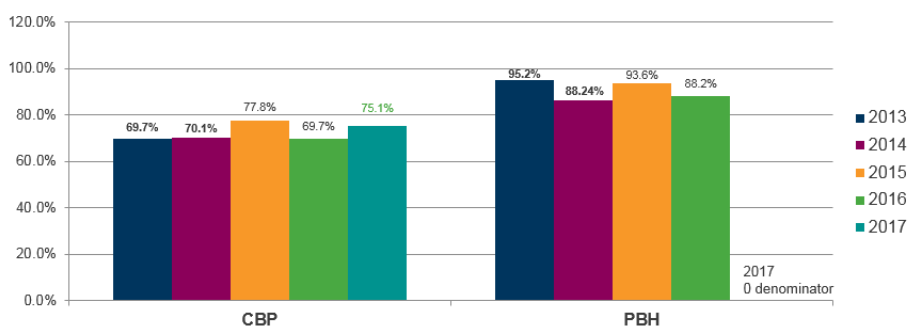
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## OC RESULTS

### OC CARDIOVASCULAR CONDITIONS

## 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

Green= met goal

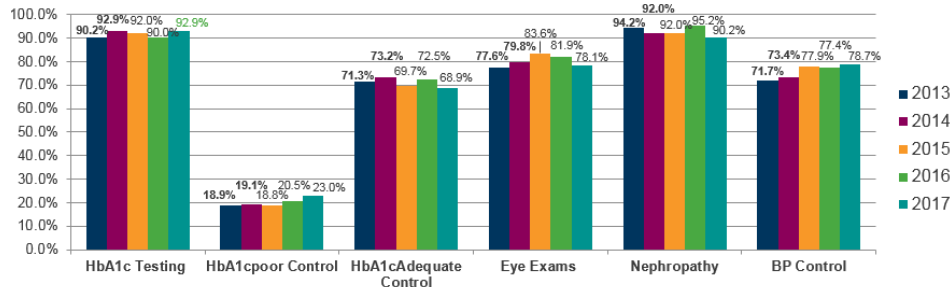
\*\* Triple weighted for STARS

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## OC COMPREHENSIVE DIABETES CARE — HbA1c

### 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

Green= met goal

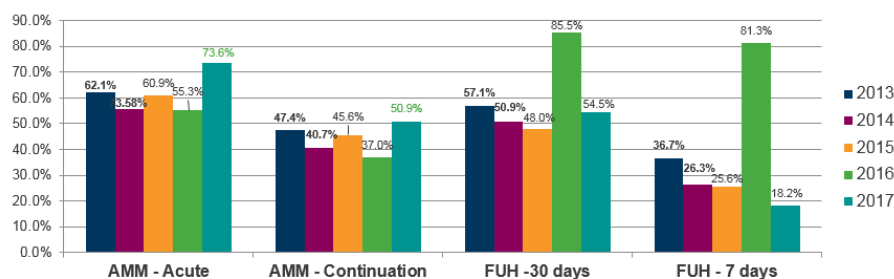
\*\*Triple weighted for STARS



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## OC BEHAVIORAL HEALTH — AMM & FUH

### 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

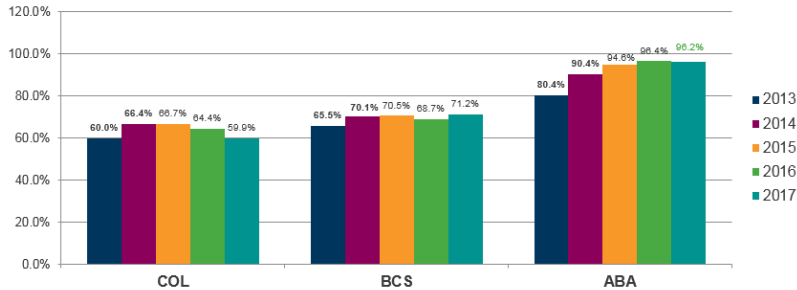
Green= met goal



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## OC PREVENTION AND SCREENING

### 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

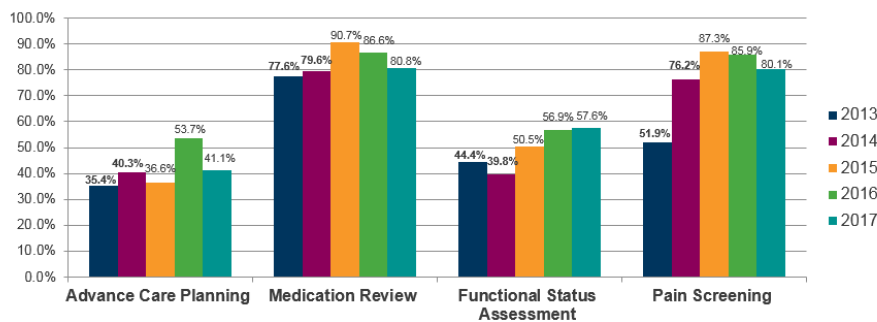
Green= met the goal

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## OC FOR OLDER ADULTS

### 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

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## OCC RESULTS

### OCC CARDIOVASCULAR CONDITIONS

#### 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 50<sup>th</sup> percentile, Green= met goal

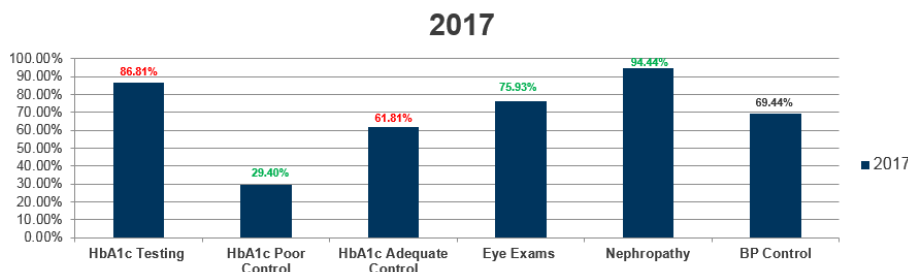
\*\* Triple weighted for STARS

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### OCC COMPREHENSIVE DIABETES CARE — HbA1c

#### 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 50<sup>th</sup> percentile, Green= met goal

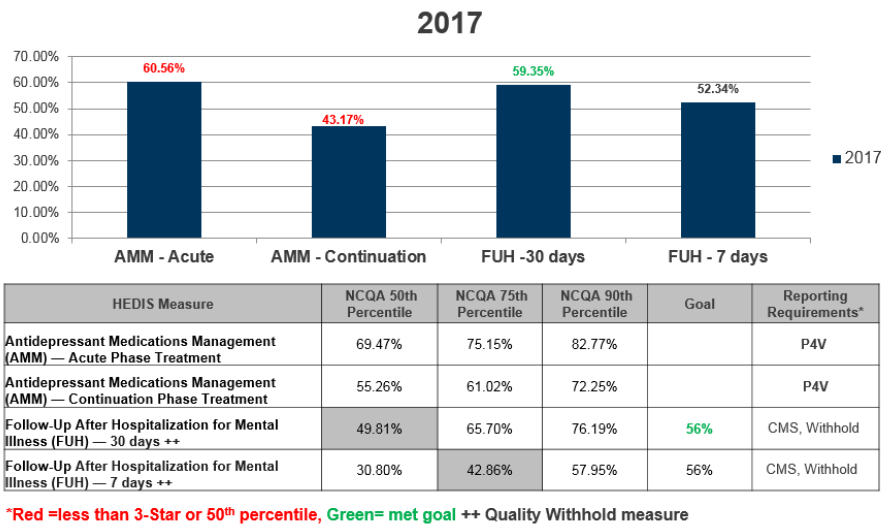
\*\* Triple weighted for STARS

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## OCC BEHAVIORAL HEALTH — AMM & FUH

### HEDIS 2017 Results: OneCare Connect Behavioral Health

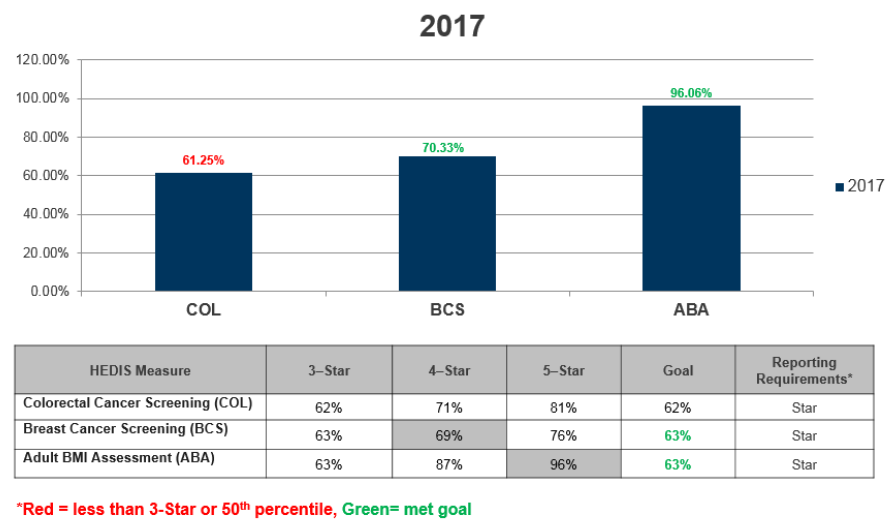


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## OCC PREVENTION AND SCREENING

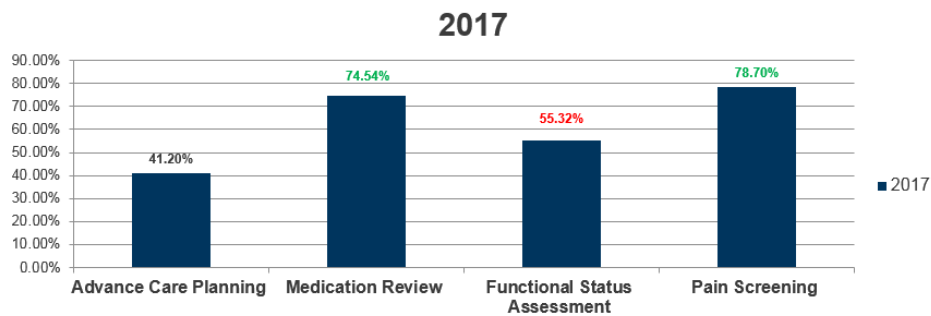
### HEDIS 2017 Results: OneCare Connect Prevention and Screening



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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 50<sup>th</sup> percentile, Green = met goal

## SUMMARY

In 2017, CalOptima was proud to again be the top-rated Medicaid plan in California, according to the NCQA Medicaid Health Insurance Plan rating 2016-2017. CalOptima's Medi-Cal program successfully achieved a commendable accreditation status by NCQA for 2017. Additionally, the DHCS recognized CalOptima for "Outstanding Performance 2017" for a large-scale plan.

CalOptima developed and implemented programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Ongoing data analysis across multiple areas provides the basis for identifying over/under utilization of services. Our approach also uses support systems for our members with vulnerabilities, disabilities and chronic illnesses. Although individual measures may vary in their level of accomplishment, our overall effort has been a considerable success. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to make a positive impact.

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken February 20, 2018** **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

#### **Report Item**

4. Consider Recommending Board of Directors' Approval of the CalOptima 2018 Quality Improvement (QI) Program and 2018 QI Work Plan

#### **Contact**

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

#### **Recommended Action**

Recommend Board of Directors' approval of the recommended revisions to the 2018 Quality Improvement Program and 2018 Quality Improvement Work Plan.

#### **Background**

As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement ("QI Program") and Quality Improvement Work Plan ("QI Work Plan") must be reviewed, evaluated and approved annually by the Board of Directors.

The QI Program defines the structure within which quality improvement activities are conducted, and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima members. It is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks. The QI Program guides the development and implementation of the annual QI Work Plan.

The QI Work Plan is the operation and functional component of the QI Program and outlines the key activities for the upcoming year. The QI Work Plan provides the detail objectives, scope, timeline, monitoring, and accountable persons for each activity. Progress against the QI Work Plan is monitoring throughout the year and reported to QIC quarterly.

CalOptima staff has updated the 2018 QI Program Description and Work Plan with revisions to ensure that it is aligned to reflect the changes regarding the health networks and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across all lines of business.

#### **Discussion**

The 2018 Quality Improvement Program is based on the 2017 Board-approved 2017 Quality Improvement Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all programs to ensure they are consistent with regulatory requirements, NCQA standards and CalOptima's strategic initiatives.

The revisions are summarized as follows:

1. Updates the introductory pages to align with CalOptima's Vision, Mission & Strategic Plan for 2017-19;
2. Updates signature page (replaces Mark Refowitz with Paul Yost)
3. Updates the plans we offer, scope of services and who we work with – including an updated list of our Health Networks;
4. Updates the Behavioral Health Services CalOptima directly manages for Medi-Cal members, and contracts to Magellan Health, Inc. for the BH services portion of OneCare and OneCare Connect functions;
5. Updates the list of CalOptima Officers and staff and included a broader representation of the key areas supporting the QI Program;
6. Incorporates the description of CalOptima's approach to population health management in the design and delivery of care;
7. Updates to include Conflict of Interest policy statement applicable to Committee and Sub-Committee members;
8. Adds Cultural Competency Training during staff orientation, training and education
9. Updates the Advisory Committees and Quality Committees/Subcommittees structure that support the QI Program;
10. Updates BHQIC to monitor member experience with behavioral health services including call center, grievance and appeals, and potential for quality improvement;
11. Updates the 2018 QI Work Plan to reflect new goals and objectives in line with CalOptima's strategic objectives;
12. Updates 2018 Delegation Grid, removing Magellan as a delegated function for the Medi-Cal line of business;
13. Adds Farsi, Chinese and Arabic languages to the OCC member materials.

The recommended changes are designed to better review, analyze, implement and evaluate components of the QI Program and Work Plan. In addition, the changes are necessary to meet the requirements specified by the Centers for Medicare and Medicaid services, California Department of Health Care Services, and NCQA accreditation standards.

### **Fiscal Impact**

The recommended action to approve the 2018 QI Program and 2018 QI Work Plan has no fiscal impact.

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachments**

1. Proposed 2018 Quality Improvement Program – Executive Summary of Revisions
2. Proposed 2018 Quality Improvement Program and 2018 Quality Improvement Work Plan
3. Power Point Presentation: 2018 Quality Improvement Program Description and Work Plan

/s/ Michael Schrader  
**Authorized Signature**

2/12/2018  
**Date**

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## **Quality Improvement (QI) Program 2018**

### **Executive Summary of Revisions**

1. Updates the introductory pages to align with CalOptima's Vision, Mission and Strategic Plan for 2017-19.
2. Updates signature page (replaces Mark Refowitz with Paul Yost).
3. Updates the plans we offer, scope of services and who we work with, including an updated list of our Health Networks.
4. Updates new initiatives on the horizon, including Whole-Person Care and Whole-Child Model.
5. Updates Behavioral Health Services that CalOptima directly manages for Medi-Cal members. For the BH services portion of OneCare and OneCare Connect, CalOptima contracts with Magellan Health, Inc.
6. Updates the list of CalOptima officers and staff, and includes a broader representation of the key areas supporting the QI Program.
7. Incorporates the description of CalOptima's approach to population health management in the design and delivery of care.
8. Updates to include Conflict of Interest policy statement applicable to committee and subcommittee members.
9. Adds Cultural Competency Training during staff orientation, training and education
10. Updates the advisory committees and Quality committees and subcommittees structure that support the QI Program.

11. Updates Behavioral Health Quality Improvement Committee (BHQIC) to monitor member experience with behavioral health services, including call center, grievance and appeals, and the potential for quality improvement.
12. Updates the 2018 QI Work Plan to reflect new goals and objectives aligned with CalOptima's strategic objectives.
13. Updates 2018 Delegation Grid, removing Magellan as a delegated function for the Medi-Cal line of business.
14. Adds Farsi, Chinese and Arabic languages to the OCC member materials.



A Public Agency

# CalOptima

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2018~~2017~~

## QUALITY IMPROVEMENT PROGRAM





**CalOptima**  
Better. Together.

**~~2017~~2018 QUALITY IMPROVEMENT  
PROGRAM  
SIGNATURE PAGE**

*Quality Improvement Committee Chair:*

\_\_\_\_\_  
**Richard Bock, M.D.**  
**Deputy Chief Medical Officer**

\_\_\_\_\_  
**Date**

*Board of Directors' Quality Assurance Committee Chair:*

\_\_\_\_\_  
**Paul Yost, M.D.** \_\_\_\_\_ **Date**

*Board of Directors Chair:*

\_\_\_\_\_  
~~**Mark Refowitz**~~ — **Paul Yost, M.D.** \_\_\_\_\_ **Date**

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## WE ARE CALOPTIMA

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

### **Our Mission**

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

### **Our Vision**

*To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all of our members.*

### **Our Values — CalOptima CARES**

**Collaboration:** We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

**Accountability:** We were created by the community, for the community, and are accountable to the community. Our Board of Directors, Member Advisory Committee, OneCare Connect Member Advisory Committee, ~~and~~ Provider Advisory Committee, Quality Assurance Committee and Finance and Audit Committee meetings are open to the public.

**Respect:** We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members

We respect and care about our partners. We develop supportive working relationships with providers, community health centers and community stakeholders.

**Excellence:** We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

**Stewardship:** We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

### **We are “Better. Together.”**

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members’ health care needs. We are “Better. Together.”

### **Our Strategic Plan**

CalOptima’s 2017–19 Strategic Plan honors our ~~longstanding~~long-standing mission focused on members while recognizing that the future holds some unknowns given possible changes for Medicaid plans serving low-income people through the Affordable Care Act. Still, any future environment will demand attention to the priorities of more innovation and increased value, as well as enhanced partnerships and engagement. Additionally, CalOptima must focus on workforce performance and financial strength as building blocks so we can achieve our strategic goals. Below are the key elements in our Strategic Plan framework.

#### **Strategic Priorities:**

- **Innovation:** Pursue innovative programs and services to optimize member access to care.
- **Value:** Maximize the value of care for members by ensuring quality in a cost-effective way.
- **Partnerships and Engagement:** Engage providers and community partners in improving the health status and experience of members.

#### **Building Blocks:**

- **Workforce Performance:** Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes.
- **Financial Strength:** Provide effective financial management and planning to ensure long-term financial strength.

## **WHAT IS CALOPTIMA?**

### **Our Unique Dual Role**

CalOptima is unique in that ~~we must be the best of it is~~ both a public agency ~~upholding public trust,~~ and a community health plan ~~seeking quality health care, efficiency and member satisfaction.~~

As both, CalOptima must:

- ~~Make~~Provide quality health care to ensure optimal health outcomes for our members
- Support member and provider engagement and satisfaction
- Be good stewards of public funds by making the best use of our resources, ~~funding~~ and expertise
- ~~Solicit stakeholder input~~
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input
- Be accountable for the decisions we make

|

## How We Became CalOptima

Orange County is unique in that it does not have county-run hospitals or clinics. By the mid-1990s, there was a coalescing crisis since not enough providers accepted Medi-Cal. This resulted in overcrowding in emergency rooms and delayed care, due to Medi-Cal recipients using emergency rooms across the county not only for acute care, but for primary care as well.

A dedicated coalition of local elected officials, hospitals, physicians and community advocates rallied and created a solution. The answer was to create CalOptima as a county-organized health system (COHS) authorized by State and Federal law to administer Medi-Cal benefits in Orange County.

CalOptima began serving members in 1995. Today, CalOptima is the largest of six COHS in the United States.

CalOptima as a public agency and a COHS has:

- Single plan responsible for providing Medi-Cal coverage in the county
- Mandatory enrollment of all full-scope Medi-Cal beneficiaries, including dual eligibles
- Responsible for almost all medical acute services and Long-Term Services and Supports (LTSS), including custodial long-term care.

In 2005, CalOptima became licensed to furnish a Medicare Advantage Special Needs Plan (MA-SNP) and MA Prescription Drug plan through a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS). This plan, called OneCare (HMO-SNP), allows CalOptima to offer Medicare and Medi-Cal benefits under one umbrella to dual-eligible individuals.

OneCare (OC) operates exclusively as a “Zero-Cost Share, Medicaid Subset Dual Special Needs Plan.” OC only enrolls beneficiaries who qualify as a zero-cost sharing Medicaid subset. To identify dual-eligible members, OC imports daily member-eligibility files from the State and Federal government with Medicaid and Medicare eligibility segments.

In July 2015, CalOptima launched OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan). OneCare Connect (OCC) is a demonstration project in an effort by California and the Federal government to begin the process—through a single-organized health-care delivery system—of integrating medical, behavioral health, long-term care services and supports, and community-based services for dual-eligible beneficiaries. One of the program’s goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community. A key feature of CalOptima is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individual care plan. Members eligible for OCC cannot enroll in OC.

## WHAT WE OFFER:

### **Medi-Cal**

In California, Medicaid is known as Medi-Cal. For more than 20 years, CalOptima has been serving Orange County's Medi-Cal population. Due to the implementation of the Affordable Care Act — as more low-income children and adults qualified for Medi-Cal — membership in CalOptima grew by an unprecedented 49 percent between 2014 and 2016!

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

### **Scope of Services**

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.

These services include but are not limited to the following:

Acupuncture	Hospice care	Outpatient mental health services – limited
Adult preventive services	Hospital/inpatient care	Pediatric preventive services
Community-based adult services	Immunizations	Child health and disability prevention (CHDP)
Doctor visits	Laboratory services	Physical therapy
Durable medical equipment	Limited allied health services	Prenatal care
Emergency care	Medical supplies	Specialty care services
Emergency transportation	Medications	Speech therapy
Non-emergency medical transportation (NEMT) <u>and non-medical transportation (NMT)</u>	Newborn care	Substance use disorder preventive services – limited
Hearing aid(s)	Nursing facility services	Vision care
Home health care	Occupational therapy	

Certain services are not covered by CalOptima, or may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program.
- Eligible conditions under California Children's Services (CCS).

### **Members With Special Health Care Needs**

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care, and are described in the Utilization Management (UM) Program- and Case Management (CM) Program.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established through special programs, such as the CalOptima Member Liaison program, and specific Memoranda of Understanding (MOU) with certain community agencies, including OC HCA, CCS and the Regional Center of Orange County (RCOC).

### **Medi-Cal Managed Long-Term Services and Supports**

~~Beginning~~Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) ~~became a benefit~~benefits for ~~all~~CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

~~LTSS includes four~~These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)
- ~~In Home Supportive Services (IHSS)~~

### **OneCare (HMO SNP)**

Our OneCare ~~(HMO SNP) means total care. Our~~ members ~~with~~have Medicare and Medi-Cal benefits ~~are~~ covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

To be a member of OC, a person must live in Orange County ~~and~~, be enrolled in Medi-Cal and Medicare Parts A and B, and not be eligible for OCC.

### **Scope of Services**

OC provides a comprehensive scope of services for the dual eligible members who are not eligible for OCC, and who voluntarily enroll in OC.

These services include but are not limited to the following:

Acupuncture and other alternative therapies	Gym membership	Prescription drugs
Ambulance	Hearing services	Preventative care
Chiropractic care	Home health care	Prosthetic devices
Dental services – limited	Hospice	Renal dialysis
Diabetes supplies and services	Inpatient hospital care	Skilled nursing facility
Diagnostic tests, lab and radiology services, and X-rays	Inpatient mental health care	<del>Taxi rides</del> <u>Transportation</u> for medical and pharmacy visits
Doctor visits	Mental health care	Urgently needed services
Durable medical equipment	Outpatient rehabilitation	Vision services
Emergency care	Outpatient substance abuse	
Foot care	Outpatient surgery	

### **OneCare Connect**

OneCare Connect is a Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds ~~supplemental~~ benefits such as vision care, ~~taxi rides to medical appointments~~, gym benefits and enhanced dental benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima’s innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member’s needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions apply.

### **Scope of Services**

OCC simplifies and improves health care for low-income seniors and people with disabilities.

These services include but are not limited to the following:

Acupuncture (pregnant women)	Hearing aids – limited	Rehabilitation services
Ambulance services	Hearing screenings	Renal dialysis
Case management	Incontinence supplies – limited	Screening tests
Chiropractic services	Inpatient hospital care	Skilled nursing care
Community-based adult services (CBAS)	Inpatient mental health care	Specialist care
Diabetes supplies and services	Institutional care	Substance abuse services
Disease self-management	Lab tests	Supplemental dental services
Doctor visits	Medical equipment for home care	<del>Taxi rides</del> <u>Transportation</u> for medical and pharmacy visits
Durable medical equipment	Mental or behavioral health services	Transgender services
Emergency care	Multipurpose Senior Services Program (MSSP)	Occupational, physical or speech therapy
Eye exams	Over-the-counter drugs – limited Prescription drugs	Urgent care
Foot care	Outpatient care	“Welcome to Medicare” preventive visit
Glasses or contacts – limited	Preventive care	
Gym membership	Prosthetic devices	
Health education	Radiology	

### **Program of All-Inclusive Care for the Elderly (PACE)**

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail ~~elders~~seniors to help them continue living independently in the community.

To be a PACE participant, members must be ~~eligible for both Medicare Parts A & B, be~~ at least 55 years old, live in our Orange County service area, be determined as eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

### **Scope of Services**

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to ~~our~~ participants.

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for participants, based on their needs as indicated by the Interdisciplinary Team.

PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

## NEW PROGRAM INITIATIVES ON OUR HORIZON:

### Palliative Care

~~CalOptima expects to implement palliative care standards for its Medi-Cal members no sooner than July 1.~~

### Whole-Person Care

Whole-Person Care is a five-year pilot ~~established by DHCS as part of California's Medi-Cal 2020 strategic plan. In Orange County, the pilot is being and~~ led by the Orange County Health Care Agency ~~to~~. ~~It will~~ focus on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness.

### Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. Currently, CCS services are carved out (separated) from most Medi-Cal managed care plans, including CalOptima. The Orange County Health Care Agency (OC HCA) manages the local CCS program. OC HCA provides case management, eligibility determination, service authorization and direct therapy under the Medical Therapy Program.

By July 1, 2018, CCS services will be a Medi-Cal managed care plan benefit. The goal is to improve health care coordination for the whole child, rather than handle CCS conditions separately. This approach is known as the Whole-Child Model.

By January 1, 2019, most other CCS functions will be part of CalOptima's Medi-Cal plan. Under this model, OC HCA will still determine eligibility, and handle the Medical Therapy Program.

CalOptima regularly meets with OC HCA about the CCS transition in Orange County. There are ongoing discussions about implementation, and decisions pending further guidance from the state. The priority for CalOptima and OC HCA is to make sure there is a seamless transition for the children and families involved. CalOptima will keep our stakeholders informed, and provide opportunities for feedback. Whole Person Care will be launched in stages, with full implementation by January 1, 2018.

### Long-Term Connect

~~CalOptima plans to realign its internal operations to better support members who reside in a long-term care facility. Referred to as "Long-Term Connect" its focus will be on increasing member/provider visits, preventing avoidable inpatient hospitalizations, and improving health outcomes. Long-Term Connect is expected to launch in July 2017.~~

## WHOM WE WORK WITH:

### Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima health network, and/or participate through CalOptima Direct, and/or the CalOptima Community Network. CalOptima members can choose one of ~~1415~~ health networks (HNs), representing more than 7,500 practitioners.

## Health Networks

CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima's HNs consist of Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), and Shared Risk Medical Groups (SRGs). Through these HNs, CalOptima members have access to nearly 1,600 Primary Care Providers (PCPs), nearly 6,100 specialists, 30 hospitals, and 36 clinics.

## CalOptima Community Network (CCN)

~~The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 13 private14 HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th 15th network available for members to select, supplementing the existing health network delivery model and creating additional capacity for growth.~~

## CalOptima Direct (COD)

CalOptima Direct is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's MA SNP), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct are not health network eligible.

## CalOptima Community Network (CCN)

~~The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 14 HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 15th network available for members to select, supplementing the existing health network delivery model and creating additional capacity for growth.~~

## Health Networks

~~CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima's HNs consist of Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), Physician Medical Groups (PMGs) and Shared Risk Medical Groups (SRGs). Through these HNs, CalOptima members have access to more than 1,500593 Primary Care Providers (PCPs), nearly 6,000092 specialists and, 30 hospitals, and 36 clinics. New health networks that demonstrate the ability to comply with CalOptima's delegated requirements are added as needed with CalOptima Board approval.~~

The following are CalOptima's contracted ~~Health Networks~~health networks:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	<del>PMG</del> SRG	SRG
<del>AMVI/Prospect</del>		<del>SRG</del>	
AMVI Care Health Network	PHC	<del>PMG</del>	PHC
Arta Western Health Network	SRG	<del>PMG</del> SRG	SRG

## CCN

CHOC Health Alliance	PHC		
Family Choice Health Network	<del>SRG</del> PHC	PMG <del>SRG</del>	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	PMG <del>SRG</del>	HMO
Noble Mid-Orange County	SRG	PMG <del>SRG</del>	SRG
OC Advantage Medical Group	PHC		PHC
Prospect Medical Group	<del>SRG</del> HMO		<del>SRG</del> HMO
Talbert Medical Group	SRG	PMG <del>SRG</del>	SRG
United Care Medical Group	SRG	PMG <del>SRG</del>	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

## BEHAVIORAL HEALTH SERVICES

### Medi-Cal Ambulatory Behavioral Health Services

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include but are not limited to: individual and group psychotherapy, psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima directly manages all administrative functions of the Medi-Cal behavioral health benefits including utilization management, claims, credentialing the provider network, and customer service.

Member can receive behavioral health services within the scope of practice for primary care physicians (PCPs) including screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary. In addition, PCPs frequently manage the treatment of mental health conditions in their patients.

If a member needs behavioral health services not provided by their PCP, CalOptima members can access behavioral health services directly, without a physician referral by contacting the CalOptima representative for behavioral health assistance. If office based services are appropriate, the member will be provided with several behavioral health practitioners, based upon geographic proximity and clinical needs. If the member meets criteria for Specialty Mental Health Services, the member is referred to the Orange County Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima. Additionally, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD).

### **OneCare and OneCare Connect Behavioral Health Services**

CalOptima has contracted with Magellan Health Inc. for the behavioral health services portion of OneCare and OneCare Connect. Functions delegated to Magellan include utilization management, credentialing, and customer service.

CalOptima OneCare and OneCare Connect members can access behavioral health services by calling the CalOptima Behavioral Health Line. Members will be connected to a Magellan representative for behavioral health assistance. If office-based services are appropriate, the member is registered and given referrals to an appropriate provider. If ambulatory Specialty Mental Health needs are identified, services may be rendered through the Orange County Mental Health Plan.

CalOptima offers SBIRT services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

### **Medi-Cal Ambulatory Behavioral Health Services**

CalOptima covers behavioral health treatment (BHT) services for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD). CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional or behavioral functioning, resulting from a mental health disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders. Mental health services include, but are not limited to: individual and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

CalOptima delegates to Magellan Health, Inc. [a managed behavioral healthcare organization (MBHO)] for UM of the provider network, network adequacy and credentialing the provider network, customer service/managing the CalOptima Behavioral Health phone line, and several quality improvement functions.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD).

Some behavioral health services are also within the scope of practice for PCPs, including offering screening, brief intervention and referral to treatment (SBIRT) services to members 18 years of age and older who misuse alcohol. Providers in primary care settings also screening for alcohol misuse, and provide people engaged in risky or hazardous drinking behavior with brief behavioral counseling interventions to reduce alcohol misuse, and/or referral to mental health

~~and/or alcohol use disorder services, as medically necessary.~~

**~~OneCare and OneCare Connect Behavioral Health Services~~**

~~CalOptima is also contracted with Magellan Health, Inc. for the behavioral health services portion of OC and OCC. The delegated functions are identical to those listed above.~~

|

## MEMBERSHIP DEMOGRAPHICS



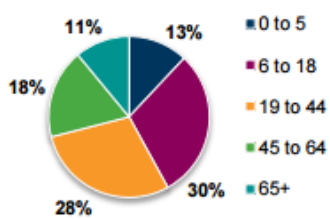
**Fast Facts: February 2017**

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

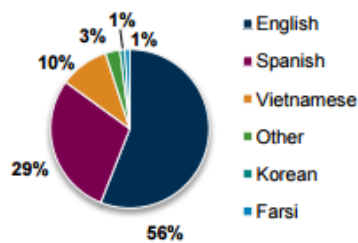
### Membership Data as of December 31, 2016

<b>Total CalOptima Membership</b> <b>800,001</b>	Program	Members
	Medi-Cal	781,733
	OneCare Connect	16,810
	OneCare (HMO SNP)	1,275
	Program of All-Inclusive Care for the Elderly (PACE)	183

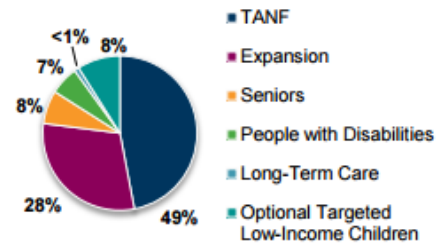
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



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

## Membership Data as of December 31, 2017

<p>Total CalOptima Membership</p> <p><b>791,476</b></p>	Program	Members
	Medi-Cal	774,646
	OneCare Connect	15,223
	OneCare (HMO SNP)	1,372
	Program of All-InclusiveCare for the Elderly (PACE)	235

### Member Age (All Programs)

12%	0 to 5
30%	6 to 18
29%	19 to 44
18%	45 to 64
11%	65+

### Languages Spoken (All Programs)

56%	English
29%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

### Medi-Cal Aid Categories

45%	Temporary Assistance for Needy Families
31%	Expansion
10%	Optional Targeted Low-Income Children
8%	Seniors
6%	People with Disabilities
<1%	Long-Term Care

## QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, clinical services and organizational services provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all of our members.

CalOptima has developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Our approach uses support systems for our members with vulnerabilities, disabilities and chronic illnesses.

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

## **AUTHORITY, BOARD OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES**~~ACCOUNTABILITY AND RESPONSIBILITY~~

### **Board of Directors**

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board of Directors promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the QI Program annually.

The QI Program is based on ongoing data analysis to identify the clinical needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of members. The CMO is charged with identifying appropriate interventions and resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

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

The Board of Directors appoints the Quality Assurance Committee (QAC) to review and accept the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC shall also make recommendations for annual modifications of the QI program and actions to be taken when objectives are not met. CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's QAC meetings are open to the public.

### **Member Advisory Committee**

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventative services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumer
- Family Support
- Foster Children
- Long-Term Services and Support
- Medi-Cal beneficiaries

- Medically indigent persons
- Orange County Health Care Agency
- Orange County Social Services Agency
- Persons with disabilities
- Persons with mental illnesses
- Persons with Special Needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by the Health Care Agency and the Social Services Agency — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

### **OneCare Connect Member Advisory Committee**

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC and four non-voting liaisons representing county agencies, collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
  - Orange County Social Services Agency
  - Orange County Community Resources Agency, Office on Aging
  - Orange County Health Care Agency, Behavioral Health
  - Orange County IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are open to the public.

### **Provider Advisory Committee**

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima members. The PAC is comprised of 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of the Orange County Health Care Agency, which maintains a standing seat. The meetings are open to the public. The 15 seats include:

- Health Network (1 seat)
- Hospitals (1 seat)

- Physicians (3 seats)
- Nurse (1 seat)
- Allied Health Services (1 seat)
- Community Health Centers (1 seat)
- Orange County Health Care Agency (HCA) (1 standing seat)
- Long Term Services and Support including (LTC facilities and CBAS) (2 seats)
- Non-Physician Medical Practitioner (1 seat)
- Traditional/Safety Net (1 seat)
- Behavioral/Mental Health (1 seat)
- Pharmacy (1 seat)

### **Whole-Child Model Family Advisory Committee**

In 2018, CalOptima's Board of Directors will establish the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state when California Children's Services (CCS) becomes a Medi-Cal managed care plan benefit. The WCM FAC will provide advice and recommendations to the Board and staff on issues concerning WCM, serve as liaison between interested parties and the Board, and assist the Board and staff in obtaining public opinion on issues relating to CalOptima WCM. The committee can initiate recommendations on issues for study, and facilitate community outreach.

The WCM FAC will be composed of the following 11 voting seats:

- Family representatives: 7 to 9 seats
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
  - CalOptima members age 18-21 who are a current recipient of CCS services; or
  - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: 2 to 4 seats
  - Community-based organizations; or
  - Consumer advocates

Of the above seats, five members serve a one-year term, and six will serve a two-year term. WCM FAC meetings will be open to the public.

## Quality Improvement Program, Role of CalOptima Officers for Quality Improvement Program

**Chief Executive Officer** (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the State and Federal Contracts.

**Chief Medical Officer** (CMO) — or physician designee — chairs the QIC, which oversees and provides direction to CalOptima's QI activities, and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

**Deputy Chief Medical Officer (DCMO)** along with the CMO oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics ([QA](#)), Quality ~~Management~~[Improvement \(QI\)](#), [Utilization Management \(UM\)](#), Case ~~Coordination, Case-~~Management ([CM](#)), ~~HE&DM,~~[Health Education & Disease Management \(HE&DM\)](#), Pharmacy Management ([PM](#)), Behavioral Health Integration ([BHI](#)), ~~and~~ Long-Term Services and Supports ([LTSS](#)), and [Enterprise Analytics](#).

**Chief Operating Officer (COO)** is responsible for oversight and day-to-day operations of several departments including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, -Electronic Business and Human Resources.

**Executive Director, Quality & Analytics (ED of Q&A)** is responsible for facilitating the company-wide QI Program, driving improvements with Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and facilitating compliance with National Committee for Quality Assurance (NCQA) standards. The ED of Q&A serves as a member of the executive team and with the CMO/DCMO [and ED of Clinical Operations](#), supports efforts to promote adherence to established quality improvement strategies and programs throughout the company- [and makes certain that quality initiatives are aligned with Clinical Operations within Medical Affairs](#). Reporting to the ED of Q&A is the Director of Quality Analytics, the Director of Health Education & Disease Management, [and](#) the Director of Quality Improvement, ~~and the Director of Behavioral Health Services.~~

**Executive Director of Clinical Operations (ED of CO)** is responsible for oversight of all operational aspects of key Medical Affairs functions, including: UM, Care Coordination, Complex Case Management, Long-Term Services and Supports and MSSP Services, along with new program implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO/DCMO [and ED of Q&A](#), makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

**Executive Director of Public Affairs (ED of PA)** serves as the State Liaison; and [is responsible for](#) the management, development and implementation of CalOptima's Communication plan, Issues Management and Legislative Advocacy. This position also oversees Strategic Development and the integration of activities for the Community Relations Program. ~~The QI department collaborates with Public Affairs to address specific developments or changes to policies and procedures that impact areas within the purview of QI.~~

**Executive Director of Compliance (ED of C)** is responsible to monitor and drive interventions so that CalOptima and its HMOs, PHCs, SRGs, ~~Managed Behavioral Health Organizations (MBHOs)~~ and ~~FDRs PMGs~~ meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight department to refer any potential sustained noncompliance issues or trends encountered during audits of HNs, ~~PMGs~~, and other functional areas. The ED of C also oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements.

**Executive Director of Network Operations (ED of NO)** leads and directs the integrated operations of the health networks, and must coordinate organizational efforts internally, as well

as externally, with members, providers and community stakeholders. The ED of NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services throughout the service delivery network.

**Executive Director of Operations** (ED of O) is responsible for overseeing and guiding Claims Administration, Customer Service, Grievance & Appeals Resolution Services, Coding Initiatives, and Electronic Business

## QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD, as well as our contracted provider networks. Through the QI Program, and in collaboration with its providers, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The CalOptima QI Program incorporates continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies):

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress toward established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to promote efforts that support the identification and correction of quality of care issues.
- It maintains ~~agencywide~~agency-wide practices that support accreditation by ~~the~~ NCQA, and meets Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) quality requirements and measures.

The Quality and Clinical Operations departments, and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

## QUALITY IMPROVEMENT DEPARTMENT

The QI department is responsible for the execution and coordination of ~~the~~ quality assurance and improvement activities. It also supports the specific focus of monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both division and department-specific as well as agencywideagency-wide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care andfor all lines of business
- Monitor and maintain agencywideagency-wide practices that support accreditation and meeting regulatory requirements.

## QUALITY ANALYTICS DEPARTMENT

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation and evaluation of initiatives to:

- Report, monitor and trend outcomes
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze problems and measure improvement
- Coordinate and communicate organizational information, both division and department specific, and agency-wide
- Participate in various reviews through the QI Program such as the All Cause Readmission monitoring, access to care, availability of practitioners and other reviews
- Facilitate satisfaction surveys for members and practitioners
- Provide agency-wide oversight of monitoring activities that are:
  - Balanced: Measures clinical quality of care and customer service
  - Comprehensive: Monitors all aspects of the delivery system
  - Positive: Provides incentive to continuously improve

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data

- Case Management reports
- Pharmacy data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider satisfaction surveys
- QI Projects: [Quality Improvement Project \(QIP\)s](#), [Performance Improvement Project \(PIP\)](#), [Plan-Do-Study-Act \(PDSA\)s](#) and [Chronic Care Improvement CCIPs](#)
- Health Risk Assessment (HRA) data

## HEALTH EDUCATION & DISEASE MANAGEMENT DEPARTMENT

The Health Education & Disease Management (HE & DM) department, also known as Population Health Management (PHM) is the third area in Quality that provides program development and implementation for ~~agencywide~~agency-wide population health programs. ~~HE & DM~~PHM Programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics covered include Asthma, Congestive Heart Failure, Diabetes, Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management and Tobacco Cessation.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the ~~sixth-grade~~sixth-grade reading level and are culturally and linguistically appropriate for our members.

~~HE & DM~~PHM supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- ~~Execute~~Execution and ~~coordinate~~coordination of programs with Case Management, QA and our Health Network Providers.

## QI PROGRAM RESOURCES ~~AND COMMITTEE STRUCTURE~~

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

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

The following staff positions provide direct support for organizational and operational QI Program functions and activities:

#### **Deputy Chief Medical Officer (DCMO) Director, Quality**

~~The DCMO Appointed by the CMO, the Medical Director of Quality~~ is responsible for the direction of the QI Program objectives to drive the organization's mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services delivered to members.

#### **Director, Quality Improvement**

Responsibilities include assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Facility Physical Access Compliance and working with the ED of Quality. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Quality Improvement Director:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - Supervisor, Quality Improvement (Credentialing)
  - Supervisor, Quality Improvement (FSR)
  - QI Program Specialists
  - QI Nurse Specialists
  - Data ~~Analyst~~Analysts
  - Credentialing Coordinators
  - Program Specialists
  - Program Assistants
  - Facility Site Review Master Trainer
  - Facility Site Review Nurse Reviewers

#### **Director, Quality Analytics**

Provides ~~administrative and~~ analytical direction to support quality measurement activities for the ~~agencywide~~agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

- The following positions report to the Director of Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics Pay for Value Manager
  - Quality Analytics QI Initiatives Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

#### **Director, Health Education & Disease Management**

Provides direction for program development and implementation for ~~the agencywide~~agency-wide population health initiatives. Ensures linkages supporting a whole-person perspective to health and health care with Case Management, Care Management, UM, Pharmacy and

Behavioral Health Integration. Also, supports the Model of Care implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

- The following positions report to the Director, Health Education & Disease Management:
  - Disease Management Manager (Program Design)
  - Disease Management Manager (Operations)
  - Disease Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Disease Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dietitians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

In addition, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our member's health status.

**Executive Director of Clinical Operations** (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: UM, Care Coordination, Complex Case Management, Long-Term Services and Supports, MSSP Services, along with new program implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO/DCMO, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

**Director of Utilization Management** assists in the development and implementation of the UM program, policies, and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director of UM also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and QI Committees, and participates in the UM Committee and the Benefit Management Subcommittee.

**Director of Clinical Pharmacy Management** leads the development and implementation of the Pharmacy Management (PM) program, develops and implements PM department policies and procedures; ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, -provides supervision of the coordination of Pharmacy-related clinical affairs, and serves on the Pharmacy & Therapeutics Subcommittee and QI Committees. The director of PM also guides the identification and interventions on key pharmacy quality and utilization measures.

**Director of Case Management** is responsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. The director supports improving quality and access through seamless care coordination for targeted member populations. Develops and implements policies, procedures and processes related to program operations and quality measures.

**Director of Long Term Services and Supports** is responsible for LTSS programs, which include CBAS, ~~In-Home Supportive Services (IHSS)~~, LTC, and MSSP. The position supports a “Member-Centric” approach and helps keep members in the least restrictive living environment, ~~collaborate~~collaborates with ~~stakeholders including~~ community partners; and ~~ensure other stakeholders, and ensures~~ LTSS ~~services~~ are available to ~~the~~ appropriate ~~population~~populations. The director also develops and implements policies, procedures, and processes related to ~~the~~ LTSS program operations and quality measures.

**Director of Behavioral Health Services** provides ~~leadership and program development expertise in the creation, expansion and improvement of services and systems that leads to the integration of physical and operational oversight for~~ behavioral health ~~care~~benefits and services for CalOptima~~provided to~~ members. The ~~director leads and assists the organization in developing and successfully implementing short and long term strategic goals and objectives toward integrated care. The director plays a key leadership role in coordinating with all levels of CalOptima staff;~~Director is responsible for monitoring, analyzing, and reporting on changes in the health care delivery environment and identifying program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services.

**Director of Enterprise Analytics** provides leadership across CalOptima in the development and distribution of analytical capabilities. The Director drives the development of the strategy and roadmap for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the roadmap. Working with departments that supply data, the team ~~will be~~is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the enterprise analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

## QUALITY IMPROVEMENT STRATEGIC GOALS

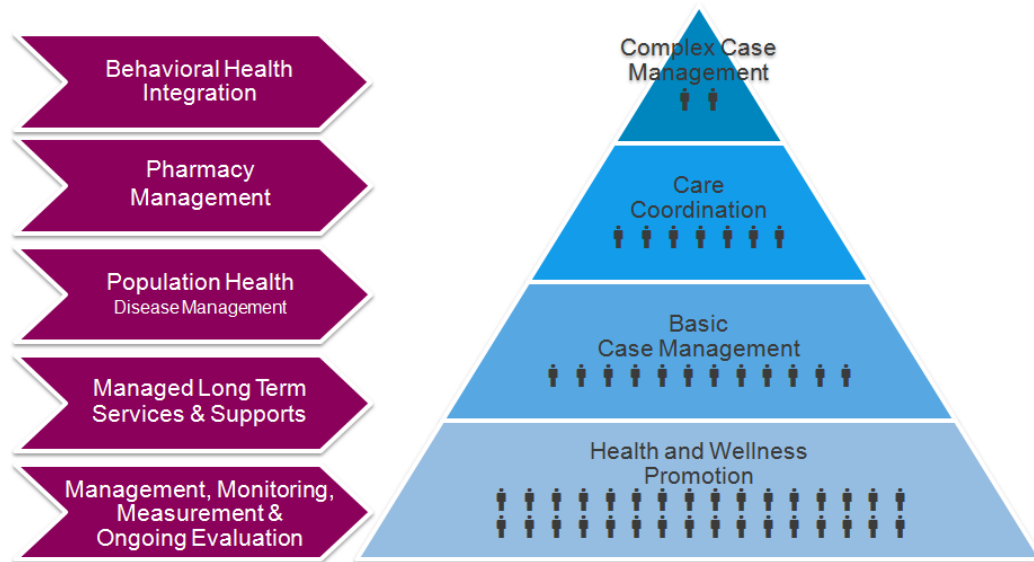
The purpose of the QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members. Through the QI Program, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

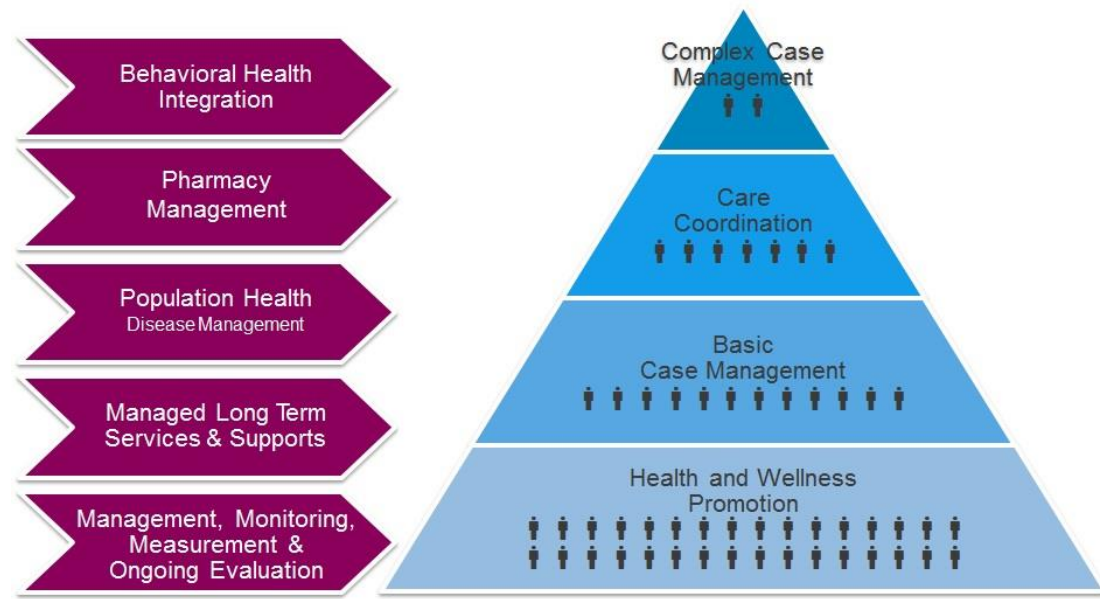
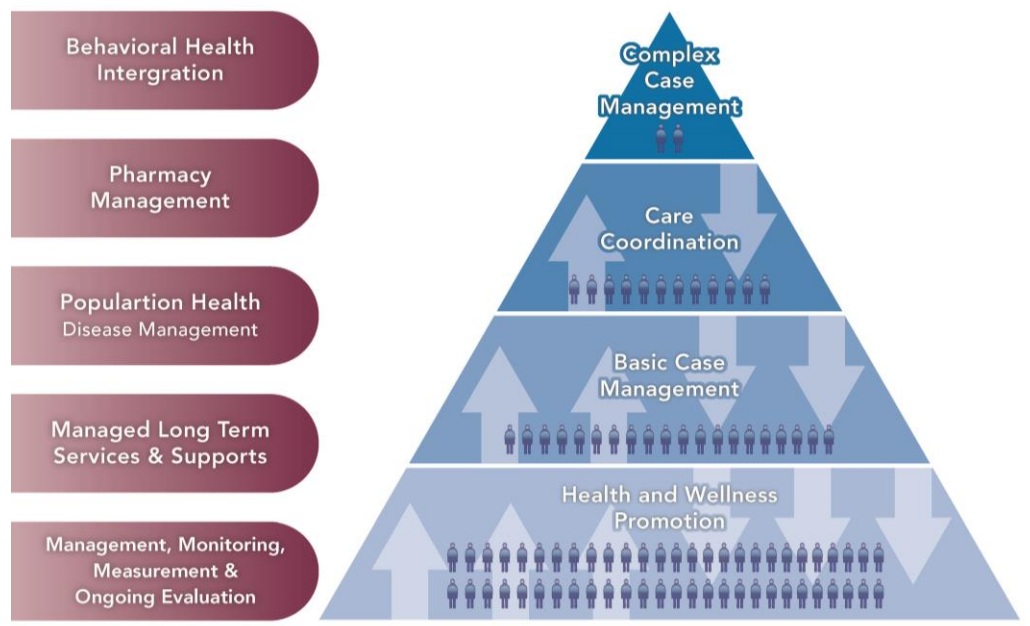
The QI Program incorporates continuous QI methodology that focuses on the specific needs of multiple stakeholders (members, health care providers and community and government agencies):

- It is organized to identify and analyze significant opportunities for improvement in care and service
- It fosters the development of quality 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 and projects carried out on an ongoing basis to ~~monitor~~ that quality of care issues are identified and corrected as needed

The QI Program supports a population health management approach, stratifying our population based on their health needs, conditions, and issues and aligns the appropriate resources to meet these needs. Our model follows an intervention hierarchy, as shown below:

## Care Management Model

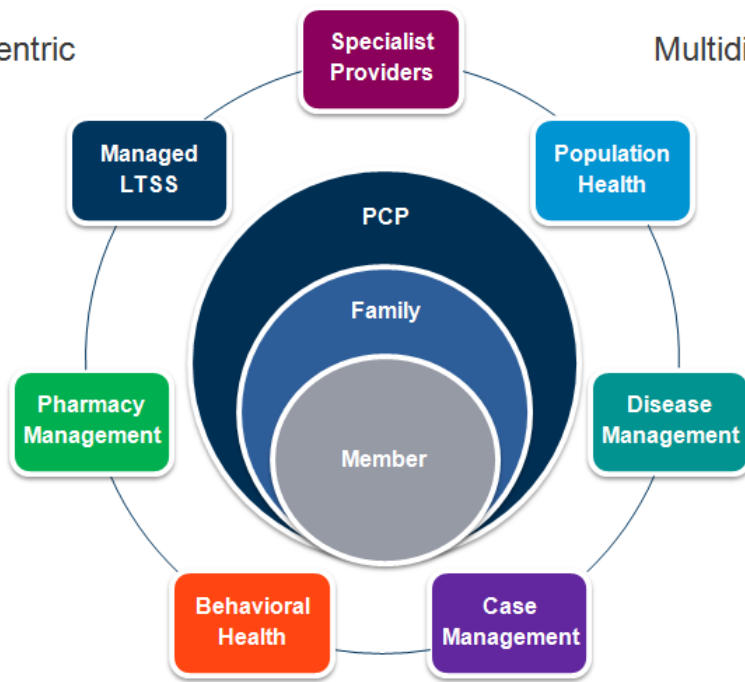


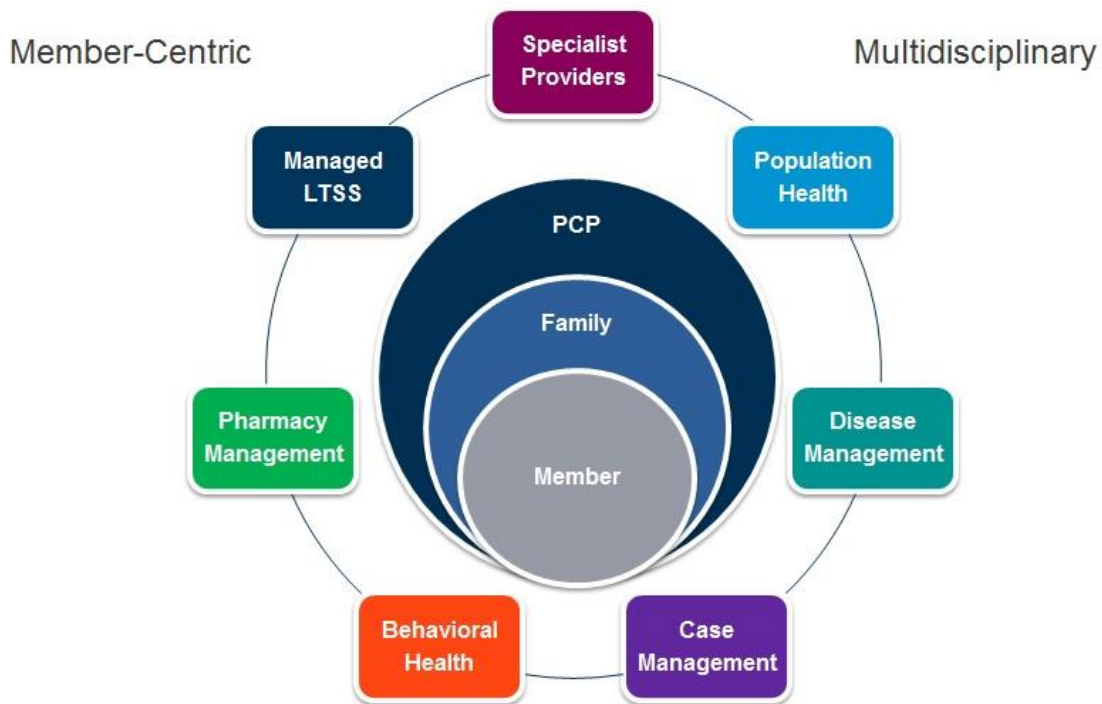
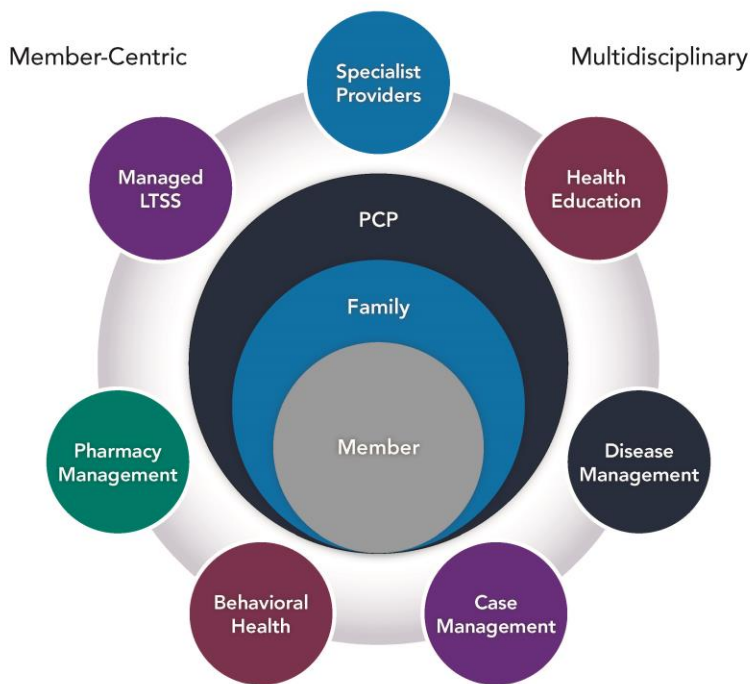


In addition, our model recognizes the importance of multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, and care settings, — plus our internal experts, supports a member-centric approach to care/care coordination.

Member-Centric

Multidisciplinary





### QI Goals and Objectives

QI goals and objectives are to monitor, evaluate and improve:

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- The important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to its demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care

- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on at least three identified opportunities
- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Member and provider satisfaction, including the timely resolution of complaints and grievances
- Risk prevention and risk management processes
- Compliance with regulatory agencies and accreditation standards
- Annual review and acceptance of the UM Program Description and Work Plan
- The effectiveness and efficiency of internal operations
- The effectiveness and efficiency of operations associated with functions delegated to the contracted ~~medical groups~~ Health Networks
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values
- Compliance with Clinical Practice Guidelines and evidence-based medicine
- ~~Compliance with regulatory agencies and accreditation standards (NCQA)~~
- Support of the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently

In addition, the QI Program:

- ~~Set~~Sets expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes
- ~~Support~~Supports the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitors utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers
- ~~Provide~~Provides oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals
- Makes certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — Orange County Health Care Agency — which may include, but are not limited to, methicillin resistant *Staphylococcus aureus* (MRSA), scabies, tuberculosis, etc., as reported by the HNs.
- ~~Promote~~Promotes patient safety and minimizes risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and works with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDOs) to assure that steps are taken to resolve and prevent recurrences

#### **QI ~~Measureable~~Measurable Goals ~~from~~for the Model of Care**

The Model of Care (MOC) is member-centric by design, and monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care- for the OneCare and OneCare Connect lines of business. The MOC meets the needs of ~~the~~ special member populations through strategic activities ~~and goals~~. Measureable. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. ~~These are reported to the QI Committee.~~ Please see the Model of Care Quality Matrix in the ~~2017~~2018 QI Work Plan. Results are communicated quarterly to the QI Committee and evaluated annually.

## QUALITY IMPROVEMENT WORK PLAN

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and CalOptima's Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. QI Work Plan ~~addendums~~ addenda may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers & Systems (CAHPS), Stars and HOS scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the State or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan and a separate UM Work Plan that includes:

- Care Coordination/Complex Case Management
- LTSS
- ~~Population~~ Health Education & Disease Management
- Organizational Quality Improvement Projects (~~t, Health Assessments and related CCIP, QIPs, PIPs, CCIPs, PDSAs~~)
- Access and Availability to Care
- Member Experience and Service (CAHPS)
- Patient Safety and Pharmacy Initiatives
- HEDIS, STARS and HOS Improvement
- Delegation Oversight
- ~~Organizational Quality Projects~~
- QI Program scope
- Yearly objectives
- Yearly planned activities

- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program
- Priorities for QI activities based on the specific needs of CalOptima's organizational needs and specific needs of Cal Optima's populations for key areas or issues identified as opportunities for improvement
- Priorities for QI activities based on the specific needs of CalOptima's populations, and on areas identified as key opportunities for improvement
- Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified

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

(SEE APPENDIX A — ~~2017~~2018 QI WORK PLAN)

## UTILIZATION MANAGEMENT

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those which are established as safe and effective, consistent with symptoms and ~~diagnosis~~diagnoses and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the ~~2017~~2018 UM Program, all review staff are trained and audited in these principles. ~~Clinical~~Licensed clinical staff ~~makes all medical necessity decisions~~reviews and ~~any denial~~approves requested services based on medical necessity ~~is made only~~utilizing evidence-based, review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer, ~~including or further~~either other qualified reviewer, to make adverse determinations. This also includes those decisions made by delegated HNs. Medical Directors actively engage subspecialty physicians as peer review consultants to assist in medical necessity determinations. Adherence to standards and evidence-based clinical criteria is obtained by cooperative educational efforts, personal contact with providers and monitoring through clinical studies.

Further details of the UM Program, activities and measurements can be found in the ~~2017~~2018 UM Program Description and related Work Plan.

## BEHAVIORAL HEALTH

CalOptima monitors and works to improve the quality of behavioral health care and services provided to our members. The Behavioral Health Integration Department reviews the quality and

outcomes of behavioral health services delivered to the members within our network of practitioners and providers.

The quality of Behavioral Health services may be determined through, but not limited to the following:

- Access to care
- Availability of practitioners
- Coordination of care
- Medical record and treatment record documentation
- Complaints and grievances
- Appeals
- Compliance with evidence-based clinical guidelines
- Language assistance
- HEDIS and STAR measurements

The Medical Director responsible for Behavioral Health services is involved in the behavioral aspects of the QI Program. The BH Medical Director is available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, providing behavioral health QI statistical data and follow-up on identified issues.

## **ENTERPRISE ANALYTICS**

Enterprise Analytics provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, Enterprise Analytics drives the development of the strategy and roadmap for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the roadmap. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services and Medical Affairs, the Enterprise Analytics team develops or extends the data architecture and data definitions. Through work with key users of data, Enterprise Analytics develops the platform(s) and capabilities to meet CalOptima's critical information. This capability for QI includes provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, and PDSA on LTC inpatient admissions.  
~~CalOptima focuses on the continuum of care for both medical and behavioral health services. Focusing on continuity and coordination of care, CalOptima monitors and works to improve the quality of behavioral health care and services provided to our members. The QI Program includes services for behavioral health and review of the quality and outcomes of those services delivered to the members within our network of practitioners and providers.~~

~~The quality of Behavioral Health services may be determined through, but not limited to the following:~~

- ~~Access to care~~
- ~~Availability of practitioners~~
- ~~Coordination of care~~
- ~~Medical record and treatment record documentation~~
- ~~Complaints and grievances~~
- ~~Appeals~~

- ~~Compliance with evidence-based clinical guidelines~~
- ~~Language assistance~~
- ~~HEDIS and STAR measurements~~

~~The Medical Director responsible for Behavioral Health services is involved in the behavioral aspects of the QI Program. The BH Medical Director is available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, providing behavioral health QI statistical data and follow up on identified issues. The BH Medical Director shall serve as the chairperson of the BH QI Committee which is a subcommittee of the CalOptima QI Committee. The BH Medical Director also serves as a voting member of CalOptima's QI Committee.~~

## CONFIDENTIALITY

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QI Committee and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs, SRGs and, MBHOs and PMGs hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a Confidentiality Agreement. This Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

## CONFLICT OF INTEREST

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employeeemployed positions serving on the the QI/UM Committees and subcommittees. Additionally, A~~all employees who make or participate in the making of~~ or participate in the

making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.  
decisions that may which foreseeably may have a material effect on substantial economic interests impact and are in positions designated in the CalOptima Conflict of Interest Code, file a Statement of Economic Interests form and the supplement to Form 700 on an annual basis.

Fiscal and clinical interests are separated. CalOptima and its delegates do not provide any financial rewards or incentives to practitioners or other individuals conducting utilization review for issuing denials of coverage, services or care.

## STAFF ORIENTATION, TRAINING AND EDUCATION

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective positions.

Each new employee is provided ~~an intensive, hands-on training and~~ orientation ~~program and job specific training~~ with a staff ~~preceptor~~ member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct Training
- Workplace Harassment Prevention Training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies & procedures, etc.
- ~~Appeals process~~
- Seniors and Persons with Disabilities Awareness Training
- Cultural Competency Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for ~~continuing~~ education reimbursement for ~~each licensed employee~~ employees.

MOC-related employees, ~~and~~ contracted providers and practitioners networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

## SAFETY- PROGRAM

Member (patient) safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner.* By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery organization continuum oversight and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety.

This ~~safety program~~ plan is based on a needs assessment and includes the following areas:

- Identification and prioritization of patient safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Plans to conduct appropriate patient safety training and education are available to members, families and health care personnel/physicians
- Patient safety program and its outcomes to be reviewed annually
- Health education and promotion
- Group Needs Assessment
- Over/Under Utilization monitoring
- Medication Management
- ~~Case Management~~ Health Education & Disease Management
- Operational Aspects of Care and Service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to -assess the member's comprehension through their language, cultural and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care; (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the Pharmacy & Therapeutics (P&T) Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating Americans with Disabilities Act (ADA) and Seniors and Persons with Disabilities (SPD) site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to -promote that equipment is kept in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including CBAS, SNF, and MSSP settings ~~and Long Term Services and Supports (LTSS) settings~~
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post-operative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of flu and pneumonia vaccine
- Administrative offices
  - Fire, disaster, and evacuation plan, testing and annual training
  -

## QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

### COMMITTEES AND KEY GROUP STRUCTURES

#### Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to review and accept the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC shall also make recommendations for annual modifications of the QI program and actions to be taken when objectives are not met. CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's QAC meetings are open to the public.

#### Member Advisory Committee

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventative services and contracting. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries

- Children
- Consumer
- Family Support
- Foster Children
- Long Term Care Services and Support
- Medi-Cal beneficiaries
- Medically indigent persons
- Orange County Health Care Agency
- Orange County Social Services Agency
- Persons with disabilities
- Persons with mental illnesses
- Persons with Special Needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions—held by the Health Care Agency and the Social Services Agency—are permanent. Each of the remaining 13 appointed members serve two year terms with no term limits.

#### **OneCare Connect Member Advisory Committee**

The OCC Member Advisory Committee (OCC MAC) is comprised of 10 voting members, each seat representing a constituency served by OCC and four non-voting liaisons representing county agencies, collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home and Community Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
  - Orange County Social Services Agency
  - Orange County Community Resources Agency, Office on Aging
  - Orange County Health Care Agency, Behavioral Health
  - Orange County IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two year terms with no term limits.

#### **Provider Advisory Committee**

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima

members. The PAC is comprised of 15 members, 14 of whom serve three year terms with two consecutive term limits, along with a representative of the Orange County Health Care Agency, which maintains a standing seat voting members, each who serve three year terms with the exception of the Orange County Health Care Agency which maintains a standing seat representing a constituency that works with CalOptima and our members. These is not subject to term limits. The 15 seats include:

- HNs
  - Health Network (1 seat)
- Hospitals (1 seat)
- Physicians (3 seats)
- Nurses
  - Nurse (1 seat)
- Allied Health Services (1 seat)
- Community Clinics/Health Centers (1 seat)
- Orange County Health Care Agency (HCA) (1 standing seat)
- LTSS/Long Term Services and Support including (LTC facilities and CBAS) (2 seats)
- Mid level practitioners
  - Non Physician Medical Practitioner (1 seat)
  - Traditional/Safety Net (1 seat)
- Behavioral/mental health/Mental Health (1 seat)
  - Pharmacy (1 seat)

### **Quality Improvement Committee (QIC)**

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

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted HMOs, PHCs, SRGs, and MBHO, and PMGs to achieve the end result of improved care and services for members. The QIC oversees the performance of delegated functions by its HMOs, PHCs, SRGs, and SRGs, and MBHO, and PMGs and contracted provider and practitioner partners. The composition of the QIC includes a participating Behavioral Health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects (QIP), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC.

Responsibilities of the QI Committee include the following:

- Recommends policy decisions
- Analyzes for effective operation and evaluates policy decisions/achievement of objectives
- Oversees the analysis and evaluation of QI activities

- Makes certain that there is practitioner participation ~~in the QI Program~~ through attendance and discussion in the planning, design, implementation and review ~~of the QI program activities~~
- Identifies and prioritizes needed actions and interventions to improve quality
- Makes certain that there is follow-up as necessary to determine their effectiveness

Practice patterns of providers, practitioners, HMOs, PHCs, SRGs, and MBHO, ~~and PMGs~~ are evaluated, and recommendations are made to promote practices that all members receive medical care that meets CalOptima standards.

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

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, HMOs, PHCs, SRGs, and MBHO, ~~and PMGs~~.

The QI Projects themselves consist of four (4) cycles:

- **Plan** Detailed description and goals
- **Do** Implementation of the plan
- **Study** Data and collection
- **Act** Analyze data and develop conclusions

The goal of the QI Program is to improve the health outcomes of members through systematic and ongoing monitoring of specific focus areas and development and implementation of ~~QI Projects~~projects -and interventions designed to improve provider and practitioner and system performance.

The QIC provides overall direction for the continuous improvement process and monitors that process to ensure that activities are consistent with CalOptima's strategic goals and priorities. It promotes efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

The composition of the QIC is defined in the QIC Charter, and includes, but may not be limited to, the following:

### **Voting Members**

- Four (4) participating physicians or practitioners, with no more than two (2) administrative medical directors
- CalOptima CMO/DCMO (Chair)
- ~~CalOptima Medical Director, Quality (Chair)~~
- CalOptima Medical Director also representing the UM Committee
- CalOptima Medical Director, Behavioral Health also representing the Behavioral Health Quality Improvement Committee (BHQIC)
- Executive Director, Clinical Operations
- Executive Director, -Network Management
- Executive Director, Operations

●—Director, ~~Business Integration~~

The QIC is supported by:

Executive Director, Quality ~~Improvement~~ & Analytics  
Director, Quality Improvement  
Director, Quality Analytics  
Director, Health Education & Disease Management  
Committee Recording ~~Secretary~~ as assigned

**Quorum**

A quorum consists of a majority of the voting members (~~at least six~~6) of which at least four (4) are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by ~~phone~~telephone.

The QIC ~~meets no less than~~shall meet at least eight (8) times per calendar year, and reports to the Board QAC ~~no less than~~ quarterly.

QIC and all QI subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

### **Minutes of the Quality Improvement Committee (QIC)**

Contemporaneous minutes reflect all Committee decisions and actions. These minutes are dated and signed by the Committee Chair to demonstrate that they are representative of the official findings of the committee.

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

- Goals and objectives outlined in the QI Charter
- Active discussion and analysis of quality issues ~~analysis~~
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of work plan activities

All agendas, minutes, reports, and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and not reproduced (except for Quality Profile documentation) in order to maintain confidentiality, privilege and protection.

### **~~QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES~~**

### Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ensure that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all external medical staff. ~~The CPRC's review and findings and reported through the QIC are reported to the QIC at least quarterly.~~

The goals of the CPRC include:

1. Maintain a peer review and credentialing program that aligns with regulatory (DHCS, ~~and DMHCS~~, CMS) and accreditation (NCQA) standards.
2. Promote continuous improvement of the quality of health care provided by providers in CalOptima Direct/CalOptima Community Network and its delegated HNs.
3. Conduct peer-level review and evaluation of provider performance and credentialing information against CalOptima requirements and appropriate clinical standards.
4. Investigate patient care outcomes that raise quality and safety concerns for corrective actions, as appropriate.

CPRC primary responsibilities include:

1. Provide peer review and credentialing functions for CalOptima.
2. Review reports submitted by internal departments including but not limited to Audit & Oversight, QI (PQI issues), and GARS (complaints) and ~~take evaluate to determine if further~~ action is required for credentialing or quality issues, ~~as appropriate.~~
3. Provide guidance and peer participation in the CalOptima credentialing and re-credentialing processes to ensure that all providers that serve CalOptima members meet generally accepted standards for their profession or industry.
4. Make final ~~determinations~~ recommendations regarding the eligibility of providers to participate in the CalOptima program based on CalOptima policies and applicable standards.
5. Review, investigate, and evaluate the credentials of CalOptima Direct/CalOptima Community Network practitioners and internal CalOptima medical staff.
6. Review facility site review results and oversee all related actions.
7. Investigate, review and evaluate quality of care matters referred by CalOptima's functional departments (including, without limitation, Customer Service, GARS, UM, Case Management, Pharmacy and LTSS) and/or the CMO or his/her physician designee related to CalOptima Direct/CalOptima Care Network or its delegated HNs.
8. Initiate and monitor imposed provider corrective actions and make adverse action recommendations, as necessary and appropriate.

In addition, as a part of CalOptima's Patient Safety Program, and utilizing the full range of methods and tools of that program, CalOptima conducts Sentinel Event monitoring. ~~A Sentinel Event is defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof."~~ The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Sentinel Event monitoring includes patient safety monitoring across the entire continuum of CalOptima's contracted providers: HMOs, PHCs, SRGs, ~~and MBHO, PMGs~~, and health care delivery organizations. The presence of a Sentinel Event is an indication of possible quality issues, and the monitoring of such events will increase the likelihood of early detection of

developing quality issues so that they can be addressed as early as possible. Sentinel Event monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program's consumer-complaint-oriented system.

All medically related quality of care cases are ~~reviewed by the~~presented at CPRC to determine the appropriate course of action and/or evaluate the actions recommended by an HMO, PHC, SRG, MBHO, ~~or PMG~~ delegate. Board certified peer-matched specialists are available to review complex cases as needed. Results of peer review are used at the reappointment cycle, or upon need, to review the results of peer review and determine the competency of the provider. This is accomplished through routine reporting of peer review activity to HMOs, PHCs, SRGs, and MBHO and PMGs for incorporation in their re-credentialing process.

The CPRC shall consist of a minimum of five physicians selected on a basis that will provide representation of active physicians from the CalOptima Community Network~~Direct network (CCN) and/or the Health Networks (HNs)~~. Physician participants shall represent a range of practitioners and specialties from CalOptima's network~~various specialties, including, but not limited to, general surgery, OB/GYN and primary care~~. In addition, the CPRC chairperson, ~~and CalOptima's CMO or DCMO/DCMO and CalOptima Medical Directors~~ are considered part of the Committee and, as such, are voting members. ~~The CPRC provides reports to CalOptima QI Committee at least quarterly.~~

#### **Grievance and Appeals Resolution Services CSubcommittee (GARS)**

The GARS ~~sub~~committee serves to protect the rights of our members, ~~and to~~ promote the provision of quality health care services and ~~enforces~~ensures that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS ~~sub~~committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS ~~sub~~committee meets at least quarterly and reported through the QIC~~and reports to the QIC~~.

#### **Pharmacy & Therapeutics SubCommittee (P&T)**

The P&T ~~sub~~committee is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T includes practicing ~~physicians and the contracted provider networks~~. ~~A majority of the members of the P&T are~~ physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T provides written decisions regarding all formulary development and revisions. The P&T meets at least quarterly, and reports to the UMC~~subcommittee~~.

#### **Utilization Management CSubcommittee (UMC)**

The UMC ~~subcommittee~~ promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM ~~sub~~committee is multidisciplinary, and provides a comprehensive

approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC ~~subcommittee~~ monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, SRGs, ~~and MBHO, and PMGs~~ to identify areas of under or over utilization that may adversely impact member care. The UMC ~~subcommittee~~ oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as development of Evidence Based Clinical Practice Guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. The UM ~~sub~~committee meets quarterly and ~~reported~~ through the QIC reports to the QIC.

The UMC ~~subcommittee~~ includes a minimum of four practicing physician representatives, reflecting CalOptima's HMO, PHC, SRG, ~~and MBHO, and PMG~~ composition, and is appointed by the CMO. The composition includes a participating Behavioral Health practitioner\* to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed. Additionally, the UMC also includes and is supported by the following staff positions:

CMO/DCMO

Medical Director, Concurrent Review

Director, Utilization Management

Director, Pharmacy

Director, Enterprise Analytics

Manager, Referral/Prior Authorization

Manager, Concurrent Review

#### Quorum:

A quorum consists of fifty percent (50%) plus one of the voting members, with at least three non CalOptima employee members present ~~participation and of the eleven, the minimum quorum must include three committee participants from the community~~. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

*\* Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.*

#### **Benefit Management Subcommittee (BMSC)**

The purpose of the BMSC is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its program lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee reports to the Utilization Management Committee, and shall also see to it that benefit updates are implemented, and communicated accordingly, to internal CalOptima staff, and that updates are provided to contracted HMOs, PHCs, SRGs, MBHO, ~~and PMGs~~. The Government Affairs/~~Legislative Affairs~~ department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules.

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### **Long-Term Services and Supports QI Subcommittee (LTSS-QISC)**

The LTSS subcommittee is composed of representatives from the LTC, CBAS, ~~HSS~~ and MSSP communities, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. LTSS subcommittee members serve as specialists to assist CalOptima in the development, implementation, and evaluation of ~~establishing~~ criteria and methodologies to measure and report quality and access standards with HCBS and in LTC facilities where CalOptima members reside. The LTSS subcommittee also serves to identify best practices, monitor over and underutilization patterns, and partner with facilities to share the information as it is identified. The LTSS subcommittee meets quarterly and reports through Clinical Operations subcommittee and reported through the QIC to the QIC.

### **Behavioral Health Quality Improvement Committee (BHQIC)**

The BHQIC ensures members receive timely and satisfactory behavioral health care services, through enhancing integration and coordination between physical health and behavioral health care providers, monitoring key areas of services to members and providers, identifying areas of improvement and guiding CalOptima towards the vision of bi-directional behavioral health care integration.

The BHQIC responsibilities are to:

- Ensure adequate provider availability and accessibility to effectively serve the membership
- Monitor member experience with behavioral health services including call center, grievance and appeals, and potential for quality improvement
- Oversee the functions of delegated activities
- Monitor ~~that~~ care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure ~~that~~ member benefits and services are not underutilized and ~~that~~ assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize member and network provider satisfaction study results when implementing quality activities
- Maintain compliance with evolving NCQA accreditation standards
- Communicate results of clinical and service measures to network providers
- Document and report all monitoring activities to appropriate committees

The designated chairman of the BHQIC ~~subcommittee~~ is the Medical Director, Behavioral Health, who is responsible for chairing the ~~subcommittee~~ and reporting through the QIC as well as reporting findings and recommendations to QIC.

The composition of the BHQIC is defined in the BHQIC Charter and includes, but may not be limited to the following:

- Medical Director, Behavioral Health Integration (Chair)
- Chief Medical Officer/Deputy Chief Medical Officer
- ~~Medical-Executive~~ Director, Quality and Analytics
- Executive Director, Clinical Operations
- Medical Director, Utilization Management
- Director, Behavioral Health Integration Services
- Clinical Pharmacist
- Medical Director, Orange County Health Care Agency
- Medical Director, MBHO

- Chief Clinical Officer, MBHO
- Medical Director, Health Network
- Medical Director, Regional Center of Orange County
- Contracting Behavioral Health Care Practitioners

The BHQIC shall meet, at a minimum, on a quarterly basis, or more often as needed.

Additionally, CalOptima is formalizing two additional subcommittees to QIC, focusing on Clinical Operations and Member Experience.

### **Clinical Operations/Population Health Subcommittee (COPHS)**

The purpose of the COPHS is to oversee, guide and ensure the integration and coordination of functions across the continuum of care, including, but not limited to, population health, [disease health](#) management, care management, complex case management, UM, LTC, pharmacy & behavioral health services. This subcommittee monitors the progress of the established program goals and metrics defined for CalOptima's disease management, complex case management programs and Model of Care. COPHS reviews these programs at least quarterly, [- report](#) [see through the QIC](#) and includes the following key individuals:

- Chief Medical Officer/Deputy Chief Medical Officer
- Executive Director, Clinical Operations
- Executive Director, Quality & Analytics
- Director, Case Management
- Director, Utilization Management
- Director, Health Education & Disease Management
- Director, Enterprises Analytics
- Director, Quality Analytics
- Director, Long-Term Services & Supports
- Director, Quality Improvement
- Director, Clinical Outcomes
- Director, Clinical Pharmacy Management
- Director, Behavioral Health Services.

### **Member Experience Subcommittee (MESMEMX)**

The final subcommittee in the quality committees structure is [MESMEMX](#) and focuses on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC, OCC and LTSS. NCQA Medicaid Plan Ratings measure three dimensions – Prevention, Treatment and Customer Satisfaction. CalOptima's QI program focuses on the performance in each of these areas. The [MESMEMX](#) is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access [&and](#) availability (CCN [&and](#) the HNs), review customer service metrics, and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.

This subcommittee meets at least bi-monthly [and is reported through the QIC](#) and includes the following key individuals:

- Chief Medical Officer/Deputy Chief Medical Officer or designee
- Executive Director, Quality & Analytics
- Director, Customer Service

- Director, Grievances & Appeals
- Director, Network Management
- Director, Provider Services
- ~~Manager, Access & Availability~~
- ~~Director, Quality Analytics~~
- Director, Health Education & Disease Management
- Director, Utilization Management
- Manager, Quality Analytics

The MEMXS focuses on improving the following key areas of satisfaction:

- Getting needed care ~~&~~and getting care quickly
- How well doctors communicate
- Customer service
- Rating of health care, providers and health plan
- Care coordination
- Access & Availability
- Other areas as defined by specific metrics, focus groups or survey results.

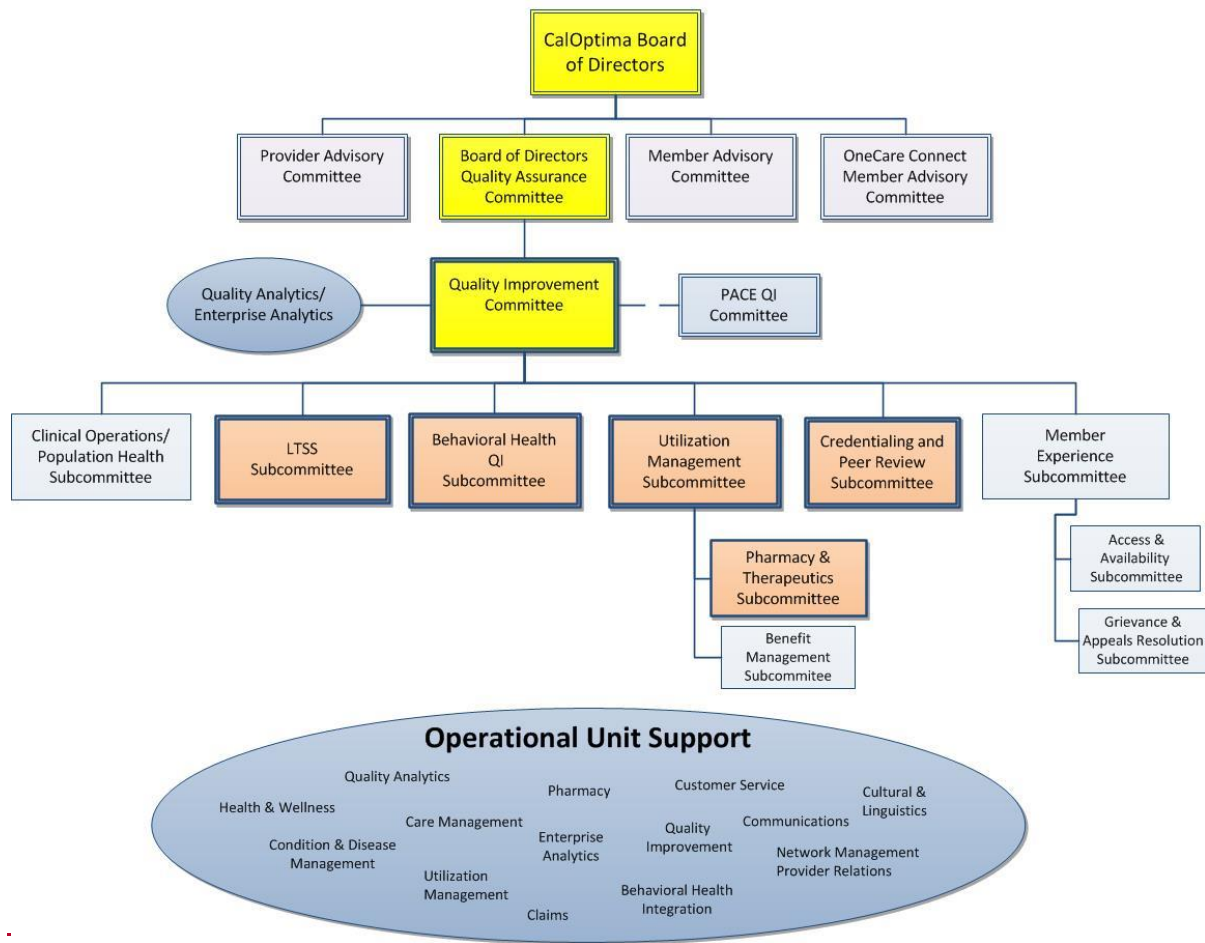
#### **Whole-Child Model Clinical Advisory Committee (WCM CAC)**

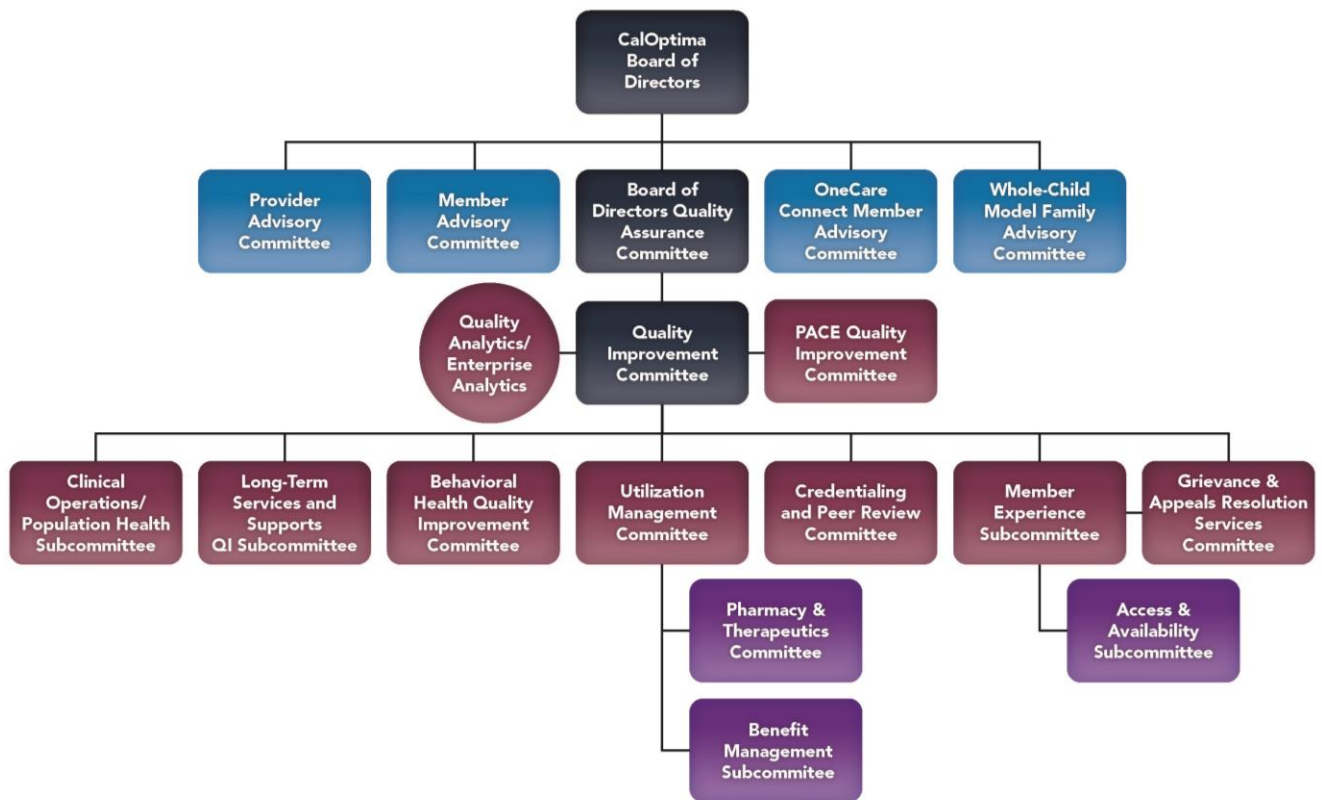
The WCM CAC is required by the state. The WCM CAC will report to the QI Committee, and is anticipated to be established in Fall 2018. The WCM CAC will advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, etc.

The committee must include the following key individuals:

- Chief Medical Officer or equivalent
- County of Orange CCS Medical Director
- CCS Paneled Providers — at least 4

## 20172018 Committee Organization Structure — Diagram





## METHODOLOGY

### QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous ~~HMO, PHC, SRG, PMG~~, and internal monitoring activities, including, but not limited to, (a) potential quality concern (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) satisfaction surveys, (f) HEDIS results, and (g) other subcommittee unfavorable outcomes
- Measures required by regulators such as DHCS and CMS

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term services and supports, and ancillary care services

- Access to and availability of services, including appointment availability, as described in the UM Program and in policy and procedure
- Coordination and continuity of care for SPD
- Provisions of chronic, complex care management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization.

- Staff, administration, and physicians provide vital information necessary to support continuous performance improvement, and is occurring at all levels of the organization
- Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
- Project coordination occurs through the various leadership structures: Board of Directors, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
- These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

### QI Project Quality Indicators

Each QI Project will have at least one (and frequently more) quality indicator(s). While at least one quality indicator must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Quality indicators will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, and MBHO, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS & STARS measures are acceptable.

Quality indicators may be ~~either~~ outcome measures, or process measures where there is strong clinical evidence of the correlation between the process and member outcome. -This evidence must be cited in the project description.

## **QI Project Measurement Methodology**

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized. See explanation of Clinical Data Warehouse below.

For studies or measures that require data from sources other than administrative data (e.g. medical records), sample sizes will be a minimum of 411 (with 5 to 10% over sampling), in order conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score.

CalOptima also uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

- Plan**
- 1) Identify opportunities for improvement
  - 2) Define baseline
  - 3) Describe root cause(s)
  - 4) Develop an action plan
- Do**
- 5) Communicate change ~~plan~~
  - 6) Implement change plan
- Study**
- 7) Review and evaluate result of change
  - 8) Communicate progress
- Act**
- 9) Reflect and act on learning
  - 10) Standardize process and celebrate success

## **CARE OF MEMBERS WITH COMPLEX NEEDS**

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt-out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education and member incentive programs

- Use of evidenced- based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)
- Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
- Coordinating services for members for appropriate levels of care and resources
- Documenting all findings
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination and basic are specific to SPD, OCC and OC members who have either completed a HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic), or the Health Network/Group and system (primary), or system/transition level (care coordination or complex) level, dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, but not limited to a Medical Director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietician, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an ICP
      - Communication with members or their representatives, vendors, and medical group
      - Review and update the ICP at least annually, and when there is a change in the member's health status
      - Referral to the primary ICT, as needed
- Primary ICT for Moderate to High-Risk Members — ICT occurs at the Physician Medical Group (PMG) level Health Network or ~~the~~ Health Plan for Community Network

- ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, health network (HN) Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker
  - Roles and responsibilities of this team:
    - Identification and management of planned transitions
    - Case management of high risk members
    - Coordination of ICPs for high risk members
    - Facilitating member, PCP and specialists, and vendor communication
    - Meets as frequent as is necessary to coordinate and care and stabilize member's medical condition

**~~Complex ICT for High-Risk Members—ICT at the Physician Medical Group (PMG) level or Health Plan for Community Network~~**

**~~Team Composition (as appropriate for identified needs): member, caregiver, or authorized representative, HN Medical Director, CalOptima clinical/HN case manager, PCP and/or specialist, social worker, and behavioral health specialist~~**

**~~Roles and responsibilities of this team:~~**

**~~Consultative for the PCP and HN teams~~**

**~~Encourages member engagement and participation in the ICT process~~**

**~~Coordinating the management of members with complex transition needs and development of ICP~~**

**~~Providing support for implementation of the ICP by the HN~~**

**~~Tracks and trends the activities of the ICTs~~**

**~~Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the ICTs to identify areas for improvement~~**

**~~Oversight of the activities of all transition activities at all levels of the delivery system~~**

**~~Meets as often as needed until member's condition is stabilized~~**

### **Dual Eligible Special Needs Plan (SNP)/OC and OCC**

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help patients regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow-up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals (e.g., patients dually eligible for Medicare and Medicaid or patients who are institutionalized)
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning
- Care management program focused on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life

CalOptima's goals for ~~2017~~2018 are:

- Continue with the comprehensive assessment strategy
- Measure and assess the quality of care CalOptima provides
- Evaluate how CalOptima addresses the special needs of our beneficiaries
- Drive interventions and actions when opportunities for improvement are identified

Please reference the ~~2017~~2018 Case Management Program Description for further details and program plans.

### **DISEASE-HEALTH MANAGEMENT PROGRAM**

The Disease-Health Management (HDM) program —is a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner and CalOptima. The HDM program stratifies the population and identifies appropriate interventions based on member needs. These interventions include coordinating care for members across locales and providing services, resources, and support to members as they learn to care for themselves and their condition. The HDM program also identifies those members in need of closer management, coordination and intervention. CalOptima assumes responsibility for the

[HDM](#) program for all of its lines of business, therefore the management for [HDM](#) is not delegated to the PHCs, SRGs, [and HMOs and PMGs](#). The contracted PHCs, SRGs, [and HMOs and PMGs](#) must participate collaboratively with interventions necessary to produce identified quality outcomes. The [HDM](#) Program is evaluated on an annual basis [and reported through the QIC](#).

Further details of the [HDM p](#)Programs, activities and measurements can be found in the [20172018 HDM Programs](#) Description.

## QUALITY ANALYTICS

Core to the QI Program is the statistical analysis of various data sources to support continuous quality improvement of our programs, projects, activities, and initiatives.- CalOptima's Clinical Data Warehouse is a dynamic environment which aggregates data from various core business processes, such as member eligibility, provider, encounters, claims, pharmacy and care management systems to support the QI program. The clinical data warehouse allows staff to apply logic, population definitions and/or evidence-based guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures and outcomes measures. CalOptima staff creates and maintains the database with quarterly data updates.

Based upon evidence-based practice guidelines built into the system, the clinical data warehouse can assess the following:

- Identify and stratify members with certain disease states
- Identify over/under utilization of services
- Identify missing preventive care services
- Identify members for targeted interventions

### **Identification/Stratification of Members**

Using clinical business rules, the data warehouse identifies members with [a](#)-specific diseases or conditions, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease or condition, the database is designed to detect treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.

### **Identify Over/Under Utilization of Services**

Using clinical business rules, the data warehouse can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days.

### **Identify Missing Preventive Care Services**

The data warehouse can identify members who are missing preventative care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50 or a retinal eye exam for a diabetic.

### **Identify Members for Targeted Interventions**

The rules for identifying members and initiating the intervention are customizable to CalOptima to fit our unique needs. By using the standard clinical rules and customizing CalOptima specific rules, the database is the primary conduit for targeting and prioritizing health education, disease management and HEDIS or Stars related interventions.

By analyzing data that CalOptima currently receives (i.e. claims data, pharmacy data, and encounter data) the data warehouse can identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, STARS and HOS measures. This information will guide CalOptima in not only targeting the members, but also the HMOs, PHCs, SRGs, [and](#) MBHO, ~~PMGs~~, and providers who need additional assistance.

### **Medical Record Review**

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality indicator) is accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be conducted by the Director, Quality Analytics or designee. If validation is not achieved on all records samples, a further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, are maintained for a minimum period, in accordance with applicable law and contractual requirements.

### **Interventions**

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

### **Improvement Standards**

**A. Demonstrated Improvement**

Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.

**B. Sustained Improvement**

Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

**Documentation of QI Projects**

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal.
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality indicator
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection, and analysis timelines
- Evaluation of re-measurement performance on each quality indicator

## **KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE**

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical “home” for each member. The primary care practitioner is this medical “home” for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the CalOptima model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.

- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

#### ~~Clinical Care and Service:~~

##### • Clinical Care and Service

- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions
- Complex Case Management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM/CM Program and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/under utilization
- Disease management

#### Administrative Oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse\* as it relates to quality of care

\* CalOptima has a ~~zero-tolerance~~zero-tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

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## DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to HMO, PHC, SRG, [and MBHO](#), ~~and PMG~~ contractors who are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

### **Delegation Oversight**

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. Predelegation review is conducted through the Audit ~~and~~ Oversight department and overseen by the Delegation Oversight Committee reporting to the Compliance Committee.

### **Non-Delegated Activities**

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services
- QI program for all lines of business, HMOs, PHCs, SRGs, [and MBHO](#), ~~and PMGs~~ must comply with all quality related operational, regulatory and accreditation standards
- [Medi-Cal Behavioral Health](#)
- DM program, may otherwise be referred to as Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, peer review process on specific, referred cases
- Development of system-wide indicators, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and health care delivery organizations (HDOs)
- Credentialing and re-credentialing of HDOs
- Development of UM and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with State and Federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

Further details of the delegated and non-delegated activities can be found in the [20172018](#) Delegation Grid.

SEE APPENDIX B — [20172018](#) DELEGATION GRID

## CULTURAL & LINGUISTIC SERVICES

CalOptima serves a large and culturally diverse population. The five most common languages spoken for all CalOptima programs are: English at 57 percent, Spanish at 28 percent, Vietnamese at 10 percent, Farsi at one percent, Korean at one percent, Chinese at one percent, Arabic at one percent and all others at three percent, combined. CalOptima provides member materials in:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic
- OC member materials are provided in three languages: English, Spanish and Vietnamese
- OCC member materials are provided in ~~five~~seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and ~~Farsi~~Arabic.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. See CalOptima Policy DD. 2002 — Cultural and Linguistic Services for a detailed description of the program.

Objectives for serving a culturally and linguistically diverse membership include:

- Analyze significant health care disparities in clinical areas
- Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Consider outcomes of member grievances and complaints
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language or gender specific risks
- Identify and reduce a specific health care disparity affecting a particular cultural, race or gender group
- Provide information, training and tools to staff and practitioners to support culturally competent communication

## PEER REVIEW PROCESS

Peer Review is coordinated through the QI Department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, tracking and trending of service and access issues are reported to the CPRC, and are also reviewed at time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or grievances and appeals resolution.

## COMPREHENSIVE CREDENTIALING PROGRAM STANDARDS

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, ~~DMHC~~, CMS and NCQA). The scope of the credentialing program includes all licensed ~~M-D-s~~, ~~D-O-s~~, DPMs (doctor of podiatric medicine), DC (doctor of chiropractic medicine), DDS (doctor of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, ~~optometrists~~, registered physician therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and ~~recredentialing~~re-credentialing activities are delegated to the HNs and performed by CalOptima for CCN.

### **Health Care Delivery Organizations**

CalOptima performs credentialing and re-credentialing of ancillary providers and HDOs (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every three years thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

### **Use of Quality Improvement Activities in the Re-credentialing Process**

Findings from quality improvement activities are included in the re-credentialing process.

### **Monitoring for Sanctions and Complaints**

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns and member complaints between re-credentialing periods.

## FACILITY SITE REVIEW, MEDICAL RECORD AND PHYSICAL ACCESSIBILITY REVIEW SURVEY

CalOptima does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted HMOs, PHCs, and SRGs, ~~and MBHO, and PMGs~~. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates Facility Site Review (FSR), Medical Record Review (MRR) for the non-delegated SRGs, and PMGs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs and PMGs to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full

scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 14-004 and CalOptima policies. Medical records of new providers shall be reviewed within ninety calendar days of the date on which members are first assigned to the provider. An additional extension of ninety calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

### **Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)**

CalOptima conducts an additional DHCS-required facility audit for American with Disabilities Act compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- ~~Exterior ramps~~
- ~~Exterior stairways~~
- ~~Entrances~~
- ~~Building Interior circulation~~
- ~~Interior doors~~
- ~~Interior ramps~~
- ~~Interior stairways~~
- ~~Elevators~~
- ~~Controls~~
- ~~Sanitary facilities~~
- ~~Reception and waiting areas~~ Exterior
- ~~Diagnostic and treatment areas~~
- Participant Areas including the Exam Room
- Restroom
- Exam Room
- Exam Table/Scale

### **Medical Record Documentation Standards**

CalOptima requires that its contracted HMOs, PHCs, ~~and SRGs, and MBHO, and PMGs~~ make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima's contracts with CMS, and DHCS, ~~and MRMIB~~.

The medical record should be protected ~~in~~ to ensure that medical information is released only in accordance with applicable Federal and/or State law.

## CORRECTIVE ACTION PLAN(S) TO IMPROVE CARE, SERVICE

When monitoring by either CalOptima's ~~QI~~Quality Improvement department or Audit & Oversight department identifies an opportunity for improvement, the delegated or functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the ~~QI~~Quality Improvement department or Audit ~~and~~& Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the ~~QI~~Quality department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e. quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Discussion of the results of clinical monitoring. (The committee/functional area may refer an unresolved matter to the appropriate committee/functional area for evaluation and, if necessary, action.)
- Intensified evaluation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- Prescribed continuing education
- Intensive monitoring and oversight
- De-delegation
- Contract termination

### **Performance Improvement Evaluation Criteria for Effectiveness**

The effectiveness of actions ~~taken~~taken, and documentation of improvements made are reviewed through the monitoring and evaluation process. Additional analysis and action will be required when the desired state of performance is not achieved. Analysis will include use of the statistical control process, use of comparative data, and benchmarking when appropriate.

## COMMUNICATION OF QUALITY IMPROVEMENT ACTIVITIES

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the QI work plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Board of Directors, and/or the QAC, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of CalOptima staff. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on CalOptima's website, in addition to the annual article in both practitioner and member newsletter. The information includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
- ~~Annual PCP pamphlet~~
- Member Advisory Committee (MAC), OCC Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC).

## ANNUAL PROGRAM EVALUATION

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC, QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization,
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions
- An evaluation of each QI Activity, including QI Projects (QIPs), with any area showing improvements in care or service as a result of QI activities receiving continued interventions to sustain improvement
- An evaluation of member satisfaction surveys and initiatives
- A report to the QIC and QAC of a summary of all quality indicators and identification of significant trends
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process
- The recommended changes, included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors for review and approval

## IN SUMMARY

As stated earlier, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

**APPENDIX A — ~~2017~~2018 QI WORK PLAN**

**APPENDIX B — ~~2017~~2018 DELEGATION GRID**

## 2018 Quality Improvement Work Plan

### I. PROGRAM OVERSIGHT

- A. 2018 QI Annual Oversight of Program and Work Plan
- B. 2017 QI Program Evaluation
- C. 2018 UM Program and UM Workplan
- D. 2017 UM Program Evaluation
- E. 2018 Case Management Program
- F. 2018 Health Management Program
- G. Credentialing Peer Review Committee Oversight
- H. BHQIC Oversight
- I. UMC Oversight
- J. Member Experience SubCommittee Oversight
- K. LTSS QISC Oversight
- L. Clinical Operations/Population Health Oversight
- M. GARS Committee
- N. PACE QIC
- O. Quality Program Oversight - NCQA
- P. Quality Program Oversight - Health Plan Rating
- Q. Quality Program Oversight - Quality Withhold
- R. Pay for Value
- S. MOC Dashboard 2016-2019

### II. QUALITY OF CLINICAL CARE - CARE MANAGEMENT

- A. Review of Health Risk Assessments for OCC New Beneficiary's
- B. Review of Health Risk Assessments for OC New Beneficiary's
- C. Review of Health Risk Assessments for SPD New Beneficiary's
- D. Annual Collection and Review of Health Risk Assessments for OCC/ OC/ SPD existing members
- E. High ER Utilization
- F. Review Of Member Satisfaction With CM Programs
- G. Coordination of CCS Medical Home and CalOptima PCP
- H. HN MOC Oversight

### III. QUALITY OF CLINICAL CARE - BEHAVIORAL HEALTH

- A. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Initiation Phase
- B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase
- C. Antidepressant Medication Management (AMM): Acute Phase Treatment

#### INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: Date:

Submitted and approved by QAC: Date:

Submitted and approved by Board of Director's Date:

Quality Improvement Committee Chairperson:

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Richard Bock, MD

Date:

Board of Directors' Quality Assurance Committee Chairperson:

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Paul Yost, MD

Date:

- D. Antidepressant Medication Management (AMM): Continuation Phase Treatment
- E. Follow-up After Hospitalization within 30 days of discharge (FUH)
- F. Follow-up After Hospitalization within 7 days of discharge (FUH)
- G. Interdisciplinary Care Treatment Team Participation
- H. Adopt Behavioral Health Clinical Practice Guidelines

#### **IV. QUALITY OF CLINICAL CARE - LONG TERM SERVICES AND SUPPORTS**

- A. Review And Assess LTSS Hospital Admissions For Members Participating with Each Program
- B. Review And Assess LTSS Emergency Department Visits For Members Participating with Each Program
- C. Review And Assess LTSS Hospital Readmissions For Members Participating with Each Program
- D. Review And Assess LTSS utilization of Long Term Care, Home and Community Based Services For Member Participating in Each Program
- E. CBAS Member Satisfaction
- F. SNF Member Satisfaction

#### **V. QUALITY OF CLINICAL CARE - IMPROVE HEDIS MEASURES**

- A. Comprehensive Diabetes Care (CDC): HbA1c Testing
- B. Comprehensive Diabetes Care (CDC): HbA1c Poor Control (>9.0%)
- C. Comprehensive Diabetes Care (CDC): HbA1c Control (<8.0%)
- D. Comprehensive Diabetes Care (CDC): Eye Exam
- E. Comprehensive Diabetes Care (CDC): Medical Attention for Nephrology
- F. Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg)
- G. All-Cause Hospital Readmissions (PRC)
- H. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care
- I. Prenatal and Postpartum Care Services (PPC): Postpartum Care
- J. Childhood Immunization Status (CIS): Combo 3
- K. Childhood Immunization Status (CIS): Combo 10
- L. Lower Back Pain (LBP)
- M. Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)
- N. Children's Access to Primary Care Practitioners (CAP): 12-24 months
- O. Children's Access to Primary Care Practitioners (CAP): 25 months - 6 years
- P. Children's Access to Primary Care Practitioners (CAP): 7-11 years
- Q. Children's Access to Primary Care Practitioners (CAP): 12-19 years
- R. Cervical Cancer Screening (CCS)
- S. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)

- T. Well-Care Visits in first 15 months of life (W15)
- U. Appropriate Testing for Children with Pharyngitis (CWP)
- V. Colorectal Cancer Screening (COL)
- W. Care of Older Adult (COA): Medication Review
- X. Care of Older Adult (COA): Functional Status Assessment
- Y. Care of Older Adult (COA): Pain Assessment
- Z. Breast Cancer Screening (BCS)
- AA. Statin Therapy for Patients with Cardiovascular Disease - Therapy (SPC)
- BB. Statin Therapy for Patients with Cardiovascular Disease - Adherence (SPC)
- CC. Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
- DD. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

#### **VI. QUALITY OF CLINICAL CARE - HEALTH EDUCATION & DISEASE MANAGEMENT**

- A. Initial Health Assessment Completion Rate
- B. Review of Disease Management Programs
- C. Implementation of Population Health & Wellness Programs
- D. Adopt Medical Clinical Practice Guidelines

#### **VII. QUALITY OF CLINICAL CARE - QUALITY IMPROVEMENT PROJECTS (QIP, PIP, PDSA, CCIP)**

- A. **OneCare CCIP:** Diabetes to improve HBA1C Testing, Targeted mailings to members; Outreach to health networks; provide monthly Prospective Rates and member detail information to health networks
- B. **OneCare CCIP:** Connect Heart Health
- C. **OneCare Connect QIP:** To Improve 30-day Readmission Rate <16.8% ; Transition of Care program; health coach outreach
- D. **OneCare QIP (NEW):** Focus on Chronic Conditions (TBD)
- E. **Medi-Cal PIP:** Improving Diabetes Care for Medi-Cal Members with Poor Control (HbA1c >9%) residing in Santa Ana, CA. (Focus on health disparities); Targeted provider outreach in the CCN network; Increase referrals and participation in CalOptima' Disease Management program; Educational classes
- F. **Medi-Cal PIP:** Improving Adult's Access to Preventive/Ambulatory Health Services: Ages 45-64 years
- G. **OneCare Connect PIP:** Improving rate of completed Individualized Care Plan Completed for members and improve rate of Members with Documented Discussions of Care Goals
- H. **OneCare Connect PDSA** - Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents (LTC - OCC); Treatment in Place training to targeted facility sites and Follow up with targeted facility sites by CalOptima nurses

## **VIII. SAFETY OF CLINICAL CARE**

- A. Utilization of Opioid Analgesics
- B. Pharmacy Benefit Manager (PBM) Oversight
- C. Providers Shall Have Timely And Complete Facility Site Reviews
- D. Follow-up on Potential Quality Of Care Complaints
- E. CBAS Quality Monitoring
- F. SNF/LTC Quality Monitoring

## **IX. QUALITY OF SERVICE**

- A. Increase CAHPS score on Rating of Health Plan
- B. Increase CAHPS score on Getting Needed Care
- C. Increase CAHPS score on Getting Care Quickly
- D. Increase CAHPS score on Customer Service
- E. Increase CAHPS score on Care Coordination
- F. Customer Service First Call Resolution
- G. Customer Service Access
- H. Review and Report GARS for all Lines of Business
- I. Member Accessing Pharmacy Benefit Information

## **X. NETWORK ADEQUACY**

- A. Credentialing Of Provider Network Is Monitored
- B. Recredentialing Of Provider Network Is Monitored
- C. Termination of Practitioners
- D. Review of access to care for urgent appointments
- E. Review of access to care non-urgent primary care appointments
- F. Review of access to care specialty appointments
- G. Review of availability of primary care practitioners (min. provider ratios)
- H. Review of availability of primary care practitioners (geographic distribution)
  - I. Review of availability of specialty practitioners (min. provider ratios)
  - J. Review of availability of specialty practitioners (geographic distribution)
- K. Review of availability of behavioral health practitioners (min. provider ratios)
- L. Review of availability of behavioral health practitioners (geographic distribution)
- M. Network Pharmacy Access

## **XI. COMPLIANCE**

- Delegation Oversight of HN Compliance (UM, CR, Claims)
- HN Compliance with CCM NCQA Standards

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT											
QIC	Program Oversight	Quality Improvement	Esther Okajima/Kelly Rex-Kimmet	2018 QI Annual Oversight of Program and Work Plan	Approve QI Program and Workplan for 2018	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption				
QIC	Program Oversight	Quality Improvement	Esther Okajima/Kelly Rex-Kimmet	2017 QI Program Evaluation	Evaluate QI Program for 2017	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation				
QIC	Program Oversight	Utilization Management	Tracy Hitzeman	2018 UM Program and UM Workplan	Approve UM Program and Workplan for 2018	UM Program and UM Work Plan will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Annual Adoption				
QIC	Program Oversight	Utilization Management	Tracy Hitzeman	2017 UM Program Evaluation	Evaluate UM Program for 2017	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Annual Evaluation				
QIC	Program Oversight	Care Management	Sloane Petrillo	2018 Case Management Program	Approve CM Program for 2018	CM Program will be adopted on an annual basis; Delegation oversight reported by DOC	Annual Adoption				
QIC	Program Oversight	HE & DM	Pshyra Jones	2018 Health Management Program	Approve HM program for 2018	HM Program will be adopted on an annual basis	Annual Adoption				
QIC	Program Oversight	Quality Improvement	Esther Okajima	Credentialing Peer Review Committee Oversight	Peer Review of Provider Network	Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC ; Delegation oversight reported by A&O quarterly to CPRC.	Quarterly Adoption of Report				
QIC	Program Oversight	Behavioral Health	Donald Sharps MD	BHQIC Oversight	Internal and External oversight of BHI Activities	BHQI meets quarterly to: monitor and identify improvement areas of member and provider services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers.	Quarterly Adoption of Report				
QIC	Program Oversight	Utilization Management	Tracy Hitzeman	UMC Oversight	Internal and External oversight of UM Activities	UMC meets quarterly; it monitored medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results	Quarterly Adoption of Report				
QIC	Program Oversight	Quality Analytics	Kelly Rex-Kimmet	Member Experience Subcommittee Oversight	Oversight of Member Experience activities to improve member experience	The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report				
QIC	Program Oversight	LTSS	Steven Chang	LTSS QISC Oversight	LTSS QI Oversight	The LTSS Quality Improvement Sub Committee meets on a quarterly basis and addresses key components of regulatory, safety, quality and clinical initiatives.	Quarterly Adoption of Report				
QIC	Program Oversight	Medical Affairs	Tracy Hitzeman/ Kelly Rex-Kimmet	Clinical Operations/Population Health Oversight	Clinical Operations Oversight	This COPHS monitors the progress of the established program goals and metrics defined for CalOptima's disease management, complex case management programs and Model of Care.	Quarterly Adoption of Report				
QIC	Program Oversight	GARS	Ana Aranda	GARS Committee	GARS Committee Oversight	The GARS Committee oversees the Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Quarterly Adoption of Report				
QIC	Program Oversight	PACE	Dr. Miles Masatsugu	PACE QIC	PACE QIC Oversight	The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC	Quarterly Adoption of Report				
QIC	Program Oversight	Quality & Analytics	Esther Okajima	Quality Program Oversight - NCQA	Maintain "Commendable" NCQA accreditation rating	Monitor specific HEDIS measures listed below. Conduct NCQA Renewal Survey submission May 2018	Maintain Commendable Status. Accreditation evaluated every three years. HEDIS measures scored annually.				
QIC	Program Oversight	Quality & Analytics	Kelly Rex-Kimmet	Quality Program Oversight - Health Plan Rating	Maintain or exceed NCQA 4.0 health plan rating	Monitor specific HEDIS measures listed below and Maintain Commendable Status.	Achieve 4.0 Health Plan Rating - Annual Assessment				
QIC	Program Oversight	Quality & Analytics	Kelly Rex-Kimmet/ Tracy Hitzeman	Quality Program Oversight - Quality Withold	Earn Quality Withhold Dollars back for OneCare Connect in OCC QW program.	Quarterly monitoring and reporting to OCC Steering Committee and QIC	Annual Assessment				
QIC	Program Oversight	Quality Analytics	Kelly Rex-Kimmet/ Sandeep Mital	Pay for Value	<ul style="list-style-type: none"><li>• Implement and monitor health network performance on P4V measures during the year;</li><li>• Calculate and distribute the P4V incentive payments to participating health networks for MY 2017; and</li><li>• Calculate and distribute the P4V incentive payments to participating providers in CCN for MY 2017</li></ul>	<ul style="list-style-type: none"><li>• Generate and share Prospective Rate reports monthly for all health networks on their performance on adult and child clinical measures</li><li>• Complete review of 2017 measures at the end of the year</li><li>• Hold provider education with Provider relations team to educate CCN providers and provider relations team on the new CCN P4V program.</li><li>• Implement CCN P4V Prospective Rate reporting</li></ul>	National and State benchmarks				
QIC	Program Oversight	Medical Affairs	Tracy Hitzeman	MOC Dashboard 2016-2019	Present OC/OCC & SPD MOC Quality Matrix to QAC and Board of Directors by 2nd Quarter, 2017 ; Re-evaluate measurements through data analysis	Define analytics and resources to support the Model of Care for OC/OCC & SPD members; Implement activities to meet or exceed measures	Meet or exceed defined MOC Metrics				
II. QUALITY OF CLINICAL CARE - CARE MANAGEMENT											

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Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Review of Health Risk Assessments for OCC New Beneficiary's	OCC- Health Risk Assessment Outreach for members in the OneCare Connect Program monitored for completion and collection for Initial HRA	OCC- Administer the initial HRA to the high risk beneficiary within: 90 days of a beneficiary s enrollment OCC- Administer the initial HRA to the low risk beneficiary within: 45 days of a beneficiary s enrollment	For OCC Initial High Risk HRA, - Achieve Collection Rate of 56%, report quarterly				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Review of Health Risk Assessments for OC New Beneficiary's	OC- Health Risk Assessment Outreach for members in the OneCare Program monitored for completion for Initial HRA	OC - Administer the Initial HRA within 90 days of beneficiary eligibility.	For OC Initial HRA - Achieve Collection Rate of 78%, report quarterly				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Review of Health Risk Assessments for SPD New Beneficiary's	SPD- Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion for Initial HRA	SPD- Administer the initial HRA to the high risk beneficiary within: 45 days of a beneficiary s eligibility; SPD- Administer the initial HRA to the low risk beneficiary within: 90 days of a beneficiary s eligibility	For SPD Initial High Risk HRA - Achieve Collection Rate of 63% report quarterly				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Annual Collection and Review of Health Risk Assessments for OCC/ OC/ SPD existing members	OCC/OC/SPD: Administer the annual HRA to the beneficiary to all participants	OCC/OC/SPD: Administer the annual HRA to the beneficiary to all participants	Achieve 50% Collection rate for OCC Annual, and 34% for OC Annual. No goal set for SPD.				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	High ER Utilization	Evaluation and intervention for ongoing review of high ER utilizers	Identify top 10 high ER utilizers for CCN per quarter (all lines of business); Open to case management with focused group of case managers ; Regular meetings to identify causes of high utilization and effective strategies for reduction in inappropriate ER utilization	5% reduction in ER visits among intervention cohort				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Review Of Member Satisfaction With CM Programs	Annual review of member feedback on the case management programs to assure high satisfaction and improved health status	Review annual satisfaction survey results, define areas for improvement and implement interventions to improve member experience with CM programs; Revise methodology to increase sample size of responses	Satisfaction with Case Management - 88%				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Coordination of CCS Medical Home and CalOptima PCP	Monitor coordination efforts between CCS Medical Home and CalOptima PCP's	TBD	TBD				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	HN MOC Oversight	Regular review of the Health Network s performance of MOC functions	Review of 100% of MOC files with monthly feedback provided to Health Networks	HN to achieve 90% score				
III. QUALITY OF CLINICAL CARE - BEHAVIORAL HEALTH											
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Initiation Phase	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"><li>Continue to hold monthly BH QI work group with representation from the various departments associated with the measures</li><li>Continue to work on current intervention focus for AMM and ADD HEDIS measures</li><li>BHI has several measures that are being monitored which may also serve as opportunity for improvements</li></ul>	Medicaid: 48.18%				
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"><li>Continue to hold monthly BH QI work group with representation from the various departments associated with the measures</li><li>Continue to work on current intervention focus for AMM and ADD HEDIS measures</li><li>BHI has several measures that are being monitored which may also serve as opportunity for improvements</li></ul>	Medicaid: 44.80%				
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Antidepressant Medication Management (AMM): Acute Phase Treatment	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"><li>Continue to hold monthly BH QI work group with representation from the various departments associated with the measures</li><li>Continue to work on current intervention focus for AMM and ADD HEDIS measures</li><li>BHI has several measures that are being monitored which may also serve as opportunity for improvements</li></ul>	Medicaid: 56.94% OneCare: 75.00% OneCare Connect: 63.45%				
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Antidepressant Medication Management (AMM): Continutation Phase Treatment	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"><li>Continue to hold monthly BH QI work group with representation from the various departments associated with the measures</li><li>Continue to work on current intervention focus for AMM and ADD HEDIS measures</li><li>BHI has several measures that are being monitored which may also serve as opportunity for improvements</li></ul>	Medicaid: 41.12% OneCare: 53.90% OneCare Connect: 47.09%				
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up After Hospitalization within 30 days of discharge (FUH)	FUH measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow up visit with a mental health practitioner.	Will monitor and measure: The percentage of discharges for which the patient received follow up <a href="#">Back to Agenda</a>	OCC Quality Withold Goal: 60.89%				

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BHQC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up After Hospitalization within 7 days of discharge (FUH)	FUH measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow up visit with a mental health practitioner.	Will monitor and measure: - The percentage of discharges for which the patient received follow up within 7 days of discharge	OCC Quality Withold Goal: 56%				
BHQC	Quality of Clinical Care	Behavioral Health	Edwin Poon	Interdisciplinary Care Treatment Team Participation	Behavioral health services, integration and coordination of care will be monitored and measured	Monitor and identify opportunities to improve integration and coordination	Maintain or improve the participation rate of 95% or higher for Medi-Cal, One Care and One Care Connect ICTs or ICPs completed				
BHQC	Quality of Clinical Care	Behavioral Health	Edwin Poon	Adopt Behavioral Health Clinical Practice Guidelines	BH Clinical Practice Guidelines will be reviewed and adopted	Adoption of at least two behavioral health Clinical practice guidelines will be reviewed and adopted	Annual Adoption of BH Clinical Practice Guidelines				
IV. QUALITY OF CLINICAL CARE - LONG TERM SERVICES AND SUPPORTS											
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang/ Cathy Osborn	Review And Assess LTSS Hospital Admissions For Members Participating with Each Program	Member review of Hospital Admissions (for each organization/program)	Measure those members participating in each program for hospital admissions 1. CBAS, 2. LTC, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang/ Cathy Osborn	Review And Assess LTSS Emergency Department Visits For Members Participating with Each Program	Member review of Emergency Department Visits (for each organization/program)	Measure those members participating in each program for ED Visits 1. CBAS, 2. LTC, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang/ Cathy Osborn	Review And Assess LTSS Hospital Readmissions For Members Parctipating with Each Program	Members reviewed for Hospital Readmissions (for each organization/program)	Measure and assess hospital readmissions within 30 days for members in each program to drive interventions to minimize hospital readmissions 1. CBAS, 2. LTC, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang/ Cathy Osborn	Review And Assess LTSS utilization of Long Term Care, Home and Community Based Services For Member Participating in Each Program	Members reviewed for utilization of Long Term Care, Home and Community Based Services (for each organization/program)	Measure and assess utilization of LTC, Home and Community Based Services for members in each program 1. CBAS, 2. IHSS, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
LTSS-QISC	Quality of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	CBAS Member Satisfaction	Monitor and/or improve member satisfaction in CBAS	a) Measure, assess and identify areas for improvement through the distribution of a member satisfaction survey.  b) Implement interventions to assure high member satisfaction	90% of the Centers will achieve an overall satisfaction rating 3 or greater				
LTSS-QISC	Quality of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	SNF Member Satisfaction	Monitor and/or improve member satisfaction in SNF/LTC facilities	a) Measure, assess and identify areas for improvement through the distribution of a member satisfaction survey.  b) Implement interventions to assure high member satisfaction	90% of the facilities will achieve an overall satisfaction rating 3 or greater				
V. QUALITY OF CLINICAL CARE - HEDIS											
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): HbA1c Testing	Outreach to members who are due for HbA1c testing. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives.	Medicaid: 87.1% OneCare: 93.82% OneCare Connect: 91.73%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): HbA1c Poor Control (>9.0%)	Outreach to members who have poor or uncontrolled HbA1c levels. For the CCN population, targeted outreach to high volume providers via medical director outreach. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 29.07% OneCare: 20% OneCare Connect: 27%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): HbA1c Control (<8.0%)	Interventions may include; targeted mailings with educational materials. Members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 59.12% OneCare: 69.71% OneCare Connect: 64.72%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): Eye Exam	Targeted outreach to members who are due for a diabetic eye exam. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 65.83% OneCare: 81% OneCare Connect: 81%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): Medical Attention for Nephrology	Targeted outreach to members who are due for a screening. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 91.24% OneCare: 94% OneCare Connect: 96%				

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QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg	Outreach to diabetic members with high blood pressure. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 72.24% OneCare: 80.12 OneCare Connect: 70.83%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	All-Cause Hospital Readmissions (PRC)	Continue to implement the Transition of Care program; focus on the health coaching intervention.	OneCare: 6% OneCare Connect: 9%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care	Targeted outreach to members who are due for prenatal/postpartum visits. Interventions may include; targeted mailings and incentives. The Bright Steps maternal health program is set to launch July, 2018.	Medicaid: 86.79%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Prenatal and Postpartum Care Services (PPC): Postpartum Care	Targeted outreach to members who are due for prenatal/postpartum visits. Interventions may include; targeted mailings and incentives. The Bright Steps maternal health program is set to launch July, 2018.	Medicaid: 69.44%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Childhood Immunization Status (CIS): Combo 3	Targeted outreach to members who are due for an immunization. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 74.39%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Childhood Immunization Status (CIS): Combo 10	Targeted outreach to members who are due for an immunization. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 37.23%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Lower Back Pain (LBP)	Provider education and outreach	Medicaid: 74.40%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 76.17%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 12-24 months	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 95.7%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 25 months - 6 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 87.87%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 7-11 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 90.77%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 12-19 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 89.52%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Cervical Cancer Screening (CCS)	Targeted outreach to members who are due for a screening. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 58.48%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	Targeted outreach to members who are due for a screening. Interventions may include; wellness events at high volume provider sites, target mailings, incentives, and facets pop-ups.	Medicaid: 80.64%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Well-Care Visits in first 15 months of life (W15)	Targeted outreach to members who are due for a screening. Interventions may include; wellness events at high volume provider sites, target mailings, incentives, and facets pop-ups.	Medicaid: 56.11%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Appropriate Testing for Children with Pharyngitis (CWP)	Provider outreach at PCP sites, Target urgent care centers	Medicaid: 67.15%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Colorectal Cancer Screening (COL)	Targeted outreach to members who are due for a screening. Interventions may include; preventive screenings event, target mailings, incentives, and facets pop-ups.	OneCare: 63% OneCare Connect: 63%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA): Medication Review	Targeted outreach to providers; obtain ICP for each members	OneCare: 88% OneCare Connect: 79%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA): Functional Status Assessment	Targeted outreach to providers; obtain ICP for each member	OneCare: 67% OneCare Connect: 67%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA): Pain Assessment	Targeted outreach to providers; obtain ICP for each member	OneCare: 94% OneCare Connect: 80%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Breast Cancer Screening (BCS)	Targeted outreach to members who are due for a screening. Interventions may include; mobile mammography event, target mailings, incentives, and facets pop-ups.	Medicaid: 65.52% OneCare: 78% OneCare Connect: 78%				
QIC	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour	Improve identified HEDIS Measures	Statin Therapy for Patients with Cardiovascular Disease - Therapy (SPC)	Physician notification faxes	Medicaid: 75.85%				
QIC	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour	Improve identified HEDIS Measures	Statin Therapy for Patients with Cardiovascular Disease - Adherence (SPC)	Physician notification faxes	Medicaid: 73.43%				
QIC	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour	Improve identified HEDIS Measures	Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	Physician notification faxes	Medicaid: 80.95%				

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QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	Provider education via the AWARE Toolkit.	Medicaid: 24.91%				
VI. QUALITY OF CLINICAL CARE - HEALTH EDUCATION & DISEASE MANAGEMENT											
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Initial Health Assessment Completion Rate	To assure all new members are connected with a PCP and their health risks are assessed	IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed within 120 days of enrollment; Reports will be available for Health Networks on IHA/SHA completion; Facility Site Reviews will review a sample of medical records for compliance with completing appropriate age level IHA/SHA; If use of alcohol or drugs, the member will have an SBIRT documented (Screening, Brief Intervention, and Referral to Treatment)	Improve plan performance over 2017 by 5%				
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Review of Disease Management Programs	Disease Management activity reviewed to assess clinical care delivered to members with Asthma, Diabetes and Heart Failure	Develop DM Program interventions to help improve HEDIS measures such as AMR, MMA, MPM, CBP; Assure DM programs are implemented across all populations; Conduct annual member satisfaction of DM programs; Evaluate the overall effectiveness of the Program-Participation Member Rates, ED, IP and RX related utilization	Improve program participation rates over 2017 by 3% Reduce ED and IP rates for program participants by 3% Increase member satisfaction with DM Programs to 90%				
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Implementation of Population Health & Wellness Programs	Expand child and adolescent components for the Shape Your Life/Weight Management Program; Implement Weight Watchers benefit for Shape Your Life CalOptima Medi-Cal members age 15 years or greater; Design and implement a comprehensive Perinatal Health Program	Establish program goals, objectives and interventions; Develop clinical and operational components to expand the reach and capability; Identify program resources and vendor support (Provider, Health Ed/RD linkages, Community Based Organizations); Implementation of revised program design	Implement revised program design-2018; Evaluate progress semi-annually				
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Adopt Medical Clinical Practice Guidelines	Clinical Practice Guidelines will be reviewed and adopted	Adoption of Clinical Practice Guidelines, as least three (3) will be reviewed and adopted (linked to DM: Diabetes, Asthma, CHF)	CPG's reviewed and adopted every two years				
VII. QUALITY OF CLINICAL CARE - QUALITY IMPROVEMENT PROJECTS											
QIC	Quality of Clinical Care	HE & DM	Pshyra Jones	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	<b>OneCare CCIP:</b> Diabetes to improve HbA1C Testing, Targeted mailings to members; Outreach to health networks; provide monthly Prospective Rates and member detail information to health networks	Goal TBD/ Starting January 2018				
QIC	Quality of Clinical Care	HE & DM	Pshyra Jones	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	<b>OneCare CCIP:</b> Connect Heart Health	Goal TBD/ Starting January 2018				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	<b>OneCare Connect QIP:</b> To Improve 30-day Readmission Rate <16.8% ; Transition of Care program; health coach outreach	TBD				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	<b>OneCare QIP (NEW):</b> Focus on Chronic Conditions (TBD)	TBD				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	<b>Medi-Cal PIP:</b> Improving Diabetes Care for Medi-Cal Members with Poor Control (HbA1c >9%) residing in Santa Ana, CA. (Focus on health disparities); Targeted provider outreach in the CCN network; Increase referrals and participation in CalOptima Disease Management program; Educational classes	TBD				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	<b>Medi-Cal PIP:</b> Improving Adult's Access to Preventive/Ambulatory Health Services: Ages 45-64 years	TBD				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	<b>OneCare Connect PIP:</b> Improving rate of completed Individualized Care Plan Completed for members and improve rate of Members with Documented Discussions of Care Goals	TBD				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	<b>OneCare Connect PDSA</b> - Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents (LTC - OCC); Treatment in Place training to targeted facility sites and Follow up with targeted facility sites by CalOptima nurses	TBD				
VIII. SAFETY OF CLINICAL CARE											
UMC	Safety of Clinical Care	Pharmacy	Kris Gericke		Promote optimal utilization of opioid analgesics	Quarterly opioid analgesic monitoring. Formulary limits and prior authorization requirements for opioid analgesics. Prescriber monitoring and education	Reduction in opioid analgesic overutilization as measured by number of prescriptions and quantity per prescription for short-acting opioid analgesics				
UMC	Safety of Clinical Care	Pharmacy	Kris Gericke	Pharmacy Benefit Manager (PBM) Oversight	Provide ongoing monitoring of the PBM contract performance guarantees	Review and report on clinical and service metrics for MedImpact as it relates to performance guarantees	PBM Performance Guarantees met per the PBM Services Agreement				

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CPRC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Katy Noyes	Providers Shall Have Timely And Complete Facility Site Reviews	To assure all new and re-credentialed providers are compliant with FSR/MRR/PAR requirements	Facility Site Reviews (FSR), Medical Record Reviews (MRR) and Physical Accessibility Review Surveys (PARS) are completed as part of initial and re-credentialing cycles; Report of FSR/MRR/PARS activity to CPRC	100% of FSR/MRR/PARS Initial or Full Scope Surveys are completed within initial and re-credentialing timeframes				
CPRC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	Follow-up on Potential Quality Of Care Complaints	To assure patient safety and enhance patient experience by timeliness of clinical care reviews	QI Nurse Specialists and Medical Directors review cases and provide determination; Report all case results to CPRC for discussion; Present cases that have a severity rating of 1 (one) or higher will be presented to CPRC for action; Follow through on Medical Director determination, when applicable, to ensure closure and compliance of all cases; Conduct a PQI trend analysis at least two times a year	Achieve a turnaround time of 90 days on 90% of cases received; Review data for trends and patterns for potential further actions				
LTSS-QISC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	CBAS Quality Monitoring	Review CBAS quality monitoring of services provided	a) Continue to assess compliance of contracted CBAS Centers. Report to LTSS QIS Subcommittee. b) Continue to review Incident and Critical Incident Reports for Potential Quality of Care issues	a) All (100%) contracted CBAS centers will be audited at least annually against the audit performed by CDA. b) All (100%) CAPs generated as a result of the audit will be returned by the due date. c) The number of CBAS centers receiving a CAP will be reduced to 75% in 2018, down from 93% in 2017. d) All (100%) Incident and Critical Incident reports will be reviewed for Potential Quality of Care issues				
LTSS-QISC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	SNF/LTC Quality Monitoring	Review SNF/LTC quality monitoring of services provided	a) Continue to assess compliance of contracted SNF/LTC Facilities. Report to LTSS QIS Subcommittee. b) Continue to review Critical Incident Reports for Potential Quality of Care issues	a) All (100%) contracted SNF/LTC Facilities will be audited at least annually against the audit performed by DHCS. b) All (100%) CAPs generated, as a result of the audit, will be returned by the due date. c) The number of SNF/LTC Facilities receiving a CAP will be below 10%. d) All (100%) Critical Incident reports will be reviewed for Potential Quality of Care issues.				
IX. QUALITY OF SERVICE											
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Rating of Health Plan	Implement CG-CAHPS to obtain provider level specific member experience data. Utilize results from CalOptima's CG-CAHPS survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan. Contract with vendor to implement Provider Coaching to improve provider satisfaction and overall member experience.	Adult Medicaid: 2.43 (50th Percentile) Child Medicaid: 2.57 (50th Percentile) OneCare Medicare: 86% (CMS 4 star goal) OneCare Connect: Medicare: 86% (CMS 4 star goal)				
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.	Adult Medicaid: 2.28 (25th Percentile) Child Medicaid: 2.37 (25th Percentile) OneCare Medicare: 82% (CMS 3 star goal) OneCare Connect: Medicare: 82% (CMS 3 star goal)				
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Getting Care Quickly	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of timely access and appointment availability standards will improve rating of Getting Care Quickly.	Adult Medicaid: 2.33 (25th Percentile) Child Medicaid: 2.54 (25th Percentile) OneCare Medicare: 79% (CMS 4 star goal) OneCare Connect: Medicare: 76% (CMS 3 star goal)				

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MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Customer Service	Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service. Contract with vendor to implement Provider Coaching for Customer Service staff.	Adult Medicaid: 2.54 (50th Percentile) Child Medicaid: 2.50 (25th Percentile) OneCare Medicare: 89% (CMS 3 star goal) OneCare Connect: Medicare: 89% (CMS 3 star goal)				
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Care Coordination	Provider and office staff in-service on best practices to better coordinate care for members will improve rating on Care Coordination.	Adult Medicaid: 2.34 (25th Percentile) Child Medicaid: 2.36 (25th Percentile) OneCare Medicare: 85% (CMS 3 star goal) OneCare Connect: Medicare: 85% (CMS 3 star goal)				
MEMX	Quality of Service	Customer Service	Belinda Abeyta/ Albert Cardenas	Customer Service First Call Resolution	Gather data and information from members after interface with Customer Service to assure expectations/reason for call was resolved	Monitor port call information and determine key strategies to assure first call resolution/member satisfaction with customer service	85% of calls resolved at first call				
MEMX	Quality of Service	Customer Service	Belinda Abeyta/ Albert Cardenas	Customer Service Access	Customer Service call lines evaluated for average speed to answer; Customer Service call line evaluated for call abandonment rate	Customer Service lines monitored for average speed to answer; Customer service lines monitored for abandonment rate	ASA 30 Seconds <5% First Call Resolution 85%				
MEMX	Quality of Service	GARS	Ana Aranda	Review and Report GARS for all Lines of Business	Global review of member “pain points”; assure appropriate actions are taken to assist the member experience, and present data to the Member Experience Committee and QIC	a) Quarterly review of all GARS data to identify issues and trends; including Health Network b) Implement any necessary corrections d) Review health network quarterly totals of grievances e) Conduct a GARS trend analysis at least two times per year f) Compare GARS trend analysis with similar PQI analysis g) Determine plan of action for follow-up on specific providers if needed	Meet Regulatory Turnaround Times 100%				
MEMX	Quality of Service	Pharmacy	Kris Gericke	Member Accesssing Pharmacy Benefit Information	Maintain member access to their pharmacy benefit and the operations of network pharmacies through the CalOptima website, or through telephone communication with CalOptima Customer Service staff	Monitor and annually report requirements for NCQA Member Connection 4: Pharmacy Benefit Information Standards	Via the CalOptima website Members are able to: -Submit Prior Authorization requests; -Conduct network pharmacy proximity searches based on zip code; -Find information on potential drug-drug interactions, common side effects and significant risks, and availability of generic substitutes; and -Receive responses to pharmacy inquiries within twenty-four (24) hours (or next business day).				
X. NETWORK ADEQUACY											
CPRC	Network Adequacy	Quality Improvement	Esther Okajima/ Melinda Enos	Credentialing Of Provider Network Is Monitored	Credentialing program activities monitored for volume and timeliness	New applicants processed within 180 calendar days of receipt of application; Report of initial credentialing file activity to CPRC	90% of initial credentialing applications are processed within 120 days of receipt of application				
CPRC	Network Adequacy	Quality Improvement	Esther Okajima/ Melinda Enos	Recredentialing Of Provider Network Is Monitored	Recredentialing of practitioners is completed timely	Recredentialing is processed every 36 months; Report of Admin term due to missed recredentialing cycle; Report of re-credentialing activity to CPRC	100% of all recredentialing files are processed within 36 months of last credentialing date				
MEMX	Network Adequacy	TBD	TBD	Termination of Practitioners	Termination of Practitioners is monitored, and Continuity and Coordination of Care reviewed and assessed	Termination of Practitioners is monitored through monthly ACT forms that are submitted to PDMS. 1) Members are notified of terminated practioners with 30 days from when CalOptima is notifie 2) Network is monitored to determine if adjustments to network are necessary.	Notification to members are within 30 days of notification to CalOptima 85% of the time.				
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of access to care for urgent appointments	1. Urgent care appointments without prior authorization within 48 hours of request 2.Urgent appointments with prior authorization with 96 hours of request	Data against goals will be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Appointment: 90% minimum performance level				

[Back to Agenda](#)



Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
AOC	Compliance	A&O	Solange Marvin	Delegation Oversight of HN Compliance (UM, CR, Claims)	Delegation Oversight of Health Networks to assess compliance of UM, CR, Claims	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as Prior Authorizations; Credentialing, Claims etc. **Report from AOC	98%				
AOC	Compliance	Care Management	Sloane Petrillo	HN Compliance with CCM NCQA Standards	Delegation Oversight of Health Networks to assess compliance of CCM	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as CCM; **Report from AOC	98%				

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
QI1A: QI Program Structure	X		X		CO responsibility P&P, even if delegated
QI1B: Annual Evaluation	X		X		CO responsibility P&P, even if delegated
QI2A: QI Committee Responsibilities	X		X		CO responsibility P&P, even if delegated
QI2B: Informing Members and Practitioners	X		X		CO responsibility P&P, even if delegated
QI3A: Practitioner Contracts	X		X		CO responsibility P&P, even if delegated
QI3B: Affirmative Statement	X		X		CO responsibility P&P, even if delegated
QI3C: Provider Contracts	X		X		CO responsibility P&P, even if delegated
QI4A: Member Services Telephone Access	X	X	X		
QI4B: BH Telephone Access Standards	X		X		CO responsibility P&P, even if delegated
QI4C: Annual Assessment-Member Experience	X				CO fields CAHPS, Kaiser complaint data included
QI4D: Opportunities for Improvement-Member Experience	X				
QI4E: Annual Assessment of BH and Services-Member Experience	X		X		Kaiser:Factor1 & Factor2
QI4F: BH Opportunities for Improvement-Member Experience	X				

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
QI4G: Assessing Experience With the UM Process	X				CO utilizes Kaiser data
QI5A: Population Assessment	X				
QI5B: Program Description-Complex Case Management (CCM)	X	X	X		
QI5C: Identifying Members for CCM	X	X	X		
QI5D: Access to Case Management-CCM	X	X	X		
QI5E: Case Management Systems-CCM	X	X	X		
QI5F: Case Management Process-CCM	X	X	X		CO responsibility P&P, even if delegated
QI5G: Initial Assessment-CCM	X	X	X		
QI5H: Case Management- Ongoing Management-CCM	X	X	X		
QI5I: Experience With Case Management-CCM	X		X		
QI5J: Measuring Effectiveness-CCM	X		X		
QI5K : Action and Re-measurement-CCM	X		X		
QI6A: Program Content-Disease Management (DM)	X		X		

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
QI6B: Identifying Members for DM Programs	X		X		
QI6C : Frequency of Member Identification-DM	X		X		
QI6D: Providing Members With Information-DM	X		X		
QI6E: Interventions Based on Assessment-DM	X		X		
QI6F: Eligible Member Active Participation-DM	X		X		
QI6G: Informing and Educating Practitioners-DM	X		X		
QI6H: Integrating Member Information-DM	X		X		
QI6I: Experience With DM	X		X		
QI6J: Measuring Effectiveness-DM	X		X		
QI7A: Adoption of Guidelines	X		X		
QI7C: Relation to DM Programs	X		X		
QI8A: Identifying Opportunities-Continuity & Coordination of Care (C&C)	X		X		
QI8B: Acting on Opportunities-C&C	X		X		

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
QI8C: Measuring Effectiveness-C&C	X		X		
QI8D: Transition to Other Care-C&C	X	X	X		
QI9A: Data Collection- C&C Behavioral Health	X				
QI9B: Collaborative Activities- C&C Behavioral Health	X				
QI9C: Measuring Effectiveness- C&C Behavioral Health	X				
QI10A: Delegation Agreement	X				
QI10B: Provision of Member Data to the Delegate	X				
QI10D: Pre-delegation Evaluation-NA	X				
QI10E: Review of QI Program	X				
QI10F: Opportunities for Improvement	X				
NET1A: Cultural Needs and Preferences	X		X		CO responsibility P&P, even if delegated
NET1B: Practitioners Providing Primary Care	X				CO responsibility Factor1-2 P&P, even if delegated
NET1C: Practitioners Providing Specialty Care	X				CO responsibility Factor1-3 P&P, even if delegated

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
NET1D: Practitioners Providing Behavioral Health (BH)	X		X		CO responsibility Factor1-3 P&P, even if delegated, Magellan/Kaiser Factor4
NET2A: Access to Primary Care	X		X		CO responsibility P&P, even if delegated
NET2B: Access to BH	X		X		CO responsibility P&P, even if delegated
NET2C: Access to Specialty Care	X		X		
NET3A: Assessment of Member Experience Accessing the Network	X		X		For BH See QI4E: Kaiser Factor 1&2
NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X		
NET3C: Opportunities to Improve Access to BH Services	X		X		For BH See QI4E: Kaiser Factor1&2
NET5A: Notification of Termination	X	X	X		
NET5B: Continued Access to Practitioners	X	X	X		
NET6A: Physician Directory Data	X		X		
NET6B: Physician Directory Updates	X		X		

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
NET6C: Assessment of Physician Directory Accuracy	X		X		
NET6D: Identifying and Acting on Opportunities	X		X		
NET6E: Physician Information Transparency	X		X		
NET6F: Searchable Physician Web-Based Directory	X		X		
NET6G: Hospital Directory Data	X		X		
NET6H: Hospital Directory Updates	X		X		
NET6I: Hospital Information Transparency	X		X		
NET6J: Searchable Hospital Web-Based Directory	X		X		
NET6K: Usability Testing	X		X		
NET6L: Availability of Directories	X		X		
NET7A: Delegation Agreement	X		X		

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
NET7B: Provisions of Member Data to the Delegate	X		X		
NET7D: Pre-delegation Evaluation	X		X		
NET7E: Review of Delegated Activities	X		X		
NET7F: Opportunities for Improvement	X		X		
UM1A: Written Program Description	X		X		CO responsibility P&P, even if delegated
UM1B: Physician Involvement	X		X		CO responsibility P&P, even if delegated
UM1C: BH Practitioner Involvement	X		X		CO responsibility P&P, even if delegated
UM1D: Annual Evaluation	X		X		CO responsibility P&P, even if delegated
UM2A: UM Criteria	X	X	X		CO responsibility P&P, even if delegated
UM2B: Availability of Criteria	X	X	X		CO responsibility P&P, even if delegated
UM2C: Consistency in Applying Criteria	X	X	X	X	CO responsibility P&P, even if delegated
UM3A: Access to Staff	X	X	X		CO responsibility P&P, even if delegated
UM4A: Licensed Health Professionals	X	X	X	X	CO responsibility P&P, even if delegated

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
UM4B: Use of Practitioners for UM Decisions	X	X	X	X	CO responsibility P&P, even if delegated
UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X		
UM4D: Practitioner Review of BH Denials-	X		X		
UM4E: Practitioner Review of Pharmacy Denials	X		X		
UM4F: Use of Board-Certified Consultants	X	X	X		
UM4G: Affirmative Statement About Incentives	X	X	X		
UM4H: Appropriate Classification of Denials	X	X	X		
UM5A: Timeliness of Non-Behavioral UM Decision Making	X	X	X		
UM5B: Notification of Non-Behavioral Decisions	X	X	X		
UM5C: Timeliness of Behavioral Healthcare UM Decision Making	X		X		
UM5D: Notification of Behavioral Healthcare Decisions	X		X		
UM5E: Timeliness of Pharmacy UM Decision Making	X		X	X	
UM5F: Notification of Pharmacy Decisions	X		X	X	

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
UM5G: UM Timeliness Report	X	X	X		HN Factor1 & Factor2. Factor5; CO Factor6
UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X		
UM6B: Relevant Information for BH Decisions	X		X		
UM6C: Relevant Information for Pharmacy Decisions	X		X		
UM7A: Discussing a Denial With a Reviewer	X	X	X		
UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X		
UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X		
UM7D: Discussing a BH Denial with a Reviewer	X		X		
UM7E: Written Notification of BH Denials	X		X		
UM7F: BH Notice of Appeal Rights/Process	X		X		
UM7G: Discussing a Pharmacy Denial With a Reviewer	X		X		
UM7H: Written Notification of Pharmacy Denials	X		X	X	
UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	X	

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
UM8A: Internal Appeals (Policies and Procedures)	X		X		CO responsibility P&P, even if delegated
UM9A: Pre-service and Post-service Appeals	X		X		CO responsibility P&P, even if delegated
UM9B: Timeliness of the Appeal Process	X		X		
UM9C: Appeal Reviewers	X		X		
UM9D: Notification of Appeal Decision/Rights	X		X		
UM11A: Pharmaceutical Management Procedures(Policies and Procedures)	X		X		
UM11B: Pharmaceutical Restrictions/Preferences	X		X		
UM11C: Pharmaceutical Patient Safety Issues	X		X		
UM11D: Reviewing and Updating Procedures	X		X		
UM11E: Considering Exceptions	X		X		
UM12A: Triage and Referral Protocols	X		X		
UM12B: Supervision and Oversight	X		X		
UM13A: Delegation Agreement	X				

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
UM13B: Provision of Member Data to the Delegate	X				
UM13D: Pre-delegation Evaluation	X				
UM13E: Review of the UM Program	X				
UM13F: Opportunities for Improvement	X				
CR1A: Practitioner Credentialing Guidelines	X	X	X		CO responsibility P&P, even if delegated
CR1B: Practitioner Rights	X	X	X		CO responsibility P&P, even if delegated
CR2A: Credentialing Committee	X	X	X		
CR3A: Verification of Credentials	X	X	X		
CR3B: Sanction Information	X	X	X		
CR3C: Credentialing Application	X	X	X		
CR4A: Recredentialing Cycle Length	X	X	X		
CR5A: Ongoing Monitoring and Interventions	X	X	X		
CR6A: Actions Against Practitioners	X	X	X		CO responsibility P&P, even if delegated

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
CR7A: Review and Approval of Provider	X	X	X		
CR7B: Medical Providers	X	X	X		
CR7D: Assessing Medical Providers	X	X	X		
CR8A: Delegation Agreement	X				
CR8C: Pre-delegation Evaluation-NA	X				
CR8D: Review of Delegate's Credentialing Activities	X				
CR8E: Opportunities for Improvement	X				
CR1C: Performance Monitoring for Re-Credentialing (CMS/DHCS)	X	X	X		CMS/DHCS Requirement
CR1D: Contracts Opt-Out Provisions (CMS)	X	X	X		CMS Requirement
CR1E: Medicare-Exclusions/Sanctions (CMS)	X	X	X		CMS Requirement
CR3D: Hospital Admitting Privileges (CMS/DHCS)	X	X	X		CMS/DHCS Requirement
CR6B: Monitoring Medicare opt Out (CMS)	X	X	X		CMS Requirement
CR6C: Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)	X	X	X		DHCS Requirement

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
CR7F: Appeals Process for Termination/Suspension (CMS)	X	X	X		CMS Requirement
CR10A: ID of HIV/AIDS Specialists: Written Process	X	X	X		DHCS Requirement
CR10B: ID of HIV/AIDS Specialists: Evidence of Implementation	X	X	X		DHCS Requirement
CR10C: ID of HIV/AIDS Specialists: Distribution of Findings	X	X	X		DHCS Requirement
RR1A: Rights and Responsibility Statement	X				
RR1B: Distribution of Rights Statement	X				
RR2A: Policies and Procedures for Complaints	X		X		CO responsibility P&P, even if delegated
RR2B: Policies and Procedures for Appeals	X		X		CO responsibility P&P, even if delegated
RR3A: Subscriber Information	X				
RR3B: Interpreter Services	X	X	X		
MEM1A: Health Appraisal (HA) Components	X		X		
MEM1B: HA Disclosure	X		X		
MEM1C: HA Scope	X		X		

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
MEM1D: HA Results	X		X		
MEM1E: Formats	X		X		
MEM1F: Frequency of HA Completion	X		X		
MEM1G: Review and Update Process	X		X		
MEM2A: Topics of Tools	X		X		
MEM2B: Usability Testing	X		X		
MEM2C: Review and Update Process	X		X		
MEM2D: Formats	X		X		
MEM3B: Functionality: Telephone Requests	X	X	X		
MEM4A: Pharmacy Benefit Information: Website	X		X	X	PBM delegate possibility for Factors 6-8
MEM4B: Pharmacy Benefit Information: Telephone	X		X		
MEM4C: QI Process on Accuracy of Information	X		X		
MEM4D: Pharmacy Benefit Updates	X		X		

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
MEM5A: Functionality: Web Site	X		X		CO: Factors 1-3; Kaiser Factors 1,2,3; Factor4 NA
MEM5B: Functionality: Telephone	X	X	X		
MEM5C: Quality and Accuracy of Information	X	X	X		HN For telephone only
MEM5D: E-Mail Response Evaluation	X		X		
MEM6A: Supportive Technology	X		X		
MEM7A: Identifying Members	X		X		
MEM7B: Targeted Follow-Up with Members	X		X		
MEM8A: Delegation Agreement	X				
MEM8B: Provision Of Member Data to the Delegate	X				
MEM8D: Pre-delegation Evaluation	X				
MEM8E: Review of Performance	X				
MEM8F: Opportunities for Improvement	X				
MED1A: Direct Access to Women's Health Services	X				

## 2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
MED1B: Second Opinion	X	X	X		
MED1C: Out-of-Network Services	X	X			
MED1D: Out-of Network Cost to Member	X	X			
MED1E: Hours of Operation Parity	X	X			
MED2A: Distribution of Practice Guidelines	X				
MED3A: Coverage of Emergency Services	X	X			
MED4A: Performance Standards and Thresholds	X				
MED4B: Site Visits and Ongoing Monitoring	X				
MED5A: Privacy and Confidentiality	X				
MED5B: Authorization	X				
MED5C: Communication of PHI	X				



# **2018 Quality Improvement Program and Workplan**

**Board of Directors' Quality Assurance Committee Meeting  
February 20, 2018**

**Kelly Rex-Kimmet,  
Interim Executive Director, Quality and Analytics**

# 2018 QI Program Description

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- Our program description:
  - Encompasses all clinical care, clinical services and organizational services provided to our members
  - Uses evidence-based guidelines, data and best practices tailored to our populations
  - Utilizes support systems for our members with vulnerabilities, disabilities and chronic illnesses

# 2018 QI Program Description Revisions

---

- Updates the introductory pages to align with CalOptima's Vision, Mission & Strategic Plan for 2017-19;
- Updates signature page
  - Replaces Mark Refowitz with Paul Yost
- Updates the plans we offer, scope of services and who we work with, including an updated list of our Health Networks
- Updates new initiatives on the horizon, including Whole-Person Care and Whole-Child Model
- Updates the Behavioral Health Services
  - CalOptima directly manages for Medi-Cal members
  - Contracts with Magellan Health, Inc. for the BH services portion for OneCare and OneCare Connect

# 2018 QI Program Description Revisions

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- Updates the list of CalOptima Officers and staff, and included a broader representation of the key areas supporting the QI Program
- Incorporates the description of CalOptima's approach to population health management in the design and delivery of care
- Updates to include Conflict of Interest policy statement applicable to committee and subcommittee members
- Adds Cultural Competency Training during staff orientation, training and education

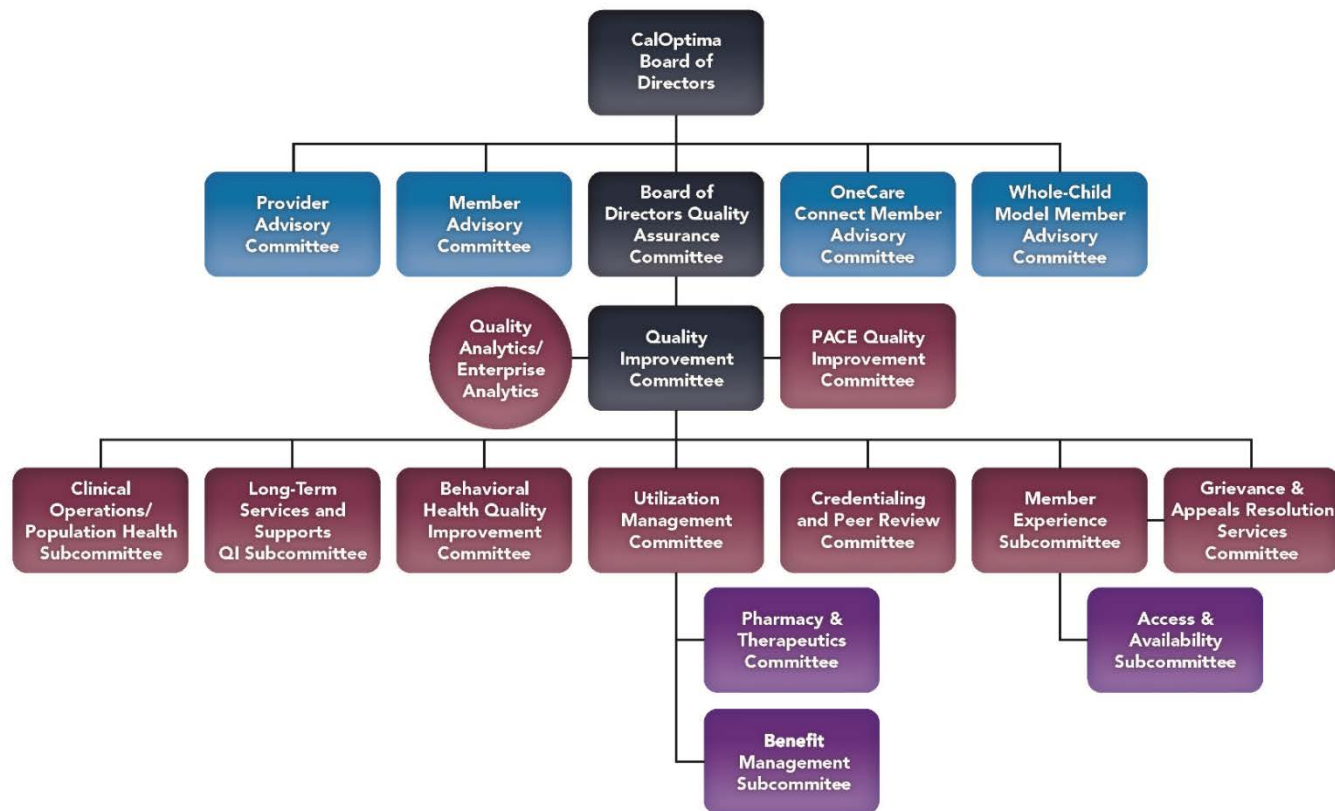
# 2018 QI Program Description Revisions

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- Updates BHQIC to monitor member experience with behavioral health services including call center, grievance and appeals, and potential for quality improvement
- Updates the 2018 QI Work Plan to reflect new goals and objectives in line with CalOptima's strategic objectives
- Updates 2018 Delegation Grid, removing Magellan as a delegated function for the Medi-Cal line of business
- Adds Farsi, Chinese and Arabic languages to the OCC member materials.

# 2018 QI Program Description Revisions

- Updates the Advisory Committees and Quality Committees and subcommittees structure that support the QI Program



# 2018 QI Work Plan Reporting & Monitoring

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- Goals set to meet or exceed previous year's achievement(s)
- Health Risk Assessments (OC/OCC/SPD) and Interdisciplinary Care Teams
- Behavioral Health Access and Coordination of Services
- LTSS initiatives, including placement, over/underutilization of services
- Pharmacy initiatives, including opioid reduction

# 2018 QI Work Plan Reporting & Monitoring

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- Continuous quality improvement projects for DHCS and CMS
- Patient safety initiatives and monitoring
- Continued focus on Member Experience in multiple areas
  - Including Access & Availability
- Improvement initiatives for HEDIS/STARS/CAHPS
- Further implementation of our Pay For Value programs
- Incorporates our Model of Care Quality Goals

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken February 20, 2018** **Regular Meeting of the CalOptima Board of Directors’** **Quality Assurance Committee**

#### **Report Item**

5. Consider Recommending the Board of Directors’ Approval of the 2018 CalOptima Utilization Management (UM) Program

#### **Contact**

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

#### **Recommended Action**

Recommend Board of Directors’ approval of the 2018 Utilization Management (UM) Program.

#### **Background**

Utilization Management activities are conducted to ensure that members’ needs are always at the forefront of any determination regarding care and services. The program is established and conducted as part of CalOptima’s purpose and mission to ensure the consistent delivery of medically necessary, quality health care services. It provides for the delivery of care in a coordinated, comprehensive and culturally competent manner. It also ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, nor does the program encourage decisions that result in underutilization. Additionally, the Utilization Management Program is conducted to ensure compliance with CalOptima’s obligations to meet contractual, regulatory and accreditation requirements.

CalOptima’s Utilization Management Program (“the UM Program”) must be reviewed and evaluated annually by the Board of Directors. The UM Program defines the structure within which utilization management activities are conducted, and establishes processes for systematically coordinating, managing and monitoring these processes to achieve positive member outcomes.

CalOptima staff has updated the 2018 UM Program Description to ensure that it is aligned to reflect health network and strategic organizational changes. This will ensure that all regulatory and NCQA accreditation standards are met in a consistent manner across the Medi-Cal, OneCare and OneCare Connect programs.

#### **Discussion**

The 2018 Utilization Management Program is based on the Board-approved 2017 Utilization Management Program and describes: (i) the scope of the program; (ii) the program structure and services provided; (iii) the populations served; (iv) key business processes; (v) integration across CalOptima; and (vi) important aspects of care and service for all lines of business. It is consistent with regulatory requirements, NCQA standards and CalOptima’s own Success Factors.

The revisions are summarized as follows:

1. Aligned program descriptions and committee references with the Quality Improvement Program

2. Updated program to reflect the transition of mild to moderate mental health benefit administration for the Medi-Cal program from Magellan to CalOptima, including a description of processes and resources implemented to support the transition.
3. Incorporated new health network risk structures (models) to reflect changes since the 2017 Program Description.
4. Updated description of responsibilities for various key positions.
5. Modified the description of Managed Long-Term Services and Supports to reflect In Home Support Services reverting to the County of Orange administrative responsibility.

The recommended changes are designed to better review, analyze, implement and evaluate the components of the UM Program, and are necessary to meet the requirements specified by the Centers for Medicare & Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

**Fiscal Impact**

There is no fiscal impact.

**Concurrence**

CalOptima Utilization Management Subcommittee

**Attachments**

1. 2018 Utilization Management Program Description Summary of Changes
2. Proposed 2018 Utilization Management Program
3. PowerPoint Presentation – 2018 Utilization Management Program Description

/s/ Michael Schrader  
**Authorized Signature**

2/12/2018  
**Date**

## **Utilization Management (UM) Program 2018**

### **Executive Summary of Revisions**

1. Aligned program descriptions and committee references with the Quality Management Program
2. Updated program to reflect the transition of mild to moderate mental health benefit administration for the Medi-Cal program from Magellan to CalOptima, including a description of processes and resources implemented to support the transition.
3. Updated Committee Structure Organization Chart, reflecting new structure and operational unit support
4. Incorporated new health network risk structures (models) to reflect changes since the 2017 Program Description.
5. Updated description of responsibilities for various key positions.
6. Modified the description of Managed Long-Term Services and Supports to reflect In Home Support Services reverting to the County of Orange administrative responsibility.



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# 20187 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION





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~~2018~~7

**2018 UTILIZATION MANAGEMENT  
PROGRAM  
SIGNATURE PAGE**

*Utilization Management Committee Chairperson:*

\_\_\_\_\_  
**Francesco Federico, M.D.**  
**Utilization Management Medical Director**

\_\_\_\_\_  
**Date**

*Board of Directors' Quality Assurance Committee Chairperson:*

\_\_\_\_\_  
**Paul Yost, M.D.**

\_\_\_\_\_  
**Date**

*Board of Directors Chairperson:*

**Paul Yost, MD**

**Date**

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# ~~20187 UTILIZATION MANAGEMENT~~

## PROGRAM DESCRIPTION

### WE ARE CALOPTIMA

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

#### Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

#### Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

#### Our Values — CalOptima CARES

**C**ollaboration: We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

**A**ccountability: We were created by the community, for the community, and are accountable to the community. Our Board of Directors, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, Quality Assurance Committee and Finance and Audit Committee meetings are open to the public.

**R**espect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members

We respect and care about our partners. We develop supportive working relationships with providers, community health centers and community stakeholders.

**Excellence:** We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

**Stewardship:** We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

### **We are “Better. Together.”**

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are “Better. Together.”

### **Our Strategic Plan**

CalOptima's 2017–19 Strategic Plan honors our long-standing mission focused on members while recognizing that the future holds some unknowns given possible changes for Medicaid plans serving low-income people through the Affordable Care Act. Still, any future environment will demand attention to the priorities of more innovation and increased value, as well as enhanced partnerships and engagement. Additionally, CalOptima must focus on workforce performance and financial strength as building blocks so we can achieve our strategic goals. Below are the key elements in our Strategic Plan framework.

### **Strategic Priorities:**

- **Innovation:** Pursue innovative programs and services to optimize member access to care.
- **Value:** Maximize the value of care for members by ensuring quality in a cost-effective way.
- **Partnerships and Engagement:** Engage providers and community partners in improving the health status and experience of members.

### **Building Blocks:**

- **Workforce Performance:** Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes.
- **Financial Strength:** Provide effective financial management and planning to ensure long-term financial strength.

## **WHAT IS CALOPTIMA?**

### **Our Unique Dual Role**

CalOptima is unique in that **IT IS** both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optional health outcomes for our members
- Support member and provider engagement and satisfaction
- Be good stewards of public funds by making the best use of our resources and expertise

- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input
- Be accountable for the decisions we make

## WHAT WE OFFER:

### Medi-Cal

In California, Medicaid is known as Medi-Cal. For more than 20 years, CalOptima has been serving Orange County's Medi-Cal population. Due to the implementation of the Affordable Care Act — as more low-income children and adults qualified for Medi-Cal — membership in CalOptima grew by an unprecedented 49 percent between 2014 and 2016!

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

### Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.

<a href="#">Acupuncture</a>	<a href="#">Hospice care</a>	<a href="#">Outpatient mental health services – limited</a>
<a href="#">Adult preventive services</a>	<a href="#">Hospital/inpatient care</a>	<a href="#">Pediatric preventive services</a>
<a href="#">Community-based adult services</a>	<a href="#">Immunizations</a>	<a href="#">Child health and disability prevention (CHDP)</a>
<a href="#">Doctor visits</a>	<a href="#">Laboratory services</a>	<a href="#">Physical therapy</a>
<a href="#">Durable medical equipment</a>	<a href="#">Limited allied health services</a>	<a href="#">Prenatal care</a>
<a href="#">Emergency care</a>	<a href="#">Medical supplies</a>	<a href="#">Specialty care services</a>
<a href="#">Emergency transportation</a>	<a href="#">Medications</a>	<a href="#">Speech therapy</a>
<a href="#">Non-emergency medical transportation (NEMT) and non-medical transportation (NMT)</a>	<a href="#">Newborn care</a>	<a href="#">Substance use disorder preventive services – limited</a>
<a href="#">Hearing aid(s)</a>	<a href="#">Nursing facility services</a>	<a href="#">Vision care</a>
<a href="#">Home health care</a>	<a href="#">Occupational therapy</a>	

Certain services are not covered by CalOptima, or may be provided by a different agency, including those indicated below:

- [Specialty mental health services are administered by Orange County Health Care Agency \(OC HCA\).](#)
- [Substance use disorder services are administered by OC HCA.](#)
- [Dental services are provided through California's Denti-Cal program.](#)
- [Eligible conditions under California Children's Services \(CCS\).](#)

### **Members With Special Health Care Needs**

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care, and are described in the Utilization Management (UM) Program and Case Management (CM) Program.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established through special programs, such as the CalOptima Member Liaison program, and specific Memoranda of Understanding (MOU) with certain community agencies, including OC HCA, CCS and the Regional Center of Orange County (RCOC).

### **Medi-Cal Managed Long-Term Services and Supports**

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

### **OneCare (HMO SNP)**

Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

To be a member of OC, a person must live in Orange County, be enrolled in Medi-Cal and Medicare Parts A and B, and not be eligible for OCC.

### **Scope of Services**

OC provides a comprehensive scope of services for the dual eligible members who are not eligible for OCC, and who voluntarily enroll in OC.

These services include but are not limited to the following:

<u>Acupuncture and other alternative therapies</u>	<u>Gym membership</u>	<u>Prescription drugs</u>
<u>Ambulance</u>	<u>Hearing services</u>	<u>Preventative care</u>
<u>Chiropractic care</u>	<u>Home health care</u>	<u>Prosthetic devices</u>
<u>Dental services – limited</u>	<u>Hospice</u>	<u>Renal dialysis</u>

<a href="#">Diabetes supplies and services</a>	<a href="#">Inpatient hospital care</a>	<a href="#">Skilled nursing facility</a>
<a href="#">Diagnostic tests, lab and radiology services, and X-rays</a>	<a href="#">Inpatient mental health care</a>	<a href="#">Transportation for medical and pharmacy visits</a>
<a href="#">Doctor visits</a>	<a href="#">Mental health care</a>	<a href="#">Urgently needed services</a>
<a href="#">Durable medical equipment</a>	<a href="#">Outpatient rehabilitation</a>	<a href="#">Vision services</a>
<a href="#">Emergency care</a>	<a href="#">Outpatient substance abuse</a>	
<a href="#">Foot care</a>	<a href="#">Outpatient surgery</a>	

## **OneCare Connect**

[OneCare Connect Cal MediConnect Plan \(Medicare-Medicaid Plan\) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect \(OCC\) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.](#)

[These members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.](#)

[At no extra cost, OCC adds benefits such as vision care, gym benefits and enhanced dental benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.](#)

[OCC achieves these advancements via CalOptima’s innovative Model of Care. Each member has a Personal Care Coordinator \(PCC\) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member’s needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.](#)

[To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions apply.](#)

## **Scope of Services**

[OCC simplifies and improves health care for low-income seniors and people with disabilities.](#)

These services include but are not limited to the following:

<a href="#">Acupuncture (pregnant women)</a>	<a href="#">Hearing aids – limited</a>	<a href="#">Rehabilitation services</a>
<a href="#">Ambulance services</a>	<a href="#">Hearing screenings</a>	<a href="#">Renal dialysis</a>
<a href="#">Case management</a>	<a href="#">Incontinence supplies – limited</a>	<a href="#">Screening tests</a>
<a href="#">Chiropractic services</a>	<a href="#">Inpatient hospital care</a>	<a href="#">Skilled nursing care</a>
<a href="#">Community-based adult services (CBAS)</a>	<a href="#">Inpatient mental health care</a>	<a href="#">Specialist care</a>
<a href="#">Diabetes supplies and services</a>	<a href="#">Institutional care</a>	<a href="#">Substance abuse services</a>
<a href="#">Disease self-management</a>	<a href="#">Lab tests</a>	<a href="#">Supplemental dental services</a>
<a href="#">Doctor visits</a>	<a href="#">Medical equipment for home care</a>	<a href="#">Transportation for medical and pharmacy visits</a>
<a href="#">Durable medical equipment</a>	<a href="#">Mental or behavioral health services</a>	<a href="#">Transgender services</a>
<a href="#">Emergency care</a>	<a href="#">Multipurpose Senior Services Program (MSSP)</a>	<a href="#">Occupational, physical or speech therapy</a>
<a href="#">Eye exams</a>	<a href="#">Over-the-counter drugs – limited Prescription drugs</a>	<a href="#">Urgent care</a>
<a href="#">Foot care</a>	<a href="#">Outpatient care</a>	<a href="#">“Welcome to Medicare” preventive visit</a>
<a href="#">Glasses or contacts – limited</a>	<a href="#">Preventive care</a>	
<a href="#">Gym membership</a>	<a href="#">Prosthetic devices</a>	
<a href="#">Health education</a>	<a href="#">Radiology</a>	

### **Program of All-Inclusive Care for the Elderly (PACE)**

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in our Orange County service area, be determined as eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

### **Scope of Services**

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participates.

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for participants, based on their needs as indicated by the Interdisciplinary Team.

PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

## **NEW PROGRAM INITIATIVES ON OUR HORIZON**

### **Whole-Person Care**

Whole-Person Care is a five-year pilot established by DHCS as part of California's Medi-Cal 2020 strategic plan and led by the Orange County Health Care Agency. It will focus on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness.

## **WHOM WE WORK WITH:**

### **Contracted Health Networks/Contracted Network Providers**

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima health network, and/or participate through CalOptima Direct, and/or the CalOptima Community Network. CalOptima members can choose one of 15 health networks (HNs), representing more than 7,500 practitioners.

### **CalOptima Community Network (CCN)**

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 14 HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing health network delivery model and creating additional capacity for growth.

### **CalOptima Direct (COD)**

CalOptima Direct is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's MA SNP), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct are not health network eligible.

### **Health Networks**

CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima's HNs consist of Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), and Shared Risk Medical Groups (SRGs). Through these HNs, CalOptima members have access to more than 1,593 Primary Care Providers (PCPs), nearly 6,092 specialists, 30 hospitals, and 36 clinics. New health networks that demonstrate the ability to comply with CalOptima's delegated requirements are added as needed with CalOptima Board approval.

The following are CalOptima's contracted health networks:

<u>Health Network/Delegate</u>	<u>Medi-Cal</u>	<u>OneCare</u>	<u>OneCare Connect</u>
<u>AltaMed Health Services</u>	<u>SRG</u>	<u>SRG</u>	<u>SRG</u>
<u>AMVI/Prospect</u>		<u>SRG</u>	
<u>AMVI Care Health Network</u>	<u>PHC</u>		<u>PHC</u>
<u>Arta Western Health Network</u>	<u>SRG</u>	<u>SRG</u>	<u>SRG</u>
<u>CCN</u>			
<u>CHOC Health Alliance</u>	<u>PHC</u>		
<u>Family Choice Health Network</u>	<u>PHC</u>	<u>SRG</u>	<u>SRG</u>
<u>Heritage</u>	<u>HMO</u>		<u>HMO</u>
<u>Kaiser Permanente</u>	<u>HMO</u>		
<u>Monarch Family HealthCare</u>	<u>HMO</u>	<u>SRG</u>	<u>HMO</u>
<u>Noble Mid-Orange County</u>	<u>SRG</u>	<u>SRG</u>	<u>SRG</u>
<u>OC Advantage Medical Group</u>	<u>PHC</u>		<u>PHC</u>
<u>Prospect Medical Group</u>	<u>HMO</u>		<u>HMO</u>
<u>Talbert Medical Group</u>	<u>SRG</u>	<u>SRG</u>	<u>SRG</u>
<u>United Care Medical Group</u>	<u>SRG</u>	<u>SRG</u>	<u>SRG</u>

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

## ~~ABOUT CALOPTIMA~~

~~THE MISSION OF CALOPTIMA IS TO PROVIDE MEMBERS WITH ACCESS TO QUALITY HEALTH CARE SERVICES DELIVERED IN A COST EFFECTIVE AND COMPASSIONATE MANNER.~~

~~CARING FOR THE PEOPLE OF ORANGE COUNTY HAS BEEN CALOPTIMA'S PRIVILEGE SINCE 1995. CALOPTIMA'S MEDICAID (MEDI-CAL) AND MEDICARE MEMBERS DESERVE THE HIGHEST QUALITY CARE AND SERVICE THROUGHOUT THE HEALTH CARE CONTINUUM.~~

## ~~CALOPTIMA'S PROGRAMS:~~

~~CALOPTIMA HAS FOUR PROGRAMS THAT IT ADMINISTERS:~~

~~1. CALOPTIMA MEDI-CAL — CALIFORNIA'S MEDICAID PROGRAM IS KNOWN AS MEDI-CAL.~~

~~ONECARE CONNECT — ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE MEDICAID PLAN) A DEMONSTRATION PROGRAM FOR LOW-INCOME PEOPLE WHO QUALIFY FOR MEDICARE AND MEDI-CAL.~~

~~2. ONECARE (HMO SNP) — A PROGRAM FOR PERSONS WHO QUALIFY FOR BOTH MEDICARE AND MEDI-CAL, BUT DO NOT QUALIFY FOR ONECARE CONNECT.~~

~~3. ONECARE CONNECT — ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE MEDICAID PLAN) A DEMONSTRATION PROGRAM FOR LOW INCOME PEOPLE WHO QUALIFY FOR MEDICARE AND MEDI-CAL.~~

~~4. CALOPTIMA PACE — PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) THAT PROVIDES COORDINATED AND INTEGRATED HEALTH CARE SERVICES TO FRAIL ELDERS WHO LIVE INDEPENDENTLY.~~

~~FOR MORE DETAILS ABOUT CALOPTIMA, AS WELL AS THE~~

~~SCOPE OF SERVICES FOR THE ABOVE PROGRAMS, PLEASE SEE  
THE 20187 QUALITY IMPROVEMENT PROGRAM PAGES 1-8.~~  
**UTILIZATION MANAGEMENT PROGRAM DESCRIPTION**

**UM Purpose**

The purpose of the Utilization Management (UM) Program Description is to define ~~the~~ CalOptima's structures and processes ~~within the UM department~~ to review health care services, treatment and supplies, including assignment of responsibility to appropriate individuals, ~~in order to~~ deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, timely manner by delegated and non-delegated providers.

**UM Scope**

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, home and community based services, as well as acute, short term, long-term facility and ancillary care services.

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## UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services to optimize members' health status. We achieve this by providing members with a sense of well-being and productivity through ensure access to quality and cost-effective health care for CalOptima members. ~~Concurrently, there is active management of the appropriate utilization of health plan services in order to ensure that appropriate processes are used to review and approve the provision of medically necessary covered services. The clinical goals include but are not limited to:~~

- Assist in the coordination of medically necessary medical and behavioral health care services in accordance with state and federal laws, regulations, contract requirements, National Committee for Quality Assurance (NCQA) Standards as indicated by evidence based clinical criteria and evidence based clinical criteria.

~~Assure that care provided conforms to acceptable clinical quality standards.~~

- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for ~~clinical~~ activities specifically regarding decisions based on medical necessity.
- Establish and maintain the processes used to review ~~and approve the provision of~~ medical and behavioral health care service requests, including timely notification to members and/or providers of an appeal rights when an adverse benefit determination is made. ~~process for adverse determinations.~~
- Identify and refer high-risk, high cost members for referral to the ~~the~~ Case Coordination Management and Care Coordination Programs, including Complex Case Management, Long-Term Services and Supports (LTSS), Behavioral Health and/or ~~the~~ Health Education & Disease Management Programs as appropriate. ~~when indicated and provided by CalOptima.~~
- Promote a high level of satisfaction across members, practitioners and stakeholders satisfaction, and client organizations.

~~Comply with all applicable regulatory and accrediting agency rules, regulations and standards, and applicable state and federal laws that govern the UM process.~~

- Protect the confidentiality of member protected health information and other personal/~~provider~~ information.
- ~~Provide a mechanism and process for i~~Identifying potential quality of care issues and referreporting them to the Quality Improvement department for further action ~~when necessary.~~
- ~~Identify and resolve problems and~~ issues that contribute result to over or under utilization underutilization or and the inefficient or inappropriate used delivery of health care services.

~~Identify opportunities to optimize the health of members through quality initiatives for health education/disease management programs, focused population interventions, and preventive care services, and coordinating the implementation of these initiatives with the activities delegated to contract Health Maintenance Organizations (HMOs), Physician Hospital Consortias (PHCs), Shared Risk Medical Groups (SRGs) and Provider Medical Groups (PMGs).~~

- Promotes improved ~~Optimize the~~ member's health and well-being by ~~benefits by~~ linking and coordinating services with ~~the~~ appropriate county/state sponsored programs such as Community Based Adult Services, (CBAS), In-Home Supportive Services (IHSS), County Specialty Mental Health and California Children's Services (CCS).

~~, and Multipurpose Senior Services Program, (MSSP).~~

- Educate practitioners ~~and~~; providers, ~~including delegated Health Networks~~ HMOs, PHCs, SRGs and PMGs on CalOptima's UM Program, policies ~~and~~; procedures, ~~and program requirements to ensure compliance with the goals and objectives of the UM Program.~~
- Monitor utilization practice patterns of practitioners to identify variations ~~from the norm~~ standard practice that may indicate need for additional education or support. ~~and implement best practice guidelines.~~

### Providers

#### Contracted Health Networks/Network Providers/Hospitals

~~In 2014, CalOptima contracted with a variety of Health Networks to provide care to Orange County's beneficiaries. Since 2008 CalOptima has also included HMOs, PHCs, and SRGs. CalOptima's HMOs, PHCs, and SRGs include over 3,500 primary care providers (PCPs) and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements will be added as needed.~~

#### Delegation of UM functions

CalOptima physician groups are delegated for the following clinical and administrative functions:

- ~~UM and Case Management~~
- ~~Claims~~
- ~~Contracting~~
- ~~Credentialing of practitioners~~
- ~~Member Services~~
- ~~Cultural and Linguistic Services~~

CalOptima delegates ~~various~~ UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM ~~Program Description~~ ~~plan and~~ ~~and~~ CalOptima policies and procedures. ~~CalOptima conducts ongoing oversight on a regular basis and performs an annual review of each delegate's UM Program.~~ Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards; including timeframes outlined in CalOptima's policy and procedure. (GG.1508: Authorization and Processing of Referrals; Attachment A, Timeliness of UM Decisions and Notifications.)
- ~~Delegates' written UM program description/plan are reviewed annually and approval by CalOptima's Quality Improvement Committee (QIC). Submission of required monthly reports which include but are not limited to: UM data, denial information and quality assurance/improvement issues and activities.~~

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

~~Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.~~

- ~~Monthly Routine~~ reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, UM Committee (UMC) and/or QIC.

- Regular audits of delegated HNs utilization management activities by the Audit and Oversight Department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to CalOptima standards and state program requirements.
- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.
- ~~Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to CalOptima standards and state program requirements.~~

In the event ~~that~~ the delegated provider does not adequately perform contractually specified delegated duties, CalOptima ~~may~~ takes further action, ~~up to and including~~ selected increasing the frequency or number of focused audits/reviews, requiring the delegate to implement corrective actions, imposing sanctions, ~~capitation adjustments, probation, suspension or de-delegation.~~

At the time of pre-delegation, CalOptima evaluates the compatibility of the delegate's UM program with CalOptima's UM Program. Once delegation is approved, CalOptima requires that the delegate provide the appropriate reports as determined by CalOptima to monitor the delegate's continued compliance with the needs of CalOptima. CalOptima annually review ongoing accreditation status and compliance. Oversight for all delegated activities is performed by CalOptima's Audit and Oversight department.

#### Medi-Cal Managed Long-Term Services and Supports

#### Beginning July 1, 2015, Long Term Services and Support

is a CalOptima benefit for all Medi-Cal enrollees. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community based services. has two primary components with four programs.

#### Nursing Facility Services for Long-Term Care: Nursing Facility:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
  - Nursing Facility Level B
  - Nursing Facility Level A
  - Subacute Adult and Pediatric
  - Intermediate Care Facility / Developmentally Disabled, (ICF/DD)
  - Intermediate Care Facility / Developmentally Disabled Habilitative, (ICF/DD-H)
  - Intermediate Care Facility / Developmentally Disabled Nursing, (ICF/DD-N)
- Nursing Facility Services for Long Term Care Services: Medical necessity for LTC is evaluated based upon the CalOptima utilizes the Department of Health Care Services (DHCS) Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services and Title 22, CCR, Sections: 51003, 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2 51303, 51511(b), 51334, 51335, and 51343.
- CalOptima is responsible for the clinical review, medical determination and performs authorization functions for Long Term Care services for the following levels of care:
  - Nursing Facility Level B, (Long Term Care)
  - Nursing Facility Level A
  - Subacute Adult and Pediatric

~~Intermediate Care Facility / Developmentally Disabled, (ICF/DD)~~  
~~Intermediate Care Facility / Developmentally Disabled Habilitative, (ICF/DD-H)~~  
~~Intermediate Care Facility / Developmentally Disabled Nursing, (ICF/DD-N)~~

#### Home and Community Based Services:

- Community Based Adult Services (CBAS): ~~An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima evaluates medical necessity for services provides CBAS as a health plan benefit. CalOptima utilizes the DHCS approved CBAS using the CBAS Eligibility Determination Tool (CEDT)) criteria to assess a member's health condition and make a medical determination for the program. CBAS is an outpatient, facility-based program that offers health and social services to seniors and persons with disabilities.~~
- Multipurpose Senior Services Program (MSSP): ~~CalOptima is responsible for identification-referral and Home and community based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long term nursing facility care integrated services within the MSSP site. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria. IHSS: CalOptima and the health networks are responsible for identification, referral and care coordination. CalOptima collaborates with Orange County Social Services Agency (SSA), IHSS, Orange County Public Authority and health networks to ensure members receive appropriate level of care services.~~

#### **Behavioral Health Services**

##### **Medi-Cal Outpatient Ambulatory Behavioral Health Services**

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include but are not limited to: individual and group psychotherapy, psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits including utilization management, claims, credentialing the provider network, member services, and quality improvement.

~~In addition, CalOptima covers behavioral health treatment (BHT) services for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD).~~

Behavioral health services within the scope of practice for primary care physicians (PCPs), ~~may~~ include ~~offering~~ screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary. In addition, PCPs frequently manage the treatment of their patients' mental health conditions.

Beginning in 2018, CalOptima will directly manage all administrative functions of the Medi-Cal

~~behavioral health benefits including utilization management, claims, credentialing the provider network, member services, and quality improvement. CalOptima members can access behavioral health services by calling the CalOptima Behavioral Health Line toll free at 855-877-3885. By selecting the Medi-Cal option, the member will be connected to a CalOptima representative for behavioral health triage.~~

~~If a member needs behavioral health office-based services not provided by their PCP are appropriate, the member will be, CalOptima members can access behavioral health services directly, without a physician referral by contacting the CalOptima representative for behavioral health assistance. The member will be provided with several behavioral health practitioners contact information, based upon geographic proximity to the member's residence and their clinical needs. If the member meets criteria for Specialty Mental Health Services, the member is referred to the Orange County Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima~~

~~In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD). provided with options of behavioral health practitioners. If the member meets criteria for Specialty Mental Health Services, the member is referred to the Orange County Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima.~~

~~CalOptima delegates to Magellan Health Inc. for utilization management of the provider network, credentialing the provider network, managing the CalOptima Behavioral Health Phone Line, and several other quality improvement functions.~~

~~CalOptima members access Behavioral Health Services by calling the CalOptima Behavioral Health Phone Line toll free at 855-877-3885. If office based services are appropriate, the member is registered in the Magellan system and referrals to an appropriate provider are given to the member. If the member meets criteria for Specialty Mental Health Services, the member is referred to the County Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima.~~

CalOptima ensures members with coexisting medical and behavioral health care needs have adequate coordination and continuity of their care. Communication with both the medical and behavioral health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and behavioral health practitioners involved.

#### Services Not Provided by CalOptima

~~Under its Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and contract.~~

~~Other services may be provided by different agencies including those indicated below:~~

~~Specialty mental health services are administered by the Orange County Health Care Agency (HCA) County Mental Health Plan.~~

~~Dental services are provided through California's Denti-Cal program.~~

~~California Children's Services (CCS) is a statewide program managed by DHCS and authorizes and pays for specific medical services and equipment provided by CCS approved specialists for children with certain physical limitations and chronic health conditions or diseases.~~

~~Regional Center of Orange County is a local agency contracted by the State of California to coordinate lifelong services and supports for people with developmental disabilities, Regional~~

Center of Orange County, (RCOC), provides services and supports that are as diverse as the people served. Each person serviced by RCOC has an individual Family Service Plan (IFSP) that addresses his or her individual needs. The following are types of services and supports available through RCOC, or that RCOC can assist clients and families access through other sources:

Prenatal Diagnostic Evaluation

Early Intervention Services, (Birth to 36 months)

Therapy Services

Respite Care Services

Child Care Services

Adult Day Program Services, (Employment and Community Based Activities)

Transportation Services

Residential Services

Psychological, Counseling and Behavioral Services

Medical and Dental Services

Equipment and Supplies

Social and Recreational Services

In addition, CalOptima provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap around services that enhance their medical benefits. These linkages are established through special programs, such as the CalOptima Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the Orange County Health Care Agency's California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate state agencies and specialist care when the benefit coverage of the member dictates. The UM department coordinates activities with the Case Management and/or Disease Management departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

#### **OneCare and OneCare Connect Behavioral Health Services**

CalOptima has contracted with Magellan Health Inc. for the behavioral health services portion of OneCare and OneCare Connect. Functions delegated to Magellan include utilization management, credentialing, and customer service.

CalOptima OneCare and OneCare Connect members can access bBehavioral hHealth sServices by calling the CalOptima Behavioral Health Line Magellan at 855-877-3885. By selecting the OneCare or and OneCare Connect option, the member will be transferred to a Magellan representative for behavioral health triage. If office-based services are appropriate, the member is registered and given referrals to an the appropriate provider are given to the member. If ambulatory Specialty Mental Health needs are identified, services may be rendered through at the Orange County Mental Health Plan.

CalOptima offers screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling

interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

#### CalOptima Direct (COD)

CalOptima Direct Administrative (COD-A) is a fee-for-service program administered by CalOptima. Some members are enrolled in COD-A on a permanent basis, and may not be eligible to join a health network because they meet certain COD-A eligibility criteria. Permanent members of COD-A include share-of-cost members, that are not enrolled in either OneCare or OneCare Connect (members eligible with both Medicare and Medi-Cal), retro-assigned, and out-of-Orange County residents. COD-A also provides benefits to new members transitioning to a health network that are enrolled in CalOptima Direct on a temporary basis.

#### CalOptima Community Network (CCN)

CalOptima Community Network (CCN) is a managed care program administered by CalOptima to serve Medi-Cal members, and dual eligibles (those with both Medicare and Medi-Cal) who elect to participate in the Cal MediConnect program detailed below. CCN is open to participation of any willing and qualified provider. CalOptima already contracts with a variety of providers: PHCs, HMOs, and SRGs. With CCN, individual providers have the option of contracting directly with CalOptima.

#### Dual-Eligible Programs

##### OneCare

*For a complete description of the OneCare program and scope of services, please see the 20187 Quality Improvement Program, pages 5-6.*

OneCare members qualify for Medicare by age (turning 65) or by disability (24 months of Social Security Disability Insurance [SSDI], End Stage Renal Disease [ESRD], or Amyotrophic Lateral Sclerosis [ALS]). Nearly one-third of OneCare members are under 65. OneCare members qualify for Medicaid by standards established by the State of California and administered at the county social services agency level. The standards for qualifying for state Medicaid include a review of income, assets, and in some cases, medical condition.

The threshold languages spoken by the majority of OneCare members are English, Spanish, Farsi, Vietnamese, Korean, and Chinese, and Arabic. Vietnamese. OneCare members represent over twenty ethnic groups including White, Asian/Pacific Islander, Alaskan native, American Indian, African American and Hispanic.

The management of OneCare's Medicare covered benefits is delegated to the PMGs. CalOptima manages the Medi-Cal wrap-around and taxi transportation determinations. CalOptima performs concurrent review for members who are admitted to out-of-area hospitals.

CalOptima works with community programs to ensure that individual needs are met for members with special health care needs and/or chronic or high-risk complex medical conditions. This includes, but is not limited to Meals on Wheels, Dayle MacIntosh Developmental Center, Orange County Social Service Agency, and Orange County Goodwill. It also includes Orange County Community Centers with direct links to the Long-Term Support Services and Supports (LTSS) and the Orange County Aging and Disability Resource Center (ADRC).

To ensure that coordinated community and clinical services are accessible and available to Seniors and Persons with Disabilities (SPD) members, CalOptima has developed a robust Model of Care that defines case management activities that includes nurses, social workers, behavioral health specialists, and personal care coordinators (PCCs). These case management services are designed to ensure coordination and continuity of care for every member, and are described in the Case Management Program Description.

#### OneCare Connect

CalOptima's OneCare Connect (Cal MediConnect) program, is a three-year demonstration project by California and the federal government to begin the process — through a single organized health care delivery system — of integrating the delivery of medical, behavioral health, LTSS and CBAS for dual-eligible beneficiaries. A key feature of OneCare Connect is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individualized care plan.

*For a complete description of the OneCare Connect program and scope of services, please see the 20187 Quality Improvement Program, pages 6–7.*

In addition, CalOptima provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits. These linkages are established through special programs, such as the CalOptima Community Liaisons, and specific program Contracts and Memoranda of Understanding (MOUs) with other community agencies and programs, such as the Orange County Health Care Agency's California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate state agencies and specialist care when the benefit coverage of the member dictates. The UM department coordinates activities with the Case Management and/or Disease Management departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

#### Services Not Provided by CalOptima

Under its Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and contract.

Other services may be provided by different agencies including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA) County Mental Health Plan.
- Dental services are provided through California's Denti-Cal program.
- California Children's Services (CCS) is a statewide program managed by DHCS and authorizes and pays for specific medical services and equipment provided by CCS approved specialists for children with certain physical limitations and chronic health conditions or diseases.
- Regional Center of Orange County is a local agency contracted by the State of California to coordinate lifelong services and supports for people with developmental disabilities. Regional Center of Orange County, (RCOC), provides services and supports that are as diverse as the people served. Each person serviced by RCOC has an individual Family Service Plan (IFSP) that addresses his or her individual needs. The following are types of services and supports available through RCOC, or that RCOC can assist clients and families access through other sources:
  - Prenatal Diagnostic Evaluation
  - Early Intervention Services, (Birth to 36 months)
  - Therapy Services
  - Respite Care Services
  - Child Care Services
  - Adult Day Program Services, (Employment and Community Based Activities)
  - Transportation Services
  - Residential Services
  - Psychological, Counseling and Behavioral Services
  - Medical and Dental Services
  - Equipment and Supplies
  - Social and Recreational Services

**CALOPTIMA'S UTILIZATION MANAGEMENT PROGRAM**~~**IN ADDITION, CALOPTIMA PROVIDES LINKAGES WITH COMMUNITY PROGRAMS TO ENSURE THAT MEMBERS WITH SPECIAL HEALTH CARE NEEDS, OR HIGH RISK OR COMPLEX MEDICAL AND DEVELOPMENTAL CONDITIONS, RECEIVE WRAP AROUND SERVICES THAT ENHANCE THEIR MEDICAL BENEFITS. THESE LINKAGES ARE ESTABLISHED THROUGH SPECIAL PROGRAMS, SUCH AS THE CALOPTIMA COMMUNITY LIAISONS, AND SPECIFIC PROGRAM MEMORANDA OF UNDERSTANDING (MOU) WITH OTHER COMMUNITY AGENCIES AND PROGRAMS,**~~

~~SUCH AS THE ORANGE COUNTY HEALTH CARE AGENCY'S CALIFORNIA CHILDREN'S SERVICES, ORANGE COUNTY DEPARTMENT OF MENTAL HEALTH, AND THE REGIONAL CENTER OF ORANGE COUNTY. THE UM STAFF AND DELEGATED ENTITY PRACTITIONERS ARE RESPONSIBLE FOR IDENTIFICATION OF SUCH CASES, AND COORDINATION OF REFERRAL TO APPROPRIATE STATE AGENCIES AND SPECIALIST CARE WHEN THE BENEFIT COVERAGE OF THE MEMBER DICTATES. THE UM DEPARTMENT COORDINATES ACTIVITIES WITH THE CASE MANAGEMENT AND/OR DISEASE MANAGEMENT DEPARTMENTS TO ASSIST MEMBERS WITH THE TRANSITION TO OTHER CARE, IF NECESSARY, WHEN BENEFITS END. THIS MAY INCLUDE INFORMING THE MEMBER ABOUT WAYS TO OBTAIN CONTINUED CARE THROUGH OTHER SOURCES, SUCH AS COMMUNITY RESOURCES.~~

### **CalOptima Board of Directors**

#### **Authority, Responsibility and Accountability**

The CalOptima Board of Directors has ultimate authority, accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC). The Board holds the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The responsibility for the direction and management of the UM Program has been delegated to the Chief Medical Officer (CMO). Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the [Utilization Management Subcommittee](#) (UMC), the Quality Improvement Committee (QIC) and the Quality Assurance Committee (QAC) on an annual basis.

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## **CalOptima Officers and Directors**

CalOptima's CMO, Deputy CMO, and Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral quality improvement, medical and behavioral utilization review and authorization, case management, disease management and health education program implementations, with successful operation of the UMC, QIC and QAC, and UMC.

## **Chief Medical Officer**

The Chief Medical Officer (CMO), along with the Deputy Chief Medical Office (DCMO) oversees the UM Program, including the strategies, programs, policies and procedures as they related to CalOptima's medical care delivery system, has operational responsibility for and provides support to. The CMO and DCMO oversee CalOptima's UM Program. CalOptima's CMO, Deputy CMO, and Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program including appropriate use of health care resources, medical and behavioral quality improvement, medical and behavioral utilization review and authorization, case management, disease management and health education program implementations, with successful operation of the QIC, QAC and UMC.

## **Deputy Chief Medical Officer**

The Deputy Chief Medical Officer (DCMO). along with the Chief Medical Office (CMO) oversees the strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The CMO and DCMO oversee CalOptima's UM Program.

The CMO's responsibilities include, but are not limited to coordination and oversight of the following activities:

- Assists in the development/revision of UM policies and procedures as necessary to meet state and federal statutes, regulations and accrediting agency requirements;
- Monitors compliance with the UM Program;
- Appoints the Chairperson of the UMC;
- Chairs the UM Workgroup (UMG);
- Provides clinical support to the UM staff in the performance of their UM responsibilities;
- Assures that the medical necessity criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy but not less than annually;
- Assures that the medical necessity criteria are applied in a consistent manner;
- Ensures that there are no financial incentives for practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care;
- Assures that reviews of cases that do not meet medical necessity criteria are conducted by appropriate physicians or other appropriate health care professionals in a manner that meets all pertinent statutes and regulations and takes into consideration the individual needs of the involved members;
- Assures that appropriate health care professionals review, approve, and sign denial letters for cases that do not meet medical necessity criteria after appropriate review has occurred in accordance with UM Policy and Procedure GG.1508: Authorization and Processing of Referrals;
- Assures the medical necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and regulations, is consistent with all applicable accreditation standards, and is done in a consistent and efficient manner;
- Provides a point of contact for practitioners calling with questions about the UM process;
- Communicates/consults with practitioners in the field as necessary to discuss UM issues;

- Coordinates and oversees the delegation of UM activity as appropriate and monitors that delegated arrangement to ensure that all applicable contractual requirements and accreditation standards are met;
  - Assures there is appropriate integration of physical and behavioral health services for all plan members;
  - Participates in and provides oversight to the UMC and all other physician committees or subcommittees;
  - Recommends and assists in monitoring corrective actions, as appropriate, for practitioners with identified deficiencies related to UM;
  - Serves as a liaison between UM and other plan departments;
  - Educates practitioners regarding UM issues, activities, reports, requirements, etc.;
- Reports UM activities to the QIC as needed.

**Executive Director of Clinical Operations (EDCO)** is responsible for oversight of all operational aspects of key Medical Affairs functions including: the Utilization Management, Case Management, and Managed Long-Term Services and Support (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED of Clinical Operations serves as a member of the executive team and, with the CMO, DCMO and the ED of QA, ensures that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals and objectives. The ED of Clinical Operations is expected to anticipate, continuously improve, communicate and leverage resources, as well as balance achieving set accountabilities with constraints of limited resources.

**Medical Director of Utilization Management**, appointed by the CMO and/or DCMO, is responsible for the direction of the UM Program objectives to drive the organization's mission, strategic goals and processes to provide high quality care to CalOptima members in a compassionate and cost-effective manner. The Medical Director ensures that an appropriate licensed professional conducts reviews on cases that do not meet medical necessity, and utilizes evidence based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO, the Medical Director of UM also provides supervisory oversight and administration of the UM Program. HeThe Medical Director of UM also oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions. -Medical Director of UMHe provides clinical education and in-services to staff weekly and on an as needed basis, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The Medical Director of UM ensures physician availability to staff during normal business hours and on-call after hours. He or she serves as the Chair of the Utilization Management Committee and the Benefit Management Subcommittee, and participates in the CalOptima Medical Directors Forum and Quality Improvement Committee. -assists in the development and implementation of the UM Program, policies, and procedures. Ensures that an appropriate licensed professional conducts reviews on cases that do not meet medical necessity, and utilizes evidence based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO, the Medical Director of UM also provides supervisory oversight and administration of the UM Program. Oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, provides clinical education and in-services to staff weekly and on an as needed basis. Presents key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on

industry trends and community standards in the clinical setting. Provides feedback to UM staff on trends identified for over/under utilization, readmissions, one day stays, and observation initiatives. Ensures availability to staff either onsite or telephonically during normal business hours and on call after hours. Serves on the Utilization and Quality Improvement Committees, serves as the Chair of the UMC and the Benefit Management Subcommittee, and may participate in the CalOptima Medical Directors Forum. Other related duties may also be performed at the discretion of the Chief Medical Officer.

**Utilization Management Medical Director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. In this role, the Medical Director oversees the UM activities of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. Ensures availability to staff either onsite or telephonically during normal business hours and on call after hours. The Medical Director works closely with the nursing leadership of these departments, and also works in collaboration with the Chief Medical Officer and all clinical staff within CalOptima.**

Utilization Management Medical Director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. In this role, the Medical Director oversees the UM activities of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. Ensures availability to staff during normal business hours and on-call after hours.

**Medical Director, Behavioral Health** provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and behavioral health care services for CalOptima members. The Medical Director provides clinical and operational oversight for behavioral health benefits and services provided to members. The Medical Director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality behavioral health outcomes. The Behavioral Health Medical Director is involved in the implementation, monitoring and directing of the behavioral health aspects of the UM Program.

**Medical Director, Senior Programs** is a key member of the medical management team and is responsible for the Medi-Medi programs (OneCare and OneCare Connect), Managed LTSS (MLTSS) programs, ~~and~~ Case Management and Transitions of Care programs. ~~She~~**The Medical Director** ~~P~~provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The Medical Director ~~is also expected to work~~ in collaboration with the other Medical Directors and the clinical staff within Disease Management, Grievance and Appeals, and Provider Relations. The Medical Director works closely with the nursing and non-clinical leadership of these departments.

**Medical Director Disease Management/Health Education/Program for All Inclusive Care for the Elderly (PACE) Programs** is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of disease management and health education programs, while also providing clinical quality oversight of the PACE Program.

**Director of Utilization Management** ~~assists in the~~ **is responsible for directing and coordinating the planning, organization, implementation and evaluation of all activities and personnel engaged in UM Departmental activities. ~~The Director~~ ~~development and implementation of the UM Program and UM Work Plan,~~ ~~maintaining and updating~~ policies, ~~and~~ ~~procedures and work flows to meet regulatory, contractual and accreditation standards.~~ ~~Ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations.~~ ~~The Director of UM also provides supervisory oversight and administration of the UM Program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and Quality Improvement Committees, participates in the UMC and the Benefit Management Subcommittee.~~**

~~Director of Clinical Pharmacy Management leads the development and implementation of the Pharmacy Management Program, develops and implements Pharmacy Management department policies and procedures; ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of Pharmacy related clinical affairs, and serves on the Pharmacy and Therapeutics Subcommittee and Quality Improvement Committees. A Pharmacist oversees the implementation, monitoring and directing of pharmacy services.~~

**Director of Behavioral Health Services** provides **operational oversight for behavioral health benefits and services provided to members.** ~~leadership and program development expertise in the creation, expansion and improvement of services and systems that leads to the integration of physical and behavioral health care services for CalOptima members.~~ ~~The Director of Behavioral Health Services~~ is responsible for monitoring, analyzing, and reporting to senior staff on changes in the health care delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors and executive staff, members, providers, health network management, legal counsel, state and federal officials, and representatives of other agencies.

~~Executive Director of Quality and Analytics provides oversight of key medical affairs functions including: Quality Management, Quality Analytics and Disease Management, which includes health education programs. The ED of Quality and Analytics serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima's strategic and operational~~

priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. Position will anticipate, continuously improve, communicate and leverage resources. The ED of Quality and Analytics will balance achieving set accountabilities with constraints of limited resources.

**Director of Quality** is responsible for ensuring that CalOptima and its HMOs PHCs ~~and~~, SRGs ~~and~~ PMGs meet the requirements set forth by DHCS, ~~and~~ Centers for Medicare/Medicaid Services (CMS), ~~and Department of Managed Health Care (DMHC)~~. The Compliance staff works in collaboration with the CalOptima Quality Improvement department to refer any potential sustained noncompliance issues or trends encountered during audits of health networks, provider medical groups, and other functional areas, such as UM, Credentialing, and Grievance & Appeals Resolution Services (GARS), as appropriate. The staff evaluates the results of performance audits to determine the appropriate course of action to achieve desired results. Functions relating to fraud and abuse investigations, referrals, and prevention are handled by the Office of Compliance.

**Director, Audit and Oversight** oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and ~~SRG Physician Medical Group (PMG)~~ delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The Director ensures that CalOptima and its subcontracted health networks perform consistently with both CMS and state requirements for all programs. Specifically, the Director leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the Director is responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. This position interacts with the Board of Directors, CalOptima executives, departmental management, health network management and Legal Counsel.

~~Director of Case Management is responsible for Case Management, Transitions of Care and the clinical operations for the Medi-Cal, OneCare, and OneCare Connect programs. The Director supports improving quality and access through seamless care coordination for targeted member populations. Develops and implements policies, procedures and processes related to program operations.~~

~~Director of Health Education & Disease Management is responsible for the development and implementation of Health Education and Disease Management programs and determines priorities for health education and member self-care management. The Director also oversees the group needs assessments to identify health education, and cultural and linguistic opportunities that improve the well-being of specific member populations. The Director is also responsible for provider clinical office education for the promotion of quality initiatives.~~

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## **UM Resources**

The following staff positions provide support for the UM department's organizational/operational ~~UM department's~~ functions and activities:

**Manager, Utilization Manager (Concurrent Review Manager [CCR])** manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The ~~Manager Supervisor~~ develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources ~~in order to~~ ensure appropriate support for utilization activities.

### **Experience & Education**

- Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (~~LVN~~  
~~license~~LVN) license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2-3 years supervisory/management experience in UM activities.

**Supervisor, Utilization Management (Concurrent Review)** provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The ~~Supervisor~~Manager is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training and in-servicing activities. Monitor for documentation adequacy including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

### **Experience & Education**

- Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (LVN) license in the State of California.
- A Bachelor's degree or relevant experience in a health care field.
- 3 years of managed care experience preferred
- Supervisor experience in Managed Care/UM preferred.

**Manager, Utilization Management (Prior Authorization [PA])**, manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

#### Experience & Education

- Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (LVN) license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in Utilization Management activities.

**Supervisor, Utilization Management (PA)** provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The Supervisor makes recommendations regarding assignments based on assessment of workload, and is a resource to the Prior Authorization staff — regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training and in-servicing activities. Monitors for documentation adequacy including clinical documentation to make a clinical determination, also, audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

#### Experience & Education

- Current and unrestricted Registered Nurse (RN) license or Licensed Vocational Nurse (LVN) license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

**Notice of Action RNs** drafts and evaluates denial letters for adequate documentation and utilization of appropriate criteria. (S)He Audits clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, enassures denial reason is written in plain language that a lay person understands, and is specific to the clinical information presented and criteria referenced. (S)He wWorkss with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

#### Experience & Education

- Current and unrestricted Registered Nurse License (RN) in the State of California
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience
- Excellent analytical and communication skills required

**Medical Case Managers (RN/LVN)** provide utilization review and authorization of services in support of members. The Case Manager is responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence based criteria. This activity is conducted prospectively, concurrently, or retrospectively. The Case Manager also provides concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs,

PHCs, ~~and SRGs and PMGs;~~ and acts as a liaison to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

#### Experience & Education

- Current and unrestricted California Board Licensed Vocational Nurse (LVN) or Registered Nurse (RN) license.
- Minimum of 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

**Medical Authorization Assistants** are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. The Medical Assistant performs medical, administrative, routine medical administrative tasks specific to the assigned unit and office support functions. The Medical Assistant also authorizes requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

#### Experience & Education

- High school graduate or equivalent; a minimum of 2 years of college preferred.
- 2 years of related experience that would provide the knowledge and abilities listed.

**Program Specialist** provides high-level administrative support to the Director of UM, the UM Managers, Supervisors and the UM Medical Directors.

#### Experience & Education

- High school diploma or equivalent; a minimum of 2 years of college preferred.
- 2–3 years previous administrative experience preferred. Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.

### **Pharmacy Department Resources**

The following staff positions provide support for Pharmacy operations:

**Director, Clinical Pharmacy** develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs; ~~contracts with and manages the pharmacy network~~ and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The Pharmacy Director is also responsible for administration of pharmacy services delivery, including, but not limited to, the contract with the ~~third-party~~third-party auditor, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies, and pharmacy organizations.

#### Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

**Manager, Clinical Pharmacists** assists the Pharmacy Director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Delegated Health Plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy Manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug UM strategies and intervention techniques. The Pharmacy Manager develops and implements methods to measure the results of these programs, assists the Pharmacy Director in preparing drug monographs and reports for the Pharmacy & Therapeutics Committee, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

#### Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 ~~years experience~~[years' experience](#) in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for Pharmacy & Therapeutics Committees.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

**Clinical Pharmacists** assist the Pharmacy Director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Health Networks and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy Director in preparing drug monographs and reports for the Pharmacy & Therapeutics Committee, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

#### Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 ~~years experience~~[years' experience](#) in clinical pharmacy practice including performing drug

use evaluations and preparing drug monographs and other types of drug information for Pharmacy & Therapeutics Committees.

- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

**Pharmacy Resident** program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

#### **Experience & Education**

- Pharm.D degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

**PBM (Pharmacy Benefits Manager)** staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's Pharmacy & Therapeutics Committee. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria. CalOptima pharmacists with a current license to practice without restriction perform all denials.

#### **LTSS Resources**

The following staff positions provide support for LTSS operations:

**Director, Long-Term Support Services (CBAS/~~IHSS~~/LTC/MSSP)-will** develops, manages and implements LTSS, including Long-Term Care (LTC) facilities, ~~IHSS~~, CBAS and MSSP and staff associated with those programs. The Director ~~is~~ will be responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. Develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF/ICF-DD/N/H) and other LTSS services.

Experience & Education

- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable
- 5–7 years varied related experience, including five years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

**Manager, Long-Term Support Services, RN (CBAS/~~IHSS~~/LTC)** The Manager is expected to develop and manage the LTSS department's work activities and personnel. The Manager will ensure that services standards are ~~met~~met, and operations are consistent with the health plan's policies and regulatory and accrediting agency requirements to ensure high quality and responsive service for CalOptima's members who are eligible for and/or receiving LTSS. The Manager must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, health networks, and other internal and external customers in a professional and competent manner. The Manager will work in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTC services

Experience and Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5–7 years varied clinical experience required.
- 3–5 years supervisory/management experience in a managed care setting and/or nursing facility.
- Experience in government or public environment preferred.
- Experience in health with geriatrics and persons with disabilities.

**Supervisor, Long-Term Support Services, RN, (CBAS, ~~IHSS~~, LTC)** The Supervisor is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. The Supervisor is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, ~~and IHSS~~, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the Supervisor will be resolving members and providers issues and barriers ensuring excellent customer service. Additional responsibilities include: managing staff coverage in all areas of LTSS to complete assignments, orienting, and training of new employees to ensure contractual and regulatory requirements are met.

#### Experience and Education

- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

**Medical Case Managers, Long-Term Support Services (MCM LTSS) (RN/LVN)**, are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, provides coordination of care, and provides ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, National Committee for Quality Assurance (NCQA) standards, Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. The MCM LTSS provides case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The MCM LTSS is the subject matter expert and acts as a liaison to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

#### Experience and Education

- A current and unrestricted RN license in the State of California or a current unrestricted LVN license in the State of California.
- Minimum of 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.

**Program Manager, CBAS (MSW/MS)** is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. The CBAS Program Manager is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviewing monthly files audit, developing inter-rater reliability questions, performing psychosocial and functional assessments, and serving as a liaison and key contact person for DHCS, California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The CBAS Program Manager is responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

#### Experience & Education

- Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required.
  - Masters preferred.

- Minimum of 3 years CBAS and program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more will involve traveling to CBAS centers and community events.

### **Qualifications and Training**

~~CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.~~

~~Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:~~

- ~~• CalOptima New Employee Orientation~~
- ~~• HIPAA and Privacy/Corporate Compliance~~
- ~~• Use of technical equipment (phones, computers, printers, facsimile machines, etc.)~~
- ~~• UM Program, policies/procedures, etc.~~
- ~~• MIS data entry~~
- ~~• Application of Review Criteria/Guidelines~~
- ~~• Appeals Process~~
- ~~• Seniors and Persons with Disabilities Awareness Training~~

~~CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations, and inter-rater reliability. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.~~

~~Appropriately licensed, qualified health professionals supervise the UM process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and behavioral health benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure. This licensure is specific to the State of California. UM employee compensation includes hourly and salaried positions. All medical management staff is required to sign an Affirmative Statement regarding compensation annually. Compensation or incentives to staff~~

~~or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited.~~

~~CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on:~~

~~The percentage of the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; o~~

### **Behavioral Health Integration (BHI) Resources**

The following staff positions provide support for BHI operations:

**Manager, Behavioral Health** implements, manages and monitors contractual relationships with entities providing behavioral health services to CalOptima members. S/he coordinates activities between CalOptima staff, contracted providers, and health networks by providing guidance and decision support when appropriate. The position represents CalOptima and interacts with the County of Orange, contracted organizations and providers, health networks, and other stakeholders in a manner that promotes collaborative working relationships.

#### Experience & Education

- Master's degree in Health Administration, Social Work, Psychology, Public Health, or other related degree is required.
- 2+ years of manager or director level experience in managed care environment, with specific experience in managing the behavioral health benefit for members covered by Medicare, Medi-Cal and/or Drug Medi-Cal.
- 3+ years of experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program.
- Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).
- Experience in managing Autism Spectrum Disorder Services in a Managed Care environment.
- Experience in developing policies and procedures to meet federal and state regulatory requirements.
- Experience in developing sound and responsible business plans and financial models.

**Manager, Behavioral Health, Clinical** is responsible for overseeing the clinical operation of CalOptima's Behavioral Health. S/He ensures the delivery of quality and consistent clinical assessment and referrals in accordance with CalOptima policies and procedures. The manager collaborates with other internal CalOptima departments to ensure all regulatory requirements are met. S/He assists the Director of Behavioral Health Services in developing and implementing behavioral health initiatives and projects. S/He represents CalOptima interacting with the County of Orange, contracted organizations and providers, health networks, and other stakeholders in a manner that promotes collaborative working relationships.

#### Experience & Education

- Master's degree in Social Work, Clinical Psychology, Marriage and Family Therapy or other related degree is required.
- Licensed (LCSW, LMFT, or Licensed Psychologist) is required.
- 4+ years of supervisor or manager level experience in managed care environment, with specific experience in providing telephonic behavioral health assessment and triage required.
- Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).
- Experience in developing policies and procedures to meet federal and state regulatory requirements.
- Experience in developing sound and responsible business plans and financial models.

**Clinicians, Behavioral Health** assist and monitor clinical service relationships with practitioners providing behavioral health services to CalOptima members. The position coordinates activities between CalOptima staff, contracted providers, and health networks by providing guidance and support.

#### Experience & Education

- Advanced degree required such as a Master's degree in Social Work, Clinical Psychology, Marriage and Family Therapy or related field of study is required.
- License preferred.
- Minimum 5-6 years of experience is required.
- Strong written and analytical skills required.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

**Member Liaison Specialists** are responsible for assisting members with behavioral health care management needs, which includes, but not limited to, securing behavioral health appointment for members, following up with members before and after appointment, providing member information and referring to community resources, conducting utilization review, and assisting members in navigating the mental health system of care. This position acts as a consultative liaison to assist members, health networks and community agencies to coordinate behavioral health services.

#### Experience & Education

- High school diploma or equivalent required.
- Bachelor's degree in behavioral health or related field is preferred.
- 2 years of experience in behavioral health, community services, or other social services setting required.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's License and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

**Manager, Behavioral Health (BCBA)** is responsible for managing Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for members diagnosed with Autism Spectrum Disorder (ASD). The Manager will oversee Care Managers who review assessments and treatment plans submitted by providers for adherence to ASD "best practice" guidelines. The

Manager will design and implement processes to ensure effective delivery of ABA services. The Manager will collaborate with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- Licensed (LCSW, LMFT, Licensed Psychologist) is preferred.
- 4+ years of supervisor or manager level experience in clinical management of ABA services is required.
- 3+ years of experience providing ABA therapy to children diagnosed with ASD is required.
- Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).
- Experience in developing policies and procedures to meet federal and state regulatory requirements.

**Care Manager (BCBA)** is responsible for the oversight and review of ABA services offered to members with ASD, including screening, triaging, and assessing members to determine appropriate level of care based on medical necessity criteria. The Care Manager is responsible for reviewing and processing requests for authorization of ABA services from behavioral health providers. This position is also responsible for utilization management and monitoring activities of autism services provided in community based setting. The Care Manager will directly interact with provider callers, acting as a resource for their needs.

Experience & Education

- Master's degree in Behavioral Health or ~~other~~another related field is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- 4+ years providing ABA therapy to children diagnosed with ASD is required.
- Possess clinical, medical utilization review, and/or quality assurance experience is preferred.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

**Member Liaison Specialist (Autism)** is responsible for providing care management support to members diagnosed with ASD seeking BHT, including ABA. The Member Liaison Specialist will assist members in linking ASD related behavioral health services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the behavioral health system of care. This position will act as a consultative liaison to assist members, health networks and community agencies to coordinate ASD related behavioral health services.

Experience & Education

- High school diploma or equivalent is required.
- Bachelor's degree in behavioral health or related field is preferred.
- 2 years of experience in behavioral health, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.

- Driver's License and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

### **Qualifications and Training**

CalOptima seeks to recruit highly-qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

- CalOptima New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- MIS data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- Seniors and Persons with Disabilities Awareness Training

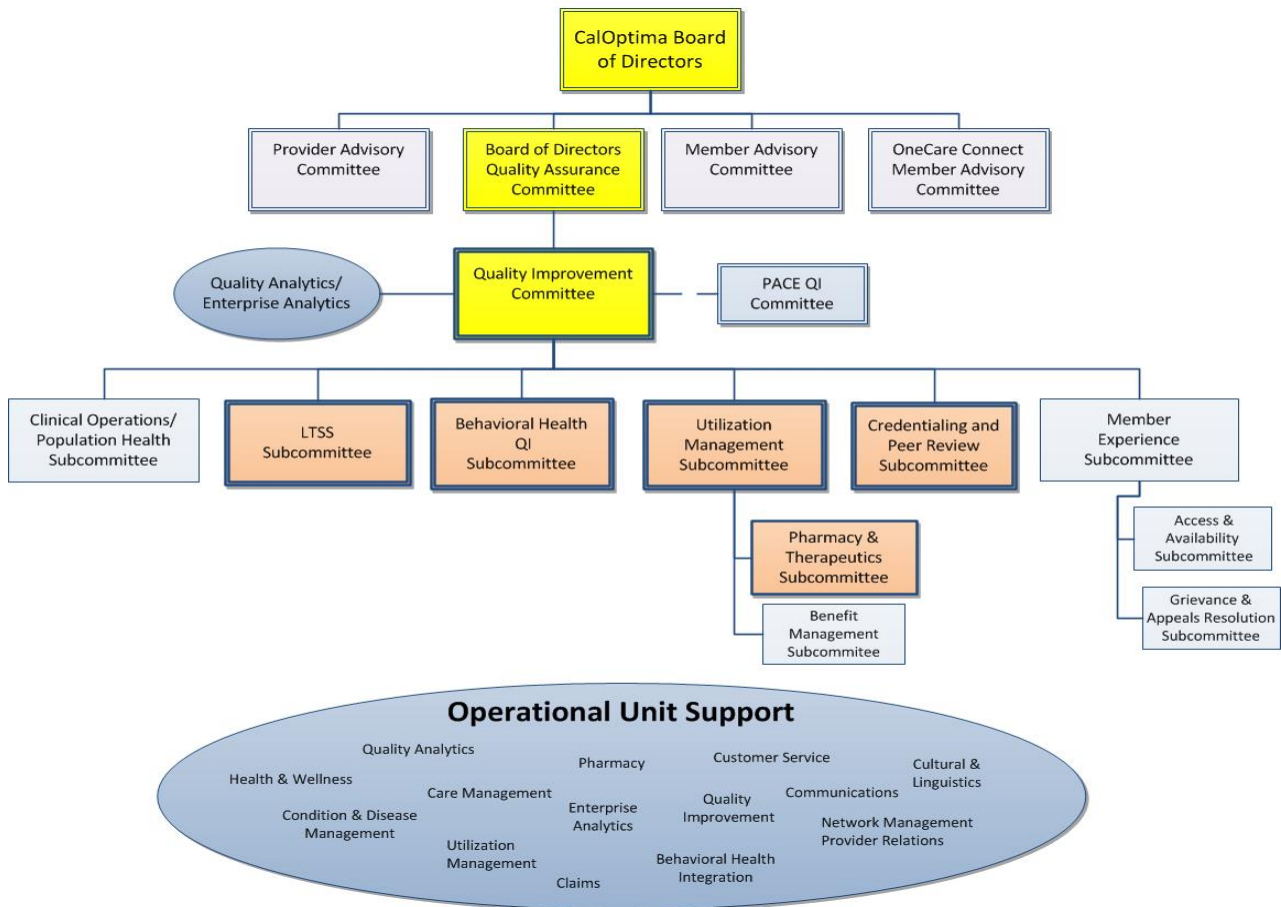
CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health professionals supervise the UM process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and behavioral health benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure. This licensure is specific to the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited. All medical management staff is required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

- The percentage of the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

## COMMITTEE STRUCTURE



### Utilization Management Committee (UMC)

The UMC is responsible for the review and approval of medical necessity criteria and protocols and [the UM Program](#), policies [and](#) procedures [and programs](#). The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, [ensure](#) coordination of care, [ensure](#) appropriate use of services and resources, and [improve](#) member and practitioner satisfaction with the UM process.

The UMC meets [at least](#) quarterly and coordinates an annual review and revision of the UM Program Description, Work Plan and Annual UM Program Evaluation. Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. The Director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding [analysis](#) of the above tracking and monitoring processes and [the](#) status of corrective action plans to the QIC. Daily oversight and operating authority of UM activities is delegated to the UMC which reports up through CalOptima's QIC and ultimately to CalOptima's QAC and the Board of Directors.

### UMC Scope

- Oversees the UM activities of CalOptima ~~in regard to~~regarding compliance with-  
~~contractual requirements~~ federal and state statutes and regulations, and contractual and  
NCQA requirements;
- ~~Develops and annually r~~Reviews and /approves the UM Program Description on an annual  
basis;  
Approves the use of medical necessity criteria;
- ~~W~~Reviews and approves the UM Work Plan on an annual basis
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for  
improving the effectiveness of initiatives and projects  
, criteria, policies and procedures;
- ~~Reviews practitioner specific UM reports to identify~~ trends and/or utilization patterns  
presented at UMC and makes recommendations ~~to the QIC~~ for further actionreview;  
~~Reviews reports specific to facility and/or geographic areas for trends and/or patterns of~~  
~~under or over utilization;~~  
~~Examines appropriateness of care reports to identify trends and/or patterns of under or over~~  
~~utilization and refers identified practitioners to the QIC for performance improvement and/or~~  
~~corrective action;~~
- Examines results of annual member and practitioner satisfaction surveys to determine overall  
satisfaction with the UM Program, identify areas for performance improvement, and  
evaluate performance improvement initiatives;
- Communicates significant~~Provides as feedback mechanism to the QIC for communicating~~  
~~findings; and~~ recommendations, ~~and a plan for implementing corrective actions~~ related to  
UM issues to the QIC;
- Identifies opportunities where UM data can be utilized in the development of quality  
improvement activities and submitted to the QIC for recommendations;
- Provides feedback to the QIC regarding effectiveness of CalOptima's P4P programs;
- Report's findings of UM studies and activities to the QIC;
- Liaisons with the QIC for ongoing review of quality indicators.

### **UMC Members**

The UMC actively involves several active network practitioners as available and to the extent that there is not a conflict of interest. CalOptima's UMC is chaired by the UM Medical Director and is comprised of the following voting members:

- CMO;
- Deputy CMO;
- Executive Director, Clinical Operations;
- Six (6) participating Practitioners from the community
- CalOptima Medical Director of Behavioral Health
- CalOptima Medical Director of Senior Programs
- CalOptima Medical Director of Quality and Analytics
- ~~Health Network Medical Directors~~
- ~~Community providers;~~
- ~~CalOptima Medical Director of Prior Authorization~~
- ~~CalOptima Medical Director of Concurrent Review~~

~~In addition, the UMC is supported by the following individuals:~~

- ~~CalOptima Medical Director of Prior Authorization~~
- ~~CalOptima Medical Director of Concurrent Review~~
- ~~CalOptima UM Director~~
- ~~Director, Utilization Management~~
- ~~Director, Quality Improvement~~
- ~~Director, of Pharmacy~~
- ~~CalOptima Manager, of Prior Authorization~~
- ~~Manager, Concurrent Review~~
- ~~Utilization~~

~~, and any additional staff may also attend the UMC as appropriate.~~

### **Benefit Management Subcommittee (BMSC)**

The Benefit Management Subcommittee is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division (MMCD) All Plan Letters (APLs), and the Medi-Cal Manual.



## **BMSC Scope**

The BMSC is responsible for the following:

- Maintain a consistent benefit set for all lines of business; and
- Revise and update CalOptima's authorization rules.
- Makes recommendations regarding the need for prior authorization for specific services;
- Clarifies financial responsibility of the benefit when needed.
- Recommends benefit decisions to the UMC; and
- Communicates benefit changes to staff responsible for implementation.

**BMSC Members**~~Recommending how to implement new or modified benefits;~~  
~~Clarifying the financial responsibility of benefit coverage;~~  
~~Recommending benefit decisions to the UMC;~~  
~~Updating and maintaining the Benefit Matrix, and~~  
~~Communicating benefit changes to staff, providers, and health networks for implementation.~~

The Subcommittee membership consists of the following:

- Medical Director, Utilization Management- Chairperson
- Executive Director, Clinical Operations
- Director, Utilization Management
- ~~Director, Case Management~~
- ~~Director, Healthy Education & Disease Management~~
- ~~Director, Regulatory Affairs~~
- ~~Director, Clinical Pharmacy Management~~
- ~~Director, Quality and Analytics~~
- ~~Director, Managed Long Term Support and Services (MLTSS)~~
- Director, Claims Management
- Director, Grievance and Appeals ResolutionClaims
- Director, Coding Initiatives

The BMSC meets ~~sixteen~~ times per year, and recommendations from the BMSC are reported to the UMC on a Quarterly basis.

## **Behavioral Health Quality Improvement Committee (BHQIC)**

The purpose of the Behavioral Health Quality Improvement ~~Committee was established in 2011 with the intended~~

~~purpose of:~~isCommittee is to:

- Ensureing members receive timely and satisfactory behavioral health care services;
- Enhanceing the integration and coordination between physical health and behavioral health care providers;
- Monitoring key areas of service utilization by members and providers;
- Identifying areas of improvement; and
- Guideing CalOptima towards the vision of bi-directional behavioral health care integration.

## **BHQIC Scope**

The BHQIC responsibilities are to:

- Ensure adequate provider availability and accessibility to effectively serve the membership
- Oversee the functions of delegated activitiesentities

- Monitor that care rendered is based on established clinical criteria, and clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure that member benefits and services are not underutilized, and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize member and Network Provider satisfaction study results when implementing quality activities
- Maintain compliance with evolving NCQA accreditation standards
- Communicate results of clinical and service measures to Network Providers
- Document and report all monitoring activities to appropriate committees

## **BHQI Members**

The designated Chairman of the BHQIC is the Medical Director, Behavioral Health, who is responsible ~~for chairing the Committee, reviewing information, as well as~~ reporting findings and making QI recommendations, and to represent the BHQI Committee at the QIC meetings. ~~The~~ voting members of the BHQI committee include:

- Chief Medical Officer/ Deputy Chief Medical Officer
- Executive Director, Clinical Operations
- Medical Director, Behavioral Health Integration
- Director of Behavioral Health Integration
- Medical Director, Medical Management
- Medical Director, Utilization Management
- Executive Director, Quality and Analytics
- Medical Director, Orange County Health Care Agency
- Medical Director, Managed Behavioral Health Organization
- Medical Director, Health Network
- Medical Director, Regional Center of Orange County ~~The composition of the BHQI Committee is defined in the BHQIC Charter.~~

The Committee may permit participation by other CalOptima staff or outside guests with relevant expertise and experience. The BHQIC meets quarterly at a minimum or more frequently as needed.

## **LTSS Quality Improvement Subcommittee (LTSS QISC)**

~~In 2014, the LTSS QISC replaced the Long Term Care QIS.~~ The LTSS QISC was created to provide a forum for LTSS programs providers to share best practices, identify challenges and barriers, and ~~together identify find~~ solutions that are member-person-centered, maximize available resources and reducing duplicate services ~~while providing quality of care and ability for members to safely reside in the least restrictive living environment.~~

## **The LTSS QISC Purpose**

- Engage stakeholders ~~input on ways to best on strategies for~~ integrating the LTSS programs with in the managed care delivery system ~~and improved quality of care.~~
- Improving and providing coordination of care for CalOptima members who resides in long-term care facilities and for those who receive Home- and Community Based Services (HCBS).

## **The LTSS QISC Responsibilities**

- Identify barriers to keeping members safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and prevent inappropriate admissions.
- Evaluate the performance, success, and challenges of LTSS program providers of the following services: CBAS, ~~HSS~~, MSSP and other HCBS.
- Monitor the important aspects of quality of care, quality of services and patient safety by collecting and organizing data for all selected indicators analyzing results.
- Provide input on enhancing the capacity and coordination among LTSS providers, community-based organizations, housing providers, and managed care plans to care for individuals discharged from institutions.

- Identify and recommend topics for LTSS providers workshops, educations and trainings.

## **The LTSS QISC Structure**

- The designated Chairman of the LTSS QISC is the Medical Director, Senior Programs, who is responsible for chairing the committee.
- The LTSS QISC includes the following participants: Activity Summary is reported to QIC, and includes, but is not limited to the following:
  - Nursing Facility Administrators
  - CBAS Administrators
  - OC SSA, Deputy Director or Designee
  - MSSP, Site Director or Designee
  - Chief Medical Officer/Deputy Medical Officer
  - Medical Director, QI and Analytics
  - Medical Director, UM
  - Executive Director, Clinical Operations
  - Executive Director, Quality Analytics
  - Manager(s), LTSS
  - Director, LTSS
- The LTSS QISC meets at least quarterly at a minimum or more frequently as needed.
- ~~The LTSS Activity Summary will be reported to QIC and includes, but is not limited to:~~
  - ~~Member review of Hospital Admission for each LTSS program;~~
  - ~~Member review of Emergency Department visit for each LTSS program;~~
  - ~~Member review for Hospital Readmissions for each LTSS program;~~
  - ~~Health Risk Assessment results for LTC OCC members;~~
  - ~~LTC Provider Annual Workshop;~~
  - ~~CBAS Provider Workshop;~~
  - ~~CBAS Centers Profile~~
  - ~~LTC Profile~~
  - ~~Care Coordination and Interdisciplinary Care Team Participation by LTSS staff;~~
- ~~Total number of participants by LTSS program~~
- ~~In addition, LTSS utilization activities' summary is reported to UMC, and includes, but is not limited to, the following;~~
  - ~~CBAS statistics such as to number of participants, assessment type, turnaround time, and denials rates;~~
  - ~~LTC statistics include, but is not limited to, bed type, turnaround time, and denials rate;~~
  - ~~MSSP statistics such as total number of participants, total number of termination, number of ER visits, average length of stay (ALOS), and skilled nursing facility (SNF) admissions.~~
  - ~~LTSS Inter Rater Reliability study result;~~
  - ~~Rate Adjustments for LTC facilities~~

## **INTEGRATION WITH THE QUALITY IMPROVEMENT PROGRAM**

The UM Program and Work Plan are evaluated and submitted for review and approval annually by both the CalOptima UMC, ~~the and the QIC and the QAC,~~ with final review and approval by the Board of Directors' QAC.

- Utilization data is collected, and aggregate aggregated and analyzed UM data, member grievances, including, but not limited to denials,

~~unused authorization, provider preventable conditions and trends representing potential over or under utilization and appeals are reviewed at the UMC and recommendations are presented to the QIC, and are presented to the participating HMOs, PHCs, SRGs and PMGs on a quarterly basis.~~

- ~~The~~ UM staff may identify ~~actual or~~ potential quality issues during utilization review activities. These issues are referred to the QI staff for ~~evaluation. follow-up~~
- The QIC reports to the Board QAC.
- The UMC is a subcommittee of the QIC~~)~~ and routinely reports activities to the QIC.

## CONFLICT OF INTEREST

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on Utilization Management Committee or who otherwise make decisions on utilization management, quality oversight and activities timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

~~Fiscal and clinical interests are separated. CalOptima and its delegates do not provide any financial rewards or incentives to practitioners or other individuals conducting utilization review for issuing denials of coverage, services or care.~~

## CONFIDENTIALITY

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs, SRGs, and Managed Behavioral

Health Organizations (MBHOs) ~~and PMGs~~ hold all information in the strictest confidence. Members of the QIC and the subcommittees sign a Confidentiality Agreement. This Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

## INTEGRATION WITH OTHER PROCESSES

The UM Program, Case Management Program, Behavioral Health Program, Managed LTSS Programs, Pharmacy & Therapeutics (P&T) Program, QI, Credentialing, Compliance, and Audit and Oversight Programs are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to CalOptima's QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Peer Review or Credentialing Committee. If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified.

In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention;
- State protective and regulatory services;
- Women, Infant and Children Services (WIC);
- EPSDT Health Check;
- Services provided by local public health departments.

### UM Process

The UM process encompasses the following program components: ~~24-hour seven-day-week nurse-triage, referral/prior authorization, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination, second and second~~ opinions ~~referral/prior authorization, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination~~. All approved services must be medically necessary. The clinical decision process begins when a request for authorization of service is received ~~at CalOptima level~~. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, or scheduled inpatient services. The process is complete when the requesting practitioner and

member (when applicable) have been notified of the determination. \_

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. -The UM Department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified.

### **Benefits**

CalOptima administers health care benefits for members, as defined by contracts with the D-HCS (Medi-Cal), a variety of programs, regulations, policy letters and all the Center for Medicare and Medicaid Services benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place, and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the CalOptima Audit and Oversight department via its delegation oversight team for compliance.

### **UM Program Structure**

The UM Program is designed to work collaboratively with delegated entities, including but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality-based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of ~~the~~CMS, -DHCS, DMHC, ~~CMS~~, CDA and NCQA at least annually. Recommendations for revisions and improvements are made, as appropriate, ~~and subsequently annually~~. The UM Work Plan is based on the findings of the annual program Work Plan evaluation. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.

The organization chart and the program Committee's reporting structure accurately reflect CalOptima's Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the UM Workgroup (UMG), the UMC and QIC, which serve as the oversight committees for CalOptima UM functions, are contained and delineated in the Committees Charters.

The CalOptima UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer, Medical Directors of UM, the Executive Director of Clinical Operations, the UMC and QIC. CalOptima-contracted delegates are delegated UM responsibilities, including the UM Program and Work Plans, which are presented annually to the QIC as part of CalOptima's Delegation Oversight Program. The QIC then reviews and approves or does not approve the delegate's UM Program and Work Plans.

## **METHODS OF REVIEW AND AUTHORIZATION OF SERVICES**

### **Medical Necessity Review**

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with the Centers for Medicare and Medicaid and the State of California for Medi-Cal, OneCare and OneCare Connect. Medically necessary means services or supplies that:

- are appropriate and needed for the diagnosis or treatment of a member's medical condition;
- are provided for the diagnosis, direct care, and treatment of the member's medical condition;
- meet the standards of good medical practice in the local area; and
- are not mainly for the convenience of the member or the doctor.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or other appropriate health care professionals, review and determine all final denial or modification decisions for requested medical and behavioral health care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified Physician or Pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services;
- Admission Review;
- Concurrent/Continued Stay Review for selected conditions;
- Discharge Planning Review;
- Retrospective Review;
- Evaluation for potential transplant services for health network members;
- Emergency Service Authorization is not required but may be reviewed;

- Identification of Opportunities for Case Management, Disease Management or Health Education of CalOptima members;
- Evaluation for potential transplant services for health network members;

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications, or termination of services;
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated;
- Member characteristics are considered when applying criteria in order to address the individual needs of the member. These characteristics include, but are not limited to:
  - Age
  - Co-morbidities
  - Complications
  - Progress of treatment
  - Psychological situation
  - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. ~~In the event that~~ If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action, GG.1508, Authorization and Processing of Referrals;
- Reasons for decisions are clearly documented in the medical management system;
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures;
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services;
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing;
- Records, including [documentation of an oral notification](#) or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law;
- ~~R~~The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested;
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a determination. Contact can be made directly [with](#) the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may

request a discussion with the Medical Director, or a copy of the specific criteria utilized.

The following is appropriate clinical information [may be](#) used to make medical necessity determinations ~~and includes~~, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

CalOptima's UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director of Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management departments are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima' program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

### **Prior Authorization**

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior authorization is required for select services such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization List. This list is accessible on the CalOptima website at [www.caloptima.org](http://www.caloptima.org).

### **Clinical Information**

Prior Authorization is required for selected services appearing on the Prior Authorization List in the provider section on the CalOptima website at [www.caloptima.org](http://www.caloptima.org). Clinical information submitted by

the provider justifies the rationale for the requested service through the authorization process which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system, ~~Altruista~~/GuidingCare is a member-centric system utilizes evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Link system allows for on-line authorizations to be submitted by the health networks and processed ~~electronically. The r~~Referrals~~electronically. Referrals~~ are auto-adjudicated through referral intelligence rules (RIR). Practitioners also ~~submit~~send referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

### **Referrals**

A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are ~~not required to issue paper referrals, but are~~ required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians and all non-emergency out-of- network practitioners as noted on the Prior Authorization List.

### **Second Opinions**

A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of- network practitioner, if there is no in- network practitioner available.

### **Extended Specialist Services**

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "Standing Referral" policy and procedure Standing Referral: GG.1112 includes guidance on how members with life-threatening conditions or diseases which require specialized medical care over a prolonged period of time can request and obtain access to specialty care centers.

### **Out-of-Network Providers**

If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

### **Pharmaceutical Management**

The Pharmacy Management Program is overseen by the CMO, and CalOptima Director, Pharmacy. All policies and procedures utilized by CalOptima related to pharmaceutical management include the

criteria used to adopt the procedure as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by the Pharmacy & Therapeutics Committee (P&T) and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals, and are made available to practitioners via the provider newsletter and/or CalOptima website.

The CalOptima P&T Committee is responsible for development of the CalOptima Formulary, which is based on sound clinical evidence, and is reviewed at least annually by actively practicing practitioners and pharmacists. Updates to the CalOptima Approved Drug List are communicated to both members and providers.

If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate, and the drug is medically necessary.
- The member has failed treatment or experienced adverse effects on the formulary drug.
- The member's treatment has been stable on a non-formulary drug, and change to a formulary drug is medically inappropriate.

To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's PBM for review. All potential authorization denials are reviewed by a Pharmacist at CalOptima, as per DHCS ~~and DMHC regulations~~ requirements. The Pharmacy Management department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members receiving multiple medication fills per month are reviewed by a Clinical Pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

## PHARMACY DETERMINATIONS

### Medi-Cal

CalOptima's Pharmacy Management department delegates initial prior authorization review to the PBM based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the CalOptima P&T Committee. The PBM may approve or defer for additional information, but final denial and appeal determinations may only be made by a CalOptima Pharmacist or CalOptima Medical Director. In addition, final decisions for requests that are outside of the available criteria must be made by a CalOptima Pharmacist or CalOptima Medical Director.

CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments,

documents or other information relevant to the appeal.

- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions.

### **OneCare/OneCare Connect**

CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

### **Formulary**

The CalOptima drug Formularies were created to offer a core list of preferred medications to all practitioners. Local providers may make requests to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the CalOptima P&T Committee. Final approval from the P&T must be received to add drugs to the Formulary. The CalOptima Formularies are available on the CalOptima website or in hard copy upon request.

### **Pharmacy Benefit Manager**

The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, customer service, pharmacy help desk, prior authorization, clinical services and quality improvement functions. The PBM [recommends](#) denial decisions based on lack of medical necessity, drugs not included in the Formulary, prior authorization not obtained, etc. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBM is monitored according to the Audit and Oversight department's policies and procedures.

## **UTILIZATION REVIEW OF SUPPLEMENTAL DENTAL BENEFITS (OC, OCC)**

### **Medical Necessity Review**

~~Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with the State of California for Medi-Cal, as well as OneCare and OneCare Connect. Medically necessary means services or supplies that: a) Are appropriate and needed for the diagnosis or treatment of a member's medical condition; are provided for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of the member or the doctor.~~

~~The CalOptima UM process uses an active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost efficient manner, without compromising quality. Physicians, or other appropriate health care professionals, review and determine all final denial decisions for requested medical and behavioral health care services.~~

The review of the denial of a pharmacy prior authorization, however, may be carried out by a qualified Physician or Pharmacist.

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, with the support of the UMC, have the authority, accountability and responsibility for denial determinations. For those contracted delegated PMGs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct members utilizing the following medical determination review processes:

Referral/Prior Authorization for selected conditions/services;

Admission Review;

Concurrent/Continued Stay Review for selected conditions;

Discharge Planning Review;

Retrospective Review;

Emergency Service Authorization is not required but may be reviewed;

Identification of Opportunities for Case Management, Disease Management or Health Education of CalOptima members;

Evaluation for potential transplant services for health network members;

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

Qualified health care professionals supervise review decisions, including care or service reductions, modifications, or termination of services;

There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated;

Member characteristics are considered when applying criteria in order to address the individual needs of the member. These characteristics include, but are not limited to:

Age

Co-morbidities

Complications

Progress of treatment

Psychological situation

Home environment, when applicable;

Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. In the event that member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action, G.C.1508;

Authorization and Processing of Referrals;

Reasons for decisions are clearly documented in the medical management system;

~~Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures;~~  
~~Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services;~~  
~~Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing;~~  
~~Records, including an oral or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law;~~  
~~Requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested;~~  
~~All members are notified in writing of any decision to deny, modify, or delay a service authorization request.~~  
~~All providers are encouraged to request information regarding the criteria used in making a determination. Contact can be made directly to the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director, or a copy of the specific criteria utilized.~~  
~~The following is appropriate clinical information used to make medical necessity determinations and includes, but is not limited to:~~

~~Office and hospital records~~

~~A history of the presenting problem~~

~~A clinical examination~~

~~Diagnostic test results~~

~~Treatment plans and progress notes~~

~~Patient's psychological history~~

~~Information on consultations with the treating provider~~

~~Evaluations from other health care providers~~

~~Photographs~~

~~Operative and pathological experts~~

~~Rehabilitation evaluations~~

~~A printed copy of criteria related to the request~~

~~Information regarding benefits for services or procedures~~

~~Information regarding the local delivery system~~

~~Patient characteristics and information~~

~~Information from responsible family members~~

~~CalOptima's UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director of Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management departments are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima' program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.~~

### **Appropriate Professionals for UM Decision Process**

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial, or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes a statement to all members in the Member Handbook, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage. ~~The organization does not specifically reward practitioners or other individuals for issuing denials of coverage of service or care, and~~ CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

## **PREVENTIVE AND CLINICAL PRACTICE GUIDELINES (CPG)**

Clinical Guidelines are developed and implemented via the QIC, and assist in making health care decisions and improving the quality of care provided to members. Medication use guidelines have been developed that are reviewed by the P&T Committee, which includes outside physician and pharmaceutical participants, whose recommendations are forwarded to the QIC for review and approval. These guidelines are posted on the CalOptima website. Additional condition specific guidelines are in development, and are based on a compilation of current medical practices researched from current literature and professional expert consensus documents. Guidelines are reviewed and updated at least annually by the respective committees. These standards for patient care are to be used as guidelines, and are not intended to replace the clinical medical judgment of the individual physician. CPGs are shared with the delegated HMOs, PHCs and SRGsHealth Networks as they are approved.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD Guidelines for both adults and children.

UM criteria are nationally recognized, evidence based standards of care and include input from recognized experts in the development, adaption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate.

CalOptima uses the following criteria sets for all medical necessity determinations:

- [Medi-Cal and Medicare Manual of Criteria;](#)
- [MCG — Evidence-based nationally recognized criteria;](#)
- [National Comprehensive Cancer Network \(NCCN\) Guidelines;](#)
- [Centers of Excellence Guidelines;](#)
- [Specialty Guidelines such as the American Academy of Pediatric Guidelines \(AAP\) and American Heart Association Guidelines;](#)
- [CalOptima Criteria for outpatient behavioral health services;](#)
- [CalOptima Medical Policy and Medi-Cal Benefits Guidelines;](#)
- [National and Local Coverage Determination Guidelines.](#)
- [National Guideline Clearinghouse](#)
- [Medicare Part D: CMS-approved Compendia](#)

Delegated ~~HMOs, PHCs and SRGs~~ Health Networks must utilize the same or similar nationally recognized criteria.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

**Is There a Headline Missing Here for the Table Below?**

Authorization Review Roles				
Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer
Chemotherapy	MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines		X	X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals		X	X
Dialysis	MCG / Medi-Cal and Medicare Manuals	X	X	X
Hearing Aids	Medi-Cal and Medicare Manuals	X	X	X
Home Health	<del>InterQual</del> MCG / Medi-Cal and Medicare Manuals		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Medical Supplies (DME Related)	Medi-Cal and Medicare Manuals	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals	RCOC Referrals	X	X
Transplants	DHCS Guidelines	Referral	X	X
Administrative Denial	CalOptima Policy	X	X	

<a href="#">Medical Necessity Denial</a>	<a href="#">MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization</a>			X
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\*If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

## **Long-Term Services and Supports**

<b>Authorization Type*</b>	<b>Criteria Utilized</b>	<b>Medical Assistant</b>	<b>Nurse</b>	<b>Medical Director / Physician Reviewer</b>
Community Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		<b>X</b>	<b>X</b>
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51335		<b>X</b>	<b>X</b>
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51334		<b>X</b>	<b>X</b>
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51003 and 51303		<b>X</b>	<b>X</b>
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51343 and 51164	<b>X</b> DDS or DMH Certified	<b>X</b>	<b>X</b>
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	<b>X</b>	<b>X</b>	<b>X</b>

\*If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

## **Medi-Cal Behavioral Health Services**

<b><u>Authorization Type*</u></b>	<b><u>Criteria Utilized</u></b>	<b><u>Medical Assistant</u></b>	<b><u>Care Manager (BCBA)</u></b>	<b><u>Medical Director / Physician Reviewer</u></b>
<u>Psychological Testing</u>	<u>Title 22, MCG, Medi-Cal Manual, CalOptima policy</u>		<b><u>X</u></b>	<b><u>X</u></b>
<u>Behavioral Health Treatment (BHT) services</u>	<u>Title 22, WIC Section 14132, MCG, H&amp;S Code 1374.73, Medi-Cal Manual, CalOptima policy</u>		<b><u>X</u></b>	<b><u>X</u></b>

## **Board Certified Clinical Consultants**

In some cases, such as for authorization of a specific procedure or service or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board certified physician from the appropriate specialty for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on a UM decision made the original request for authorization or determination or is in, or is affiliated with the same practice group as the practitioner who made the original request or determination.

For the purposes of Behavioral Health review and oversight as a delegated vendor, Magellan ensures there are peer reviewers/clinical consultants. Peer reviewers are behavioral health professionals who are qualified, as determined by Magellan's Medical Director, to render a clinical opinion about the behavioral health condition, procedure, and/or treatment under review. Peer reviewers must hold a current unrestricted California license to practice medicine in the appropriate specialty to render an opinion about whether a requested service meets established medical necessity criteria.

## **New Technology Review**

### **Medi-Cal, OneCare, OneCare Connect**

CalOptima's P&T Committee and Benefit Management Subcommittee shall study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for members in accordance with [CalOptima Policy GG.1534 Evaluation of New Technology and Uses](#).

## **Preventive and Clinical Practice Guidelines (CPG)**

~~Clinical Guidelines are developed and implemented via the QIC, and assist in making health-care decisions and improving the quality of care provided to members. Medication use guidelines have been developed that are reviewed by the P&T Committee, which includes outside physician and pharmaceutical participants, whose recommendations are forwarded to the QIC for review and approval. These guidelines are posted on the CalOptima website. Additional condition-specific guidelines are in development, and are based on a compilation of current medical practices researched from current literature and professional expert consensus documents. Guidelines are reviewed and updated at least annually by the respective committees. These standards for patient care are to be used as guidelines, and are not intended to replace the clinical medical judgment of the individual physician. CPGs are shared with the delegated HMOs, PHCs, SRGs and PMGs as they are approved.~~

~~While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD Guidelines for both adults and children.~~

UM criteria are nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adaption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate.

CalOptima uses the following criteria sets for all medical necessity determinations:

Medi-Cal and Medicare Manual of Criteria;

MCG — Evidence based nationally recognized criteria;

National Comprehensive Cancer Network (NCCN) Guidelines;

Centers of Excellence Guidelines;

Specialty Guidelines such as the American Academy of Pediatric Guidelines (AAP) and American Heart Association;

CalOptima Criteria for outpatient behavioral health services;

CalOptima Medical Policy and Medi-Cal Benefits Guidelines;

National (CMS) and local (state) Determination Guidelines.

National Guideline Clearinghouse

Medicare Part D: CMS approved Compendia

Delegated HMOs, PHCs, SRGs and PMGs must utilize the same or similar nationally recognized criteria.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

### **Practitioner and Member Access to Criteria**

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting CalOptima's UM department or may discuss the UM decision with CalOptima Medical Director. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. Similar information is found in the Member Handbook and on the CalOptima website at [www.caloptima.org](http://www.caloptima.org).

### **Inter-Rater Reliability**

At least annually, the CMO and Executive Director of Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions; apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director of Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, CalOptima's UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight.

### **Provider/Member Communication**

Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TDD/TTY services for deaf, hard of hearing or speech impaired members are available toll free at **800-735-2929**. The phone numbers for these are included in the Member Handbook, on the web, and in all member letters. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services.

Inbound and outbound communications may include directly speaking with practitioners and members, or faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

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### **Access to Physician Reviewer**

The CalOptima Medical Director or appropriate practitioner reviewer (behavioral health and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation, and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling CalOptima's main toll-free phone number and asking for the CalOptima Medical Director. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner.

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, with the support of the UMC, have the authority, accountability and responsibility for denial determinations. For those contracted delegated SRGs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

### **Requesting Copies of Medical Records**

UM staff does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent telephonic review, copies of medical records are only required when difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay during a verbal review. In those cases, only the necessary or pertinent sections of the record are required. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times. Members requesting a copy of CalOptima's designated record set are not charged for the copy.

### **Sharing Information**

CalOptima's UM staff share all clinical and demographic information on individual patients among various divisions (e.g. discharge planning, case management, disease management, health education, etc.) to avoid duplicate requests for information from members or practitioners.

### **Provider/Member Communication**

CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment;
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

# TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

## UM Decision and Notification Timelines

Medi-Cal <del>and OneCare Connect (Medi-Cal)</del> <u>Clinical Medical</u> — Decision Making	OneCare <del>(Medicare)</del> and OneCare Connect <del>(Medicare)</del> <u>Clinical Medical</u> — Decision Making
<ul style="list-style-type: none"> <li>Performed by <del>processed by</del> CalOptima UM <del>department staff</del> for <u>COD-A and CCN</u> members <del>in direct or non-delegated network</del></li> <li>Performed<del>processed</del> by <u>Health Network</u> UM <del>department at the PMGs</del>staff for <u>HN</u> members               <ul style="list-style-type: none"> <li>Requests for transplant services for HN members are performed by CalOptima UM staff</li> </ul> </li> <li>Qualified physician review for <del>r any</del> modifications or denials</li> <li>Qualified psychologist or psychiatrist review for modifications or denials of behavioral health services</li> <li>Qualified pharmacist review for <del>any -</del> <u>pharmacy modifications</u> or denials</li> </ul>	<ul style="list-style-type: none"> <li>Performed by CalOptima UM staff for <u>CCN</u> members</li> <li>Performed by Health Network UM staff for HN members               <ul style="list-style-type: none"> <li>For OneCare HN members Medi-Cal “wrap” benefits and requests for out of area services (SRGs only) are performed by CalOptima UM staff. <del>Processed by UM department at the Physician Medical Groups</del></li> </ul> </li> <li>Behavioral Health Determinations Performed by Managed Behavioral Health Organization <del>Processed by Case Management department at CalOptima for out of area and Medi-Cal wrap authorizations</del></li> <li>Qualified physician review for any modifications or denials</li> <li>Qualified psychologist or psychiatrist review for modifications or denials of behavioral health services</li> <li>Qualified pharmacists or physician review for <del>any</del> pharmaceutical partial approvals or denials</li> </ul>

<u>Medi-Cal</u> <u>Timeframes for Decision</u> <u>Timeframes for Decision</u>	<u>OneCare and OneCare Connect</u> <u>Timeframes for Decision</u> <u>Timeframes for Decision</u>
<p><b>Timeframes for Determinations:</b></p> <p><b>Routine:</b> -5 business days from receipt of all medically necessary information to make a determination, not to exceed <u>14 calendar days from receipt of request</u> <del>and -5 business days from receipt of all medically necessary information to make a determination</del></p> <p><b>Urgent:</b> 72 hours <u>from receipt of request</u></p> <p><b>Retrospective:</b> 30 <u>calendar</u> days <u>from receipt of request</u></p> <p>Timeframes for Notification:-          Authorization Request Type: <del>Routine (Non-Urgent) Pre-Service: (Oral or Electronic)</del>          Provider: <del>Initial within 24 hours of the decision</del> Member: <del>None specified</del>          Provider: <del>Within 2 working days of making the decision</del>          Member: <del>Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request.</del></p>	<p>Routine (Non-Urgent): <del>Pre-Service Extension Needed:</del>          Provider: <del>Within 24 hours of making the</del></p> <p><b>Timeframes for Determinations (non-Part B):-</b></p> <p><b>Routine:</b> 14 calendar days <u>from receipt of request</u> <del>and 5 business days from receipt of request.</del></p> <p><b>Routine- Extension Needed:-</b> May extend for an additional 14 days if additional information may result in an approval.</p> <ul style="list-style-type: none"> <li>—Provider: <u>Within 24 hours of extension decision</u></li> <li>Member:- <u>Within 24 hours of extension decision</u></li> </ul> <p><b>Urgent:</b> 72 hours</p> <p><b>-Retrospective:</b> 30 <u>calendar</u> days <u>from receipt of request</u></p> <p>Timeframes for Notification (non-Part D)-          Authorization Request Type:          For Expedited requests, oral notification to the member must be made within 72 hours from the receipt of the request and must include expedited appeal rights. Written notification must be sent to the member and provider within three days of oral notification.</p> <p>For standard determinations the member must be notified of the decision no later than <u>2 working days from making the decision, not to exceed 14 days from after receipt of the request.</u></p>

<u>Medi-Cal</u> <u>Timeframes for Notification</u>	<u>OneCare and OneCare Connect</u> <u>Timeframes for Notification (non-Part D)</u>
<p><b>Routine:</b>          Provider: Verbal/ Electronic: within 24 hours of</p>	<p><b>Standard (Routine):</b>          Provider: Written notification must be sent</p>

<u>decision</u> <u>Written: within 2 working days of the</u> <u>decision, if verbal previously given</u>  <u>Member: Verbal not required</u> <u>Written: (Required only for delay,</u> <u>modification or denial). Within 2</u> <u>working days of the decision, not to</u> <u>exceed 14 calendar days from the</u> <u>receipt of the request.</u>  <u><b>Expedited (Urgent):</b></u> <u>Provider: Verbal Electronic: within 72 hours</u> <u>from the receipt of the request; must</u> <u>include expedited appeal rights.</u> <u>Written (if verbal notification given):</u> <u>Within 2 working days of the decision</u>  <u>Member: Verbal: not required</u> <u>Written: (Required only for delay,</u> <u>modification or denial) Within 2 working</u> <u>days of making the decision.</u>	<u>within three days of decision.</u>  <u>Member: Notified of the decision no later</u> <u>than 2 working days from the</u> <u>decision, not to exceed 14 days from</u> <u>receipt of the request.</u>  <u><b>Expedited (Urgent):</b></u> <u>Provider: Verbal/ Electronic: notification 72</u> <u>hours from the receipt of the request;</u> <u>must include expedited appeal rights.</u> <u>Written (If verbal notification given):</u> <u>Within 2 working days of the decision</u>  <u>Member: Verbal: Within 24 hours of decision</u> <u>Written: Within 2 working days of</u> <u>making the decision</u>
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<p><b><u>Routine:</u></b>  <del>Provider: Verbal/ Electronic within 24 hours of decision</del>  <del>Written: within 2 working days of the decision, if verbal previously given</del>  <del>Member: Verbal not required</del>  <del>Written (Required only for delay, modification or denial). Within 2 working days of the decision, not to exceed 14 calendar days from the receipt of the request.</del></p> <p><b><u>Expedited (Urgent):</u></b>  <del>Provider: Verbal/Electronic: Within 72 hours from the receipt of the request; must include expedited appeal rights.</del>  <del>Written (if verbal notification given): Within 2 working days of the decision</del>  <del>Member: Verbal: not required</del>  <del>Written: (Required only for delay, modification or denial) Within 2</del></p>	<p><b><u>Standard (Routine):</u></b>  <del>Provider: Written notification must be sent within three days of decision.</del>  <del>Member: Notified of the decision no later than 2 working days from the decision, not to exceed 14 days from receipt of the request.</del></p> <p><b><u>Expedited (Urgent):</u></b>  <del>Provider: Verbal/ Electronic notification 72 hours from the receipt of the request; must include expedited appeal rights.</del>  <del>Written (If verbal notification given): Within 2 working days of the decision</del>  <del>Member: Verbal: Within 24 hours of decision</del>  <del>Written: Within 2 working days of making the decision</del></p>
<p><b><u>Medi-Cal</u></b></p>	<p><b><u>OneCare and OneCare Connect Timeframes for Notification (non-Part D) (cont.)</u></b></p>

<u>Timeframes for Notification</u>  <u>(cont.)</u>	<u>Concurrent:</u> <u>-Practitioner:- Verbal/ electronic: -Within 24</u> <u>hours of making —the decision</u>
<u><b>Concurrent:</b></u> <u>-Practitioner: -Verbal/ Electronic: Within 24 hours</u> <u>of making —the decision</u> <u>—Written (if verbal notification): -</u> <u>Within 2 working days of —the</u> <u>decision.</u> <u>Following completion of treatment, an</u> <u>authorization summary is provided within 2</u> <u>working days.</u>  <u>-Member: -Verbal: -Nnot required.</u> <u>—Written: (Required only for delay, —</u> <u>modification or denial). -Within 2 working</u> <u>days of decision</u> <u>—</u> <u><b>Retrospective:</b></u> <u>-Practitioner: Verbal: -not required</u> <u>—Written: (Required only for—</u> <u>—modification</u> <u>or denial): —Within</u> <u>30 days of receipt- —of-</u> <u>information necessary to —</u> <u>make the determination</u>  <u>Member: Verbal: Nnot required</u> <u>—Written: (Required only for—</u> <u>—modification or</u> <u>denial): —Within</u> <u>30 days of receipt— —of</u> <u>information necessary to —</u> <u>make the determination</u>	<u>—Written (if verbal</u> <u>notification): -Within 2 working days of —</u> <u>the decision.-</u> <u>Following completion of treatment, an</u> <u>authorization summary is provided within 2</u> <u>working days.</u>  <u>-Member: -Verbal: Nnot required.</u> <u>—Written: (Required only for denial). -</u> <u>Within 2 working —days of decision</u>  <u><b>Retrospective:</b></u> <u>-Practitioner: Verbal: Nnot required</u> <u>—Written: (Required only for-</u> <u>denial):-</u> <u>-Within 30 days of receipt —</u> <u>of information necessary to —</u> <u>make the determination</u>  <u>Member: Verbal: -Nnot required</u> <u>—Written: (Required only for-</u> <u>denial): —</u> <u>Within 30 days of receipt -</u> <u>of information necessary</u> <u>to make the determination</u>  <u>Notice requirement: -CMS “Medicare Notice of</u> <u>-Non-Coverage” including specific</u> <u>language for expedited appeal for expedited</u> <u>initial- organization determination</u>

~~decision.~~

~~Member: None specified~~

~~Written Notification of Denial or Modification:~~

~~Provider: Within 2 working days of making the decision~~

~~Member: Within 14 calendar of making the decision, not to exceed 28 calendar days from receipt of the request~~

~~Member: Within 2 working days of making the~~

~~If an extension is requested the member must be notified no later than the expiration of the request (28 days maximum.) Notification includes the reason for the delay and their right to file an expedited grievance if they disagree with the extension request.~~

~~Expedited Authorization (Pre Service):~~

~~(Oral or Electronic)~~

~~Provider: Within 24 hours of making the decision~~

~~Member: None specified~~

~~Written Notification of Denial or Modification:~~

~~Provider: Within 2 working days of making the decision.~~

~~Member: Within 2 working days of making the decision.~~

~~Expedited Authorization (Pre Service) —~~

~~Extension Needed:~~

~~(Oral or Electronic)~~

~~Provider: Within 24 hours of making the decision~~

~~Member: None specified~~

~~Written Notification of Denial or Modification:~~

~~Provider: Within 2 working days of making the decision~~

~~Member: Within 2 working days of making the decision.~~

~~Concurrent:~~

~~(Oral or Electronic)~~

~~Practitioner: Within 24 hours of making the decision (for approvals and denials).~~

~~Member: None Specified~~

~~Written Notification of Denial or Modification:~~

~~Provider: Within 2 working days of making the decision.~~

<p>decision.</p> <p>NOTE: For Provider and Member: If oral notification is given within 24 hours of request, written notification must be given no later than 3 working days after the oral notification.</p> <p>Post Service—Retrospective Review: (Oral or Electronic)</p> <p>Member and Provider: None specified</p> <p>Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of request.</p> <p>Post Service—Extension Needed: (Oral or Electronic)</p> <p>Provider and Member: None specified</p> <p>Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of the information necessary to make the determination</p>	
<p>Denial Letter/Member Notification—State mandated “Notice of Action”</p>	<p>Denial Letter/Member Notification</p> <p>CMS mandated “Medicare Notice of Non-Coverage” including specific language for expedited appeal for expedited initial organization determination</p>

<b>Medi-Cal <del>and OneCare Connect (Medi-Cal)</del> Pharmaceutical — Decision Making</b>	<b>OneCare <del>(Medicare)</del> and OneCare Connect Pharmaceutical — Decision Making <del>(Medicare)</del></b>
<b><del>Pharmaceutical — Decision Making</del></b>	<b><del>Pharmaceutical — Decision Making</del></b>
<ul style="list-style-type: none"> <li>Processed by CalOptima Pharmacy Management department or Pharmacy Benefits Manager</li> <li>Qualified <del>pharmacist or</del> physician review for any modifications or denials <del>Qualified pharmacist review for any modifications or denials</del></li> <li>Qualified physician review for any appeal- <del>denials</del></li> </ul>	<ul style="list-style-type: none"> <li><del>Processed by CalOptima Pharmacy Management department or Pharmacy Benefits Manager</del></li> <li><del>Qualified pharmacist or physician review for any modifications or denials</del></li> <li><del>Qualified physician review for any appeals</del> <ul style="list-style-type: none"> <li><del>Processed by Pharmacy Management department at CalOptima</del></li> <li><del>Qualified physician review for any appeals</del></li> </ul> </li> </ul>

<b><u>Medi-Cal</u> Pharmacy — Timeframes for Determinations</b>	<b><u>OneCare and OneCare Connect</u> Pharmacy — Timeframes for Determinations (Part D):</b>
<b><u>Pharmacy — Timeframes for Determinations</u></b>	<b><u>—Timeframes for Determinations (Part D):</u></b>
<p>÷</p> <p><b><u>Standard (Non-urgent)</u></b> <b><u>Preservice:Response (approval, Deferral, Denial) W</u></b>within 24 <u>hours a decision to approve, modify, —deny or defer is required.</u></p> <p><b><u>Standard (Non-urgent) Preservice,</u></b> <b><u>Extension Needed:- Within 5 working days of receiving needed information, but no longer than 14 calendar days or next business day of receiving the request.</u></b> Approvals or Denials Routine 5 business days Urgent 72 hours Retrospective 30 days <b><u>Expedited (Urgent) Preservice: W</u></b>within 24 <u>——hours a decision to approve, modify, –deny or defer is required.</u></p>	<ul style="list-style-type: none"> <li>Routine: 72 hours</li> <li>Urgent: 24 hours</li> <li><u>Retrospective: 14 days</u></li> </ul> <p><b><u>Pharmaceutical —Timeframes for Notification- (Part D)</u></b> <b><u>Authorization Request Type:</u></b> <b><u>For expedited requests, written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.</u></b> <b><u>For standard requests, written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written</u></b></p>

**Expedited (Urgent) Preservice, Extension**

**Needed:-** Within 72 hours of the initial request

**Concurrent:** A deferral must be made within 24 hours if indicated. Approval, modification or denial within 72 hours.

**Post-Service/Retrospective:** ~~W~~ within 30 days of receipt

Pharmacy: Timeframes for Notification:-

Authorization Request Type: Routine (Non-

Urgent) Pre-Service: (Oral or Electronic)

Provider: Initial within 24 hours of the decision-

Member: None specified

Timeframes for Notification

Medi-Cal

**Standard (Non-Urgent) Pre-Service (for-**  
**modifications or denials only):**

Provider: Electronic/written: within 2 business days of the decision-

Member: written: within 2 business days of the decision

Provider: Within 2 working days of making the decision

**Member:** Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request.

**Routine (Non-Urgent): Pre-Service-**  
**Extension Needed:**

Provider: Electronic/written: within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request.

Within 24 hours of making the decision:

Member: Written: within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request.

None specified

Written Notification of Denial or Modification:-

Provider: Within 2 working days of making the

notification must be provided within 3 calendar days of the oral notification.

For retrospective requests, written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.

decision

Member: ~~Within 14 calendar of making the decision, not to exceed 28 calendar days from receipt of the request~~

**~~Expedited Authorization (Pre Service):-~~**

~~(Oral or Electronic)~~

Provider: ~~Within 24 hours of making the decision~~

Member: ~~None specified~~

~~Written Notification of Denial or Modification:-~~

~~\_\_\_\_\_ Provider: Electronic/written: Within 2-  
\_\_\_\_\_ working business days of making the  
decision.~~

~~\_\_\_\_\_ Member: Written: Within 2 business-  
working days \_\_\_\_\_ of making the decision.~~

**~~Expedited (Urgent) Preservice, Extension~~**

**~~Needed: NOTE: For Provider and~~**

**~~Member: If oral notification is given within 24 hours of request, written notification must be given no later than 3 working days after the oral notification.~~**

~~\_\_\_\_\_ Provider: Electronic/written: within 2-  
business days of the decision~~

~~\_\_\_\_\_ Member: Written: within 2 business days  
of the decision~~

**~~Concurrent:-~~**

~~Provider: Electronic/written: Within 24-  
\_\_\_\_\_ hours of making the decision.~~

~~\_\_\_\_\_ Member: Written: Within 24 hours  
\_\_\_\_\_ of making the decision.~~

**~~Post Service/ Retrospective~~**

**~~Review: (Oral or Electronic)~~**

~~Member and Provider: None specified~~

~~Written Notification of Denial or Modification:-~~

~~\_\_\_\_\_ Practitioneovider and~~

~~Member: Written: within 30-~~  
~~calendar days of receipt of request.~~

~~Member: Written: within 30 days of~~  
~~receipt of request.~~

~~Post Service Extension~~

~~Needed: (Oral or Electronic)~~

~~Provider and Member: None specified~~

~~Written Notification of Denial or Modification:~~

~~Provider and Member: Within 30 calendar days~~  
~~of receipt of the information necessary to make~~  
~~the determination~~







<u>Medi-Cal</u> <u>Pharmacy — Timeframes for</u> <u>Notification</u>	<u>OneCare and OneCare Connect</u> <u>Pharmacy — Timeframes for</u> <u>Notification (Part D)</u>
<p><b><u>Routine (Non-Urgent): Pre-Service Extension Needed:</u></b></p> <p><u>Provider: Electronic/written: Within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request.</u></p> <p><u>Member: Written: Within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request.</u></p> <p><b><u>Expedited Authorization (Pre-Service):</u></b></p> <p><b><u>Notification of Denial or Modification:</u></b></p> <p><u>Provider: Electronic/written: Within 2 business days of making the decision.</u></p> <p><u>Member: Written: Within 2 business days of making the decision.</u></p> <p><b><u>Expedited (Urgent) Preservice, Extension Needed:</u></b></p> <p><u>Provider: Electronic/written: Within 2 business days of the decision</u></p> <p><u>Member: Written: Within 2 business days of the decision</u></p> <p><b><u>Concurrent:</u></b></p> <p><u>Provider: Electronic/written: Within 24 hours of making the decision.</u></p> <p><u>Member: Written: Within 24 hours of making the decision.</u></p> <p><b><u>Post Service/ Retrospective Review:</u></b></p> <p><u>Practitioner: Written: Within 30 days of receipt of request.</u></p> <p><u>Member: Written: Within 30 days of receipt of request.</u></p>	<p><u>Authorization Request Type:</u></p> <p><b><u>For expedited requests:</u></b></p> <p><u>Written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.</u></p> <p><b><u>For standard requests:</u></b></p> <p><u>Written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.</u></p> <p><b><u>For retrospective requests:</u></b></p> <p><u>Written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.</u></p>

<b>Medi-Cal Denial Letter/Member Notification</b>	<b>OneCare and OneCare Connect Denial Letter/Member Notification</b>
State mandated “Notice of Action”	CMS mandated “Medicare Notice of Non-Coverage” including specific language for expedited appeal for expedited initial organization determination

### **UM Urgent/Expedited Prior Authorization Services**

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima within five (5) days prior to the requested service date. Prior authorization is never required for emergent or urgent care services. Facilities are required to notify CalOptima of all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Post-stabilization services require authorization. Once the member’s emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required.

### **UM Routine/Standard Prior Authorization Services**

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within five (5) business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. CalOptima makes a determination for urgent concurrent, expedited continued stay, post stabilization review or in cases for ongoing ambulatory care or if the lack of treatment may result in an emergency visit or emergency admission within 24 hours of receipt of the request for services. A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service). Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

### **~~Nurse Advice Phone Line—How should the HE be represented here with CareNet?~~**

~~CalOptima has a twenty four hour, seven days per week NCQA accredited Nurse Advice Phone Line accessible to all lines of business. The health line is designed to reduce unwarranted ER visits and associated costs; elevate member knowledge, engagement, health and satisfaction; and boost clinical, financial and operational outcomes. Multiple communication options allow the member access by web, email and phone.~~

~~A bilingual staff of RNs assess and triage symptoms, make urgent and non urgent care recommendations using evidence based guidelines and resources, give provider and facility referrals and educate members on diagnoses, conditions and medications. The Nurse Advice Phone Line also helps support CalOptima member’s comprehensive needs by cross referring members to existing programs such as case or disease management, Perinatal Support Services, IHSS, MSSP, Health~~

Education, and local resources available in the community.

## **Emergency Services**

Emergency room services are available 24 hours/day, 7 days/week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition. CalOptima covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a Plan network practitioner, or Plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as previously stated.

Although CalOptima may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, including emergent admissions, CalOptima does not refuse to cover an emergency service based on the practitioner's or the facility's failure to notify CalOptima of the screening and treatment within the required time frames, except as related to any claim filing time frames. Members who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

### **Admission/Concurrent Review Process**

The admission/concurrent review process assesses the clinical status of the member and verifies the need for continued hospitalization and facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed,
- Validating the diagnosis;
- Assessment of the clinical status of the member to determine special requirements to
  - facilitate a safe discharge to another level of care;
- Additional days/service/procedures proposed, and
- Reasons for extension of the treatment or service.

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonic. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management, disease management, or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

### **Hospitalist/SNFist Program**

The goal of the Hospitalist/SNFist Program is for early identification and management of members, either in the Emergency Room or inpatient setting, with prompt linkage to an identified hospitalist/SNFist to ensure that the member receives the appropriate care in the most appropriate setting. Appropriate setting is determined by medical providers using established evidence based clinical and administrative criteria. Other program objectives include:

Initiate appropriate care plan consistent with:

- Established estimated length of stay criteria
- Medical necessity criteria to establish appropriate level of care
- Member psychosocial needs impacting ongoing care
- Communication of current and ongoing needs impacting discharge planning and after-care requirements to PCP and others involved in the members care
- Facilitation of transfer of members from non-contracted facilities to facilities with a

contracted hospitalist team

Contracted hospitalist groups, facilities case management staff, and Emergency Room personnel receive training from CalOptima staff on:

- Early identification of CalOptima Direct (COD) members
- Process for notification of hospitalists
- Face sheet and/or telephonic notification to CalOptima
- Care Plan development and implementation
- Discharge Planning

The role of the hospitalist is to work together with the Emergency Department team to determine the optimal location and level of care for the member's treatment needs. If, based on clinical information and medical necessity criteria, the member requires admission to the facility; the hospitalist assumes primary responsibility for the member's care as the admitting physician and will coordinate the member's care together with CalOptima medical management staff. If at any time the member is appropriate for transfer to a lower level of care, whether directly from the emergency room or after admission, the hospitalist will facilitate the transfer to the appropriate setting, in concert with the accepting facility and with CalOptima staff.

### **Discharge Planning Review**

Discharge planning begins within 48 hours of an inpatient admission, and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention;
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the members care;
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources;
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization;
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Concurrent Review Process.

### **Denials**

A denial of services, also called an adverse organization determination, is a reduction, modification,

suspension, denial or termination of any service based on medical necessity or benefit limitations. Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time frames as noted in the Referral/Authorization Processing Policy and Procedure. The written notification is easily understandable and includes the member specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and time frames for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (behavioral health practitioner, pharmacist, etc.) serves as the point of contact for the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

### **UM-Grievance Appeals-Process**

CalOptima has a comprehensive review system to address matters when Medi-Cal, OneCare or OneCare Connect members wish to exercise their right to review of a UM decision to deny, delay, terminate or modify a request for services. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. GrievancesAppeals for members enrolled in COD, or one of the contracted HMOs, PHCs, and SRGs and PMGs, are submitted to CalOptima's GARS. The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution. The grievanceappeals process is in accordance with CalOptima Policy and Procedure HH.1102: Grievance and Appeals Resolution Services. This process includes:

- Collection of data
- Communication to the member and provider
- Thorough evaluation of the substance of the grievance-appeal
- Resolution of operational or systems issues
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case

The grievance UM-appeal-process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the initial decision, he/she may file for a State Hearing with the California Department of Social Services.

GrievancesUM-appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances-Appeals are

reviewed by an objective reviewer, other than the reviewer who made the initial denial determination; however, the initial reviewer may participate in the appeal process if new or additional information is submitted.

The UM or CM Medical Director or designee evaluates ~~grievances~~~~appeals~~ regarding the denial, delay, termination, or modification of care or service. The UM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An “Expert Panel” roster is maintained from which, either via Letter of Agreement or Contract, a Board Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the ~~required~~ regulatory time ~~lines~~limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member’s appeal by calling the CalOptima Customer Service department.

A Member ~~Grievance~~Grievance Resolution Letter will be sent within thirty (30) calendars after receipt of the grievance.

### **Expedited ~~Grievances~~Appeals**

A member or member’s representative may request the appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited appeal requests shall be reviewed and resolved in as expeditious a manner as the matter requires, but no later than 72 hours after receipt.

At the time of the request, the information is reviewed and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature, and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member, or could jeopardize the member’s ability to regain maximum functionality.

### **Provider Preventable Conditions (PPCs)**

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals, and
2. Other provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

## **LONG-TERM SERVICES AND SUPPORTS**

### **Long-Term Care**

The Long-Term Care case management program includes authorizations for the following facilities: skilled nursing, intermediate care, sub-acute care, intermediate care—developmentally disabled, intermediate care—developmentally disabled—habilitative, and intermediate care— developmentally disabled—nursing. It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. An on-site visit is scheduled to assess patient's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system. Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. In addition, the LTC staff provides education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

### **CBAS**

An outpatient, facility based program offering day time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of a nursing facility. Services may include: health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational, and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

### **MSSP**

CalOptima has responsibility for the payment of the MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to: senior center programs, case management, money management and counseling, respite, housing assistance, assistive devices, legal services, transportation, nutrition services, home health care, meals, personal care assistance with hygiene, personal safety and activities of daily living.

### **IHSS**

CalOptima is responsible ~~for member referral to for payment of services for CalOptima members who receive services from~~ the IHSS program (which is operated by the County of Orange) ~~for individuals who may qualify for services~~. The program provides services to those members who are disabled, blind, or 65 years of age or older and are unable to live safely at home without help who meet the financial need requirement. Services are provided by a caretaker that the member hires. The

County determines eligibility under the program. It also determines the number of hours that an individual can receive services. Under an MOU with the county, CalOptima works collaboratively to ensure that referrals are being made ~~and to involve members and their caregivers, when agreed to, in the care planning process.~~

### **Retrospective Review**

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director, UM or designee, reviews the request for retrospective authorization. If supporting documentation satisfies the administrative waiver of notification [requirements](#) the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director, UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. The decision, to authorize or deny, is made within thirty (30) calendar days of receipt.

### **Transitions of Care (TOC)**

TOC is a 4-week patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides patients or caregivers with tools and support to encourage and sustain self-management skills in an effort to minimize a possible readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- **Knowledge of Red Flags**: Patient is knowledgeable about indications that their condition is worsening and how to respond;
- **Medication Self-Management**: Patient is knowledgeable about medications and has a medication management system;
- **Patient-Centered Health Record**: Patient understands and uses a Personal Health Record (PHR) to facilitate communication with their health care team and ensure continuity of care across providers and settings;
- **Physician Follow-Up**: Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

### **Complex Case Management**

The Case Management Program is an ongoing outpatient collaborative process that strives to assure the delivery of health care services in a responsible, optimally cost-efficient manner. Case Management is a distinct and unique program that identifies eligible persons, with specific health care needs, in order to facilitate the development and implementation of a care plan to efficiently use health care resources to achieve optimum member outcomes. Case Management activities are complimentary, not duplicative, of UM activities.

Case Managers are licensed nurses with caseloads that are variable, depending on the complexity of the cases managed.

The case management program includes:

- Standardized mechanisms for member identification through use of data;
- Multiple avenues for referrals to case management;
- Following members across the continuum of health care from outpatient or ambulatory to inpatient settings;
- Use of evidence-based clinical practice guidelines or algorithms;
- Initial assessment and ongoing management process;
- Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the member and/or his or her family and/or care giver(s);
- Developing comprehensive long and short-term goals;
- Analyzing all data for formulating appropriate recommendations;
- Coordinating services for members for appropriate levels of care and resources;
- Documenting all findings;
- Monitoring, reassessing, and modifying care to ensure quality, timeliness, and effectiveness of services;
- Mechanism for identification and referral of quality of care issues to QI department;
- Assessing the outcomes of case management and presenting findings to the Medical Director of Case Management.

### **Case Management Process**

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other healthcare delivery organizations and community resources, as applicable.

#### Referral/Case Identification

- Intake
- Assessment
- Risk Stratification
- Care Plan development, with long and short term goals

For further details of the structure, process, staffing, and overall program management please refer to the 2018 Case Management Program document.

### **Transplant Program**

The CalOptima Transplant Program is coordinated by CalOptima's Medical Director and managed by in collaboration with the Case Management department's ~~collaboration~~. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs ~~or~~, SRGs ~~and PMGs~~, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and ~~tools~~ education needed to proactively manage members identified as potential transplant candidates. The CalOptima Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence, or CMS Center(s) of Excellence for OneCare, as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant

staff, and the facilities. CalOptima monitors and maintains oversight of the Transplant Program, and reports to the UMC to oversee the accessibility, timeliness and quality of the transplant process across networks.

### **Coordination of Care**

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases which are referred to the Case Management ~~and/or Disease Management~~ department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medicaid is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider ~~under-in~~ certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes ~~o~~into CalOptima or a member terminates from CalOptima to a new health plan.

### **Disease Management (DM)**

DM is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. CalOptima's DM Program is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. The diagnosis based programs are offered telephonically, involving interaction with a trained health care professional, and require an extended series of interactions, including a strong educational element. CalOptima's DM Programs emphasize prevention, and members are expected to play an active role in managing their diseases.

### **DM Process**

CalOptima's DM Programs are disease specific and evaluated for relevance to CalOptima's membership demographics and utilization patterns. DM Programs may include, but are not limited to: Asthma, Chronic Kidney Disease, COPD, Diabetes, Pregnancy Management, and Depression. The major components of each disease management program include:

- Identification of members with specified diagnosis;
- Stratification or classification of these members according to the severity of their disease, the appropriateness of their treatment, and the risk for complications and high resource utilization;
- Provision of proven interventions that will improve the clinical status of the member and reduce the risk for complications and long-term problems;
- Involvement of the member, family/caregiver(s), and physician to promote appropriate use of resources;
- Education of patient and family/caregiver(s) to promote increased understanding of the

- disease and increase self-management of the disease in an effort to decrease exacerbations;
- Ongoing measurement of the process and its outcomes in order to document successes and/or identify necessary revisions of the program.

Members with a potential diagnosis applicable to the specific DM Program are identified through various sources, including, but not limited to: inpatient census reports, medical claims data (office, emergency department, outpatient, and inpatient levels of care), pharmaceutical claims data, health risk assessments (HRA) results, laboratory reports, data from UM/CM processes, new member welcome calls, member self-referral, and physician referral.

Based on the data received during the identification phase, members are stratified into risk groups that guide the care coordination interventions provided. Members are stratified into Low, Moderate, or High-Risk categories. Definitions for each risk category are program specific and are outlined in the program's description document. Members may change between risk groups based on data retrieved during each reporting period, as well as through collaboration/interaction with the member or PCP. Members enrolled into a disease management program receive some level of intervention, which may include, but is not limited to: identification, assessment, disease specific education, reminders about preventive/monitoring services, assistance with making needed appointments and transportation arrangements, referral to specialists as needed, authorization for services and/or medical equipment, coordination of benefits, and coordination with community based resources. Education is a crucial component of the disease management program. Education is presented to members and their treating physician(s) and may be provided through mailings, telephone calls, or home visits.

High-risk members are referred to CalOptima's Complex Case Management Program for development of an individualized care plan. Both the member/family/caregiver(s) and the physician will be included in the development of the care plan. Including the member/family/caregiver(s) in the development of the individualized goals and interventions promotes ownership of the program and stimulates a desire for success. Care plan goals and interventions are reviewed routinely and [CalOptima the plan](#) of care is adjusted as necessary by the care coordinator to assure an optimal outcome for the member.

### **Measuring Effectiveness**

Effectiveness of both the Complex Case Management and DM Programs are measured on, at a minimum, an annual basis. Methods of evaluation include condition specific indicators (e.g. Healthcare Effectiveness Data and Information Set [HEDIS] measures for Comprehensive Diabetes Care), utilization data, such as frequency of ER visits or inpatient admissions, and self-reported member information such as satisfaction with the program, level of understanding of the disease, or improvement in life impact, such as days of school or work missed. This measurement and analysis is documented as part of the annual [QIUM](#) Program evaluation.

Over/under utilization monitoring is tracked by UM and reported to UMC. Measures are monitored and reviewed for over and underutilization, [and/or](#) changes in trends. Actions are determined based on trends identified and evaluated for effectiveness.

The following are measures tracked and monitored for over/under utilization trends:

- ER admissions
- Bed Days
- Admits per 1000
- ALOS
- Readmission Rates
- Used/Unused Authorizations
- Inter-rater Reliability for all licensed staff utilizing clinical review criteria
- Grievances — Member per 1000 per Year
- Appeals — Member per 1000 per Year
- Overturn Rates — Provider per 1000 per Year
- Satisfaction with Primary Care Access
- Provider Satisfaction
- Member Satisfaction
- HEDIS/Consumer Assessment of Healthcare Providers and Systems (CAHPS)

### **State Fair Hearing (Medi-Cal Line of Business Only)**

CalOptima Medi-Cal members have the right to request a **State** Fair Hearing from the California Department of Social Services at any time during the appeals process, or within 90 days of an adverse decision. A member may file a request for a **State** Fair Hearing and a request for an appeal at the same time. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Fair Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each resolution letter sent to the member or the member's representative.

### **Independent Medical Review**

OneCare and OneCare Connect members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). TCMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. OneCare is notified when a request is made by a member or member representative. OneCare supports the process with providing the medical records for the **QIO**'s review. The QIO notifies the member or member representative and OneCare of the outcome of their review. If the decision is overturned, OneCare complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

## **PROGRAM EVALUATION**

The UM Program is evaluated at least annually, and modifications made as necessary. The **UM Medical Director** and **Executive Director of Utilization Management** evaluate the impact of the UM Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- Drug Utilization Review (DUR) profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC [and QAC](#) for approval.

## **SATISFACTION WITH THE UM PROCESS**

CalOptima provides an explanation of the GARS process, ~~Administrative-Fair~~ Hearing, ~~and Independent Review, and DHCS Board of Appeals review~~ processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima QI department for investigation and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results (CAHPS), member/provider complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM process, and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.



## **2018 Utilization Management Program**

**Board of Directors' Quality Assurance Committee Meeting  
February 20, 2018**

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

# 2018 UM Program Description

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- Defines CalOptima's structure and process for review of health care services, treatment and supplies
- Explains how services are reviewed in an effective, timely manner
- Includes the assignment of appropriate individuals for review
- Outlines monitoring processes to evaluate the effectiveness of the program and identify opportunities for improvement

# 2018 UM Program Description Revisions

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- Program introduction updated to reflect CalOptima's Strategic Plan for 2017-19
- Direct administration of mild to moderate mental health benefits for our Medi-Cal only members
- Health Network model references
- Enhanced committee reporting structure
- Long Term Services and Supports covered benefit categories (IHSS reverted wholly to County administration)



**CalOptima**  
Better. Together.

# **2017 PACE Quality Assurance Performance Improvement (QAPI) Plan Evaluation**

**Board of Directors' Quality Assurance Committee Meeting  
February 20, 2018**

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

# 2017 PACE QAPI Program Evaluation

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- Quality Assessment Performance Improvement (QAPI) Plan Evaluation:
  - Represents the analysis of the core clinical and service PACE indicators
  - Analysis provides guidance on opportunities for improvement in 2018.

# 2017 Accomplishments

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- Membership growth to 236 participants
- Completed two successful DHCS Level of Care Audits
- 100% Influenza and Pneumococcal Immunization Rates
- Infection Rates lower than national benchmarks
- 100% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed
- Only one participant in Long Term Care
- Improvement in 1-hr transportation violations
- Significant Patient Satisfaction Improvement

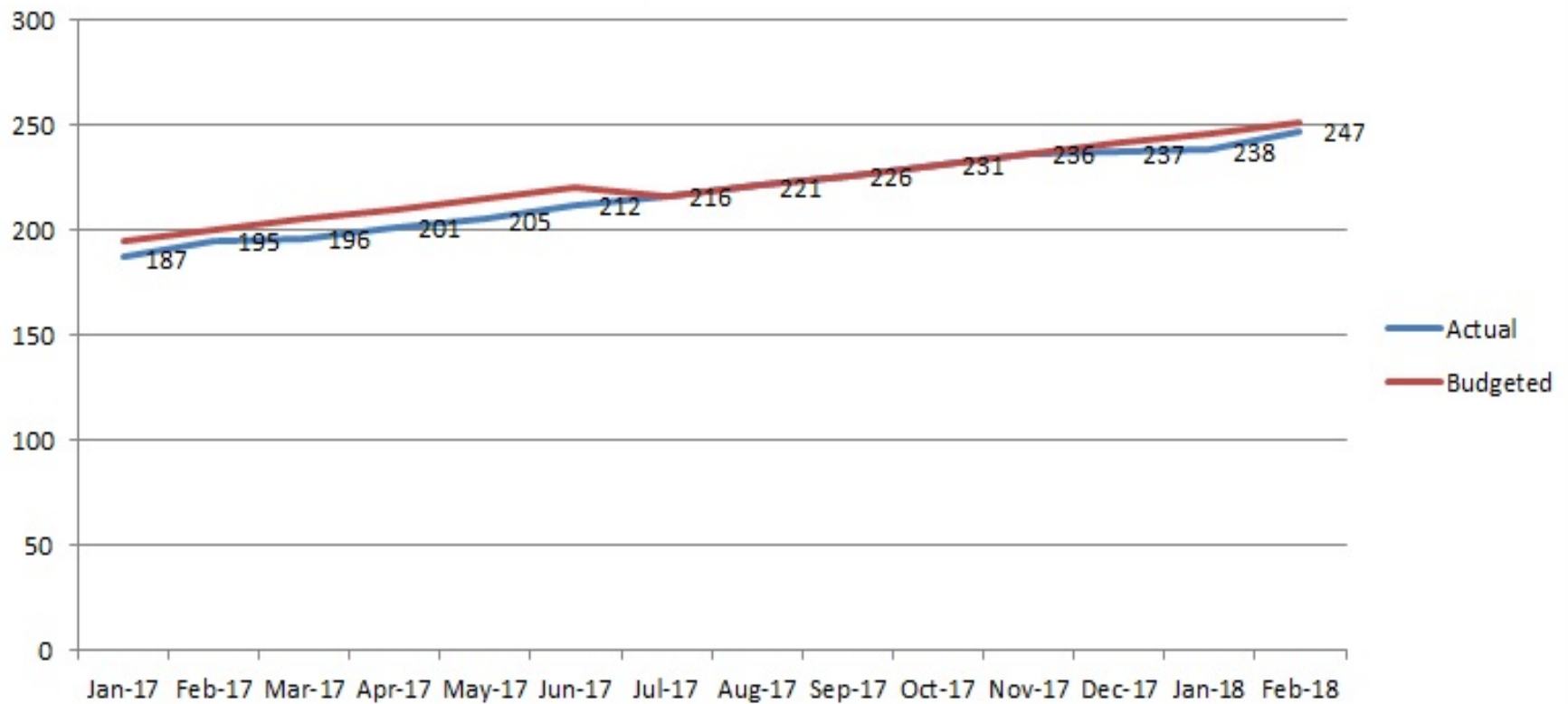
# 2017 Accomplishments

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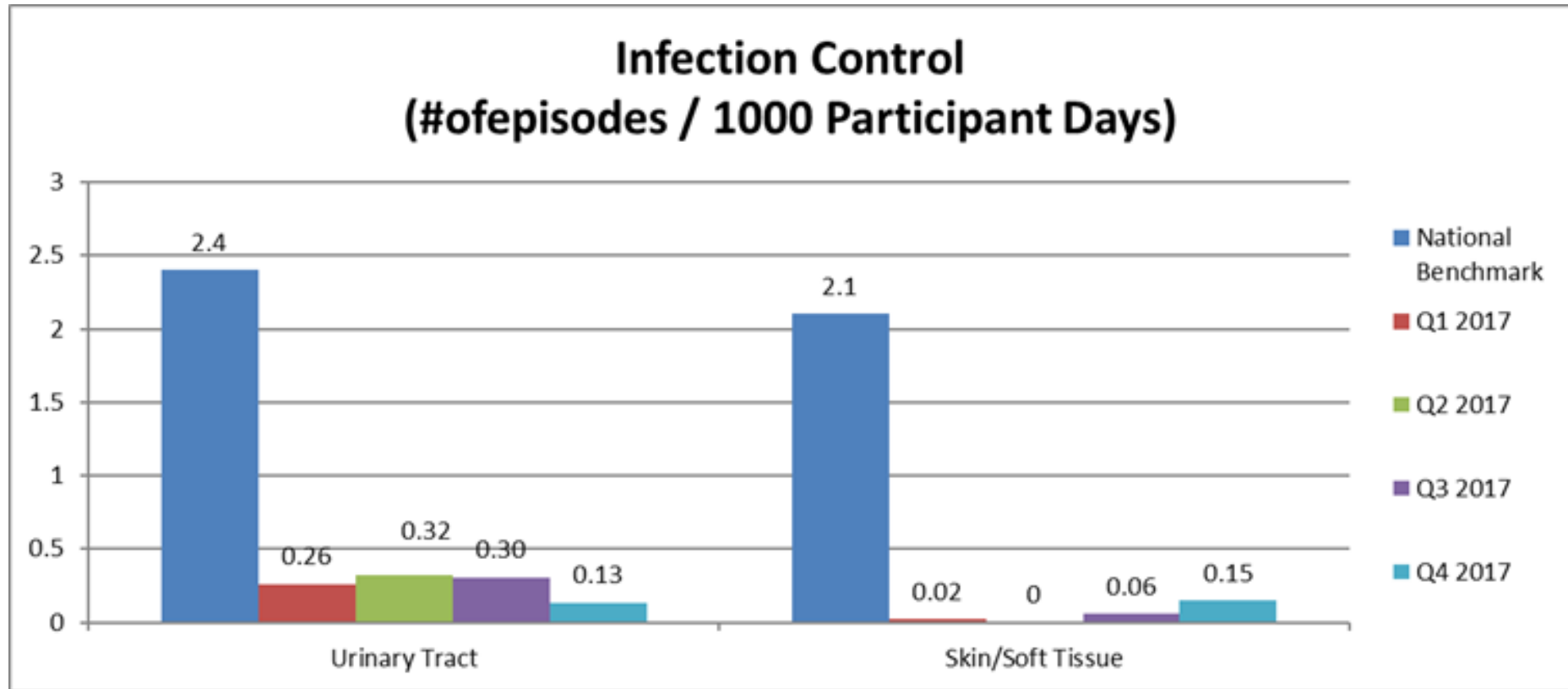
- Diversity of Participants and Staff Participants
  - Participants
    - Represent 15 different ethnicities
    - Speaking 9 languages
    - 56% of our Participants utilize English as their second language
  - PACE staff
    - 90% of PACE staff are Bilingual/Multilingual
    - Speaking 12 unique languages

# Total Membership

Monthly Total Membership  
Q1 2017-Q4 2017



# Element 5: Infection Control (Episodes per 1000 Participant Days)



# Element 6: Annual Diabetic Eye Exams

				MEDICARE Quality Compass 2016 HEDIS Percentiles			
	2017 PACE Rate	2017 PACE Goal	2016 OCC Rate	25 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	75 Percentile	90 <sup>th</sup> Percentile
Annual Diabetic Eye Exam	91%	>90%	71.74%	61.13	68.95%	77.19	83.10%

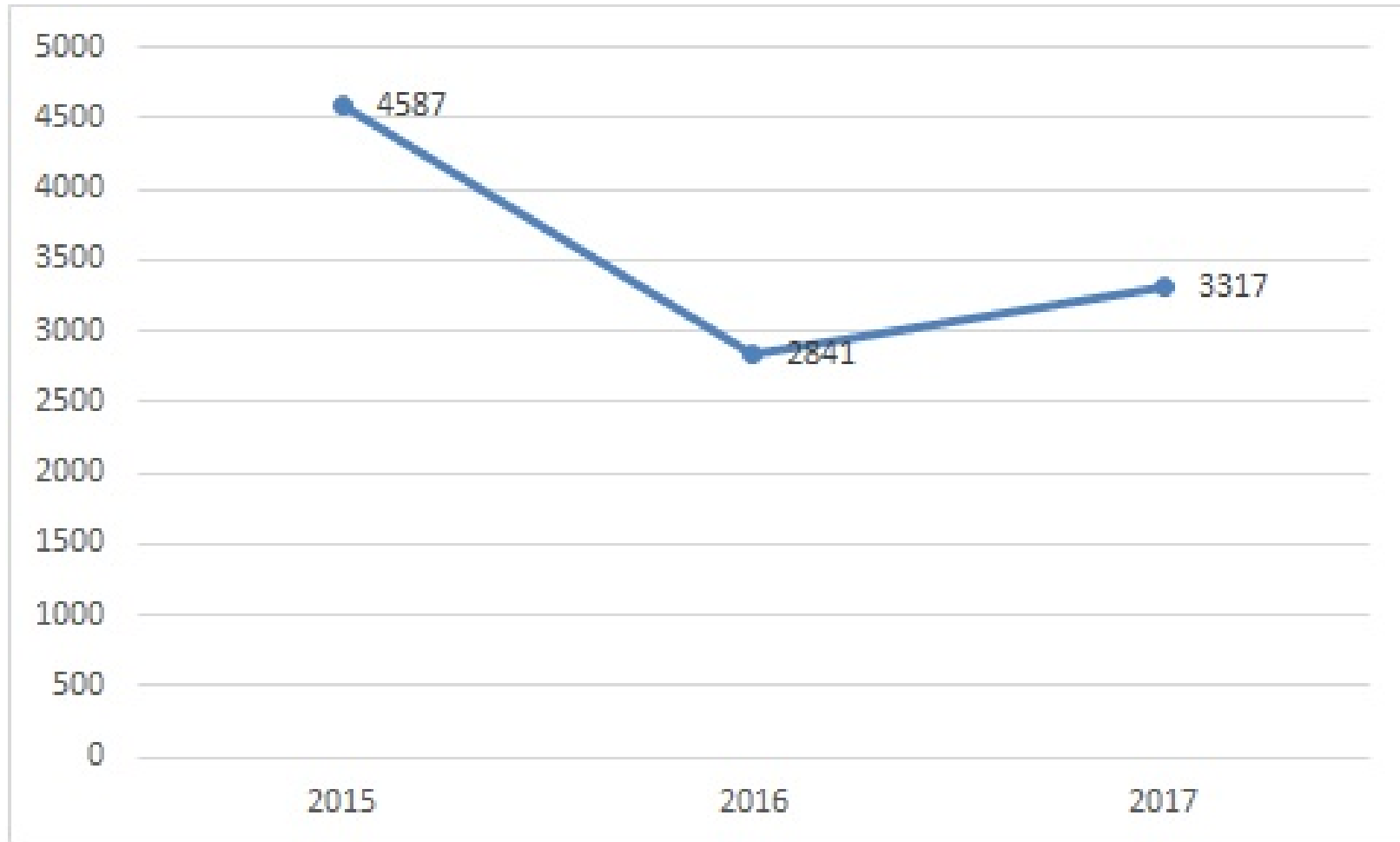
# Elements 7-10: Care for Older Adults

				2018 Star Cut Points			
	2017 PACE Rate	2017 PACE Goal	2016 OCC Rate	2 Star	3-Star	4-Star	5-Star
Advanced Care Planning	100%	>75%	41.2%	N/A	N/A	N/A	N/A
Medication Review	100%	100%	74.54%	59% to 79%	79% to 88%	88% to 93%	93%
Functional Status Completion	95%	100%	55.32%	46% to 67%	67% to 78%	78% to 92%	92%
Pain Screening	100%	100%	78.70%	40% to 62%	62% to 80%	80% to 94%	94%

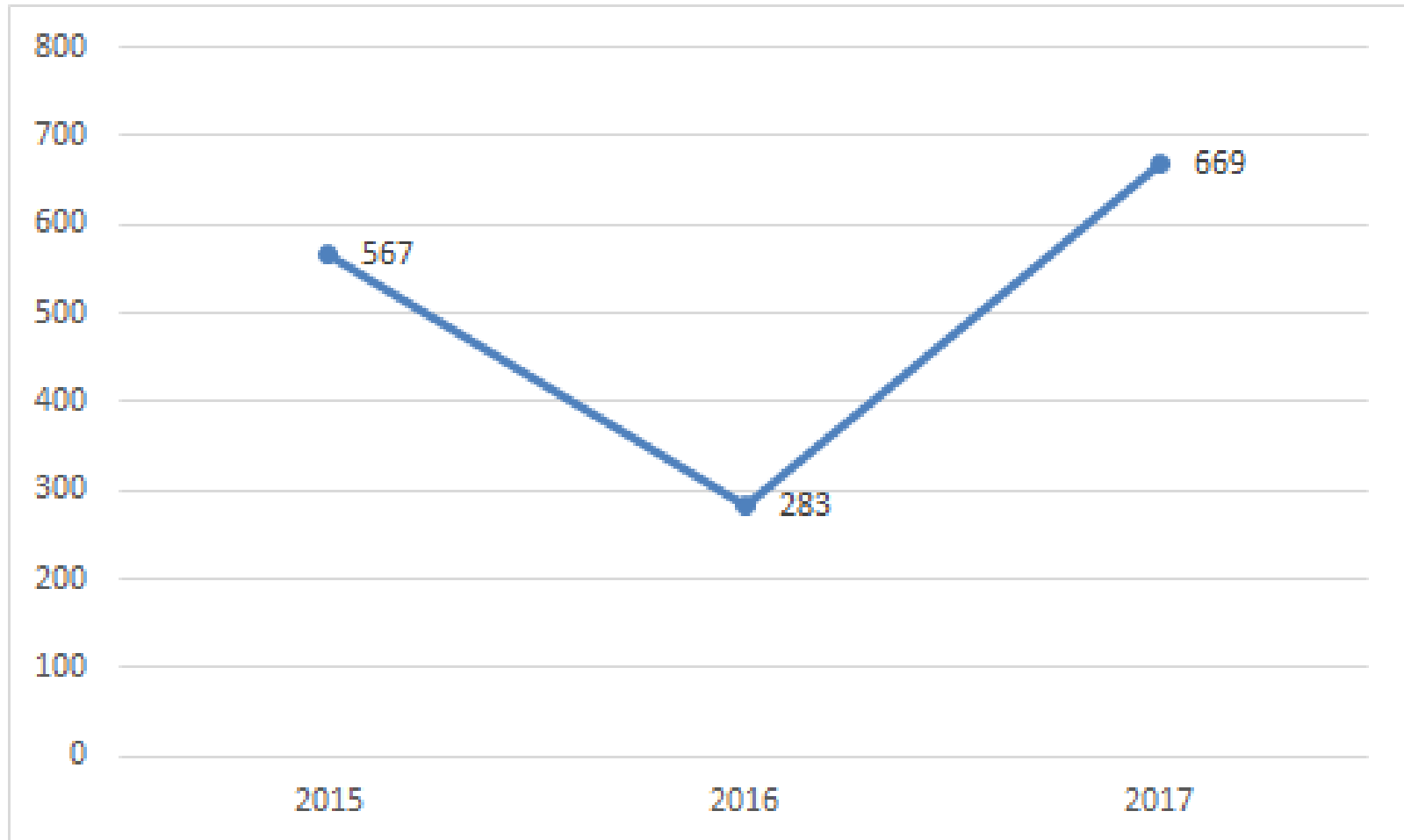
## Elements 11 & 12: Potential Harmful Drug/Disease Interactions in the Elderly (lower is better)

				Quality Compass 2016 HEDIS Percentiles			
	2017 PACE Rate	2017 PACE Goal	2016 OCC Rate	25 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	75 Percentile	90 <sup>th</sup> Percentile
Dementia + Tricyclic Antidepressants or anticholinergic Agents	9%	<38.82%	40.05%	51.95%	46.51%	41.88%	37.50%
Chronic Renal Failure + NSAID	0%	<3.93%	25.24%	13.33%	9.21%	6.22%	3.70%

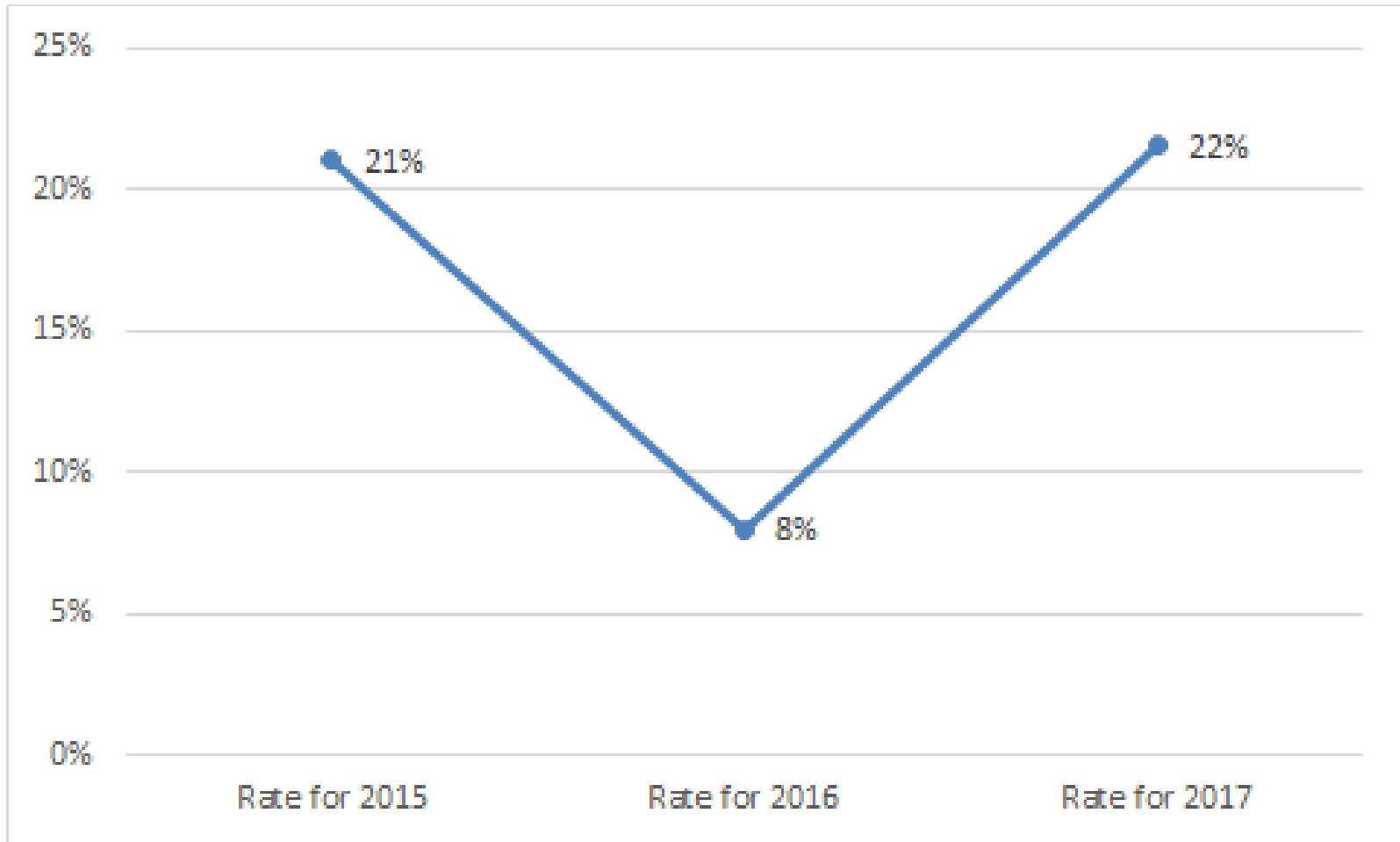
## Element 14: Hospital Bed Days (Goal: <2104 Bed Days/1000/Year)



## Element 15: ER Utilization (Goal <458 Visits/1000/Year)



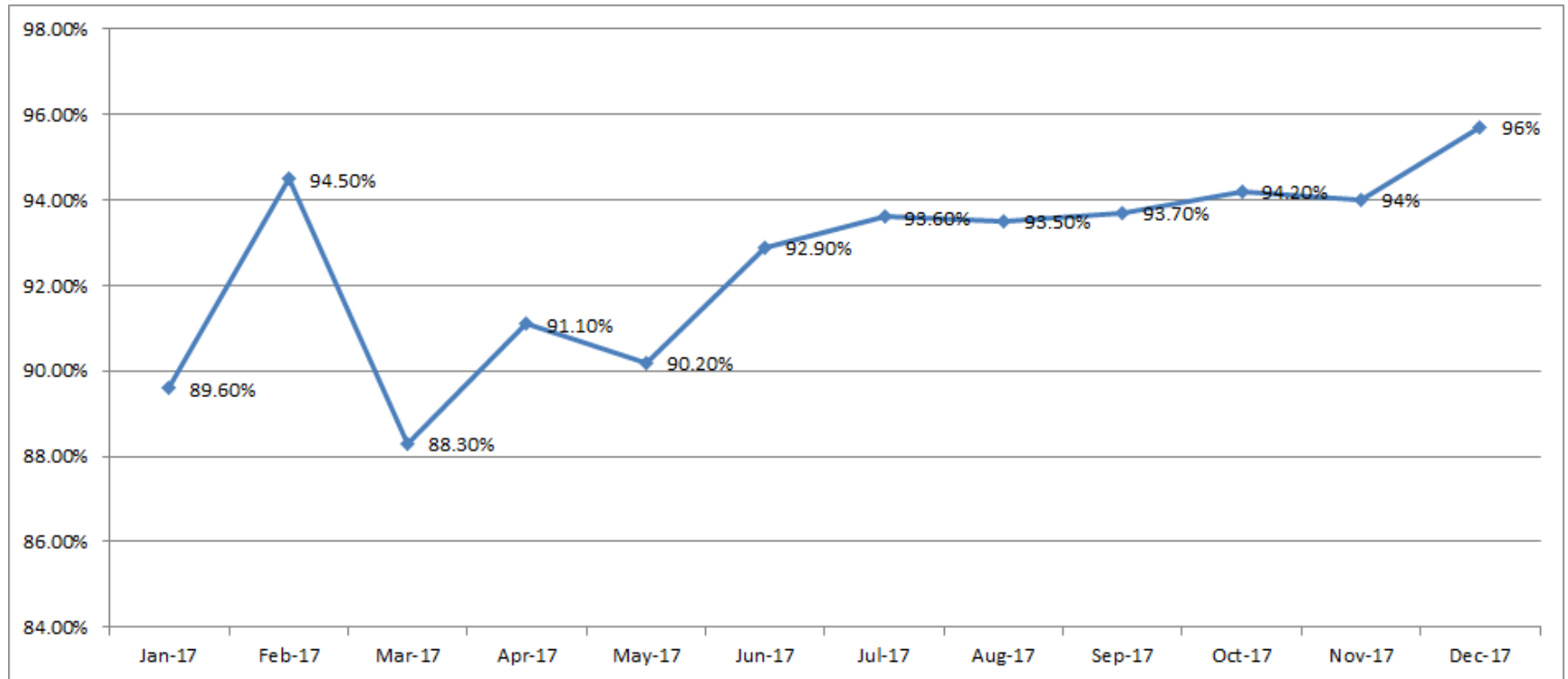
## Element 16: 30-Day All-Cause Readmissions (Goal <10%)



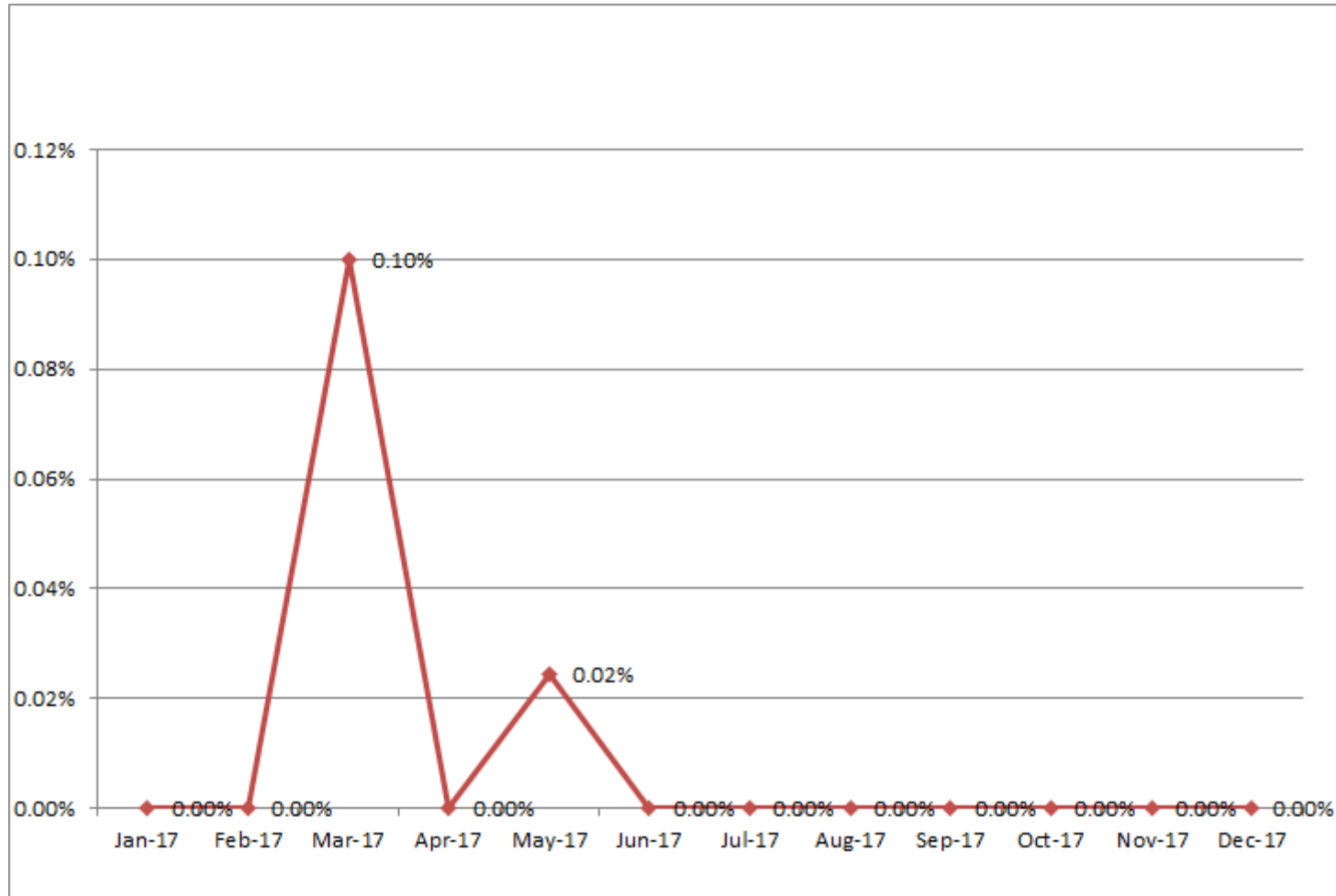
# Element 18: 2017 Annual Participant Satisfaction Survey Results

Domain	2016 CalOptima PACE	2017 CalOptima PACE	2017 CalPACE Average	2017 National Average
Transportation	98%	98%	93%	95.5%
Center Aids	92%	96%	93%	91.7%
Home Care	92%	93%	87%	87.8%
Medical Care	86%	92%	88%	89.5%
Health Care Specialist	85%	92%	87%	87.4%
Social Worker	96%	95%	94%	95.5%
Meal	71%	63%	71%	73.1%
Rehabilitation Therapy and Exercise	98%	97%	95%	93.2%
Recreational Therapy	82%	86%	84%	82.7%
Other Indicators	92%	94%	89%	89.4%
Overall Satisfaction	89%	90%	88%	88.4%

# Element 20:Transportation (On-Time Performance)



## Element 21: Transportation (1-Hour Violations)



# Opportunities for Improvement in 2018

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- Utilization
  - Hospitalists and nursing facility providers
  - ER Diversion
  - Palliative and Hospice-like programs
  - Specialist coordination with PACE/IDT
- Membership Growth
  - ACS Expansion
  - Community Physician Waiver
  - Service area expansion
- Participant Satisfaction
- Additional Quality of Care HEDIS Elements

# Recommended Action

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Receive and file the 2017 PACE Quality Assessment Performance Improvement (QAPI) Plan Evaluation

# **CALOPTIMA PACE**

## **2017 CALOPTIMA PACE QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) PLAN ANNUAL EVALUATION**

## SIGNATURE PAGE

*Quality Improvement Subcommittee Chairperson:*

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**Richard Helmer, MD**  
**Chief Medical Officer**

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**Date: 2/20/2018**

*Board of Directors' Quality Assurance Committee Chairperson*

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**Paul Yost, M.D.**

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**Date: 2/20/2018**

*Board of Directors Chairperson*

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**Paul Yost, M.D.**

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**Date: 3/1/2018**

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## **I. EXECUTIVE SUMMARY**

CalOptima PACE opened for operations on October 1<sup>st</sup>, 2013. We have seen steady growth over the last three years with 13 members at the end of 2013, 183 members at the end of 2016 and 236 members at the end of 2017. Our members represent 15 different ethnicities who speak 9 different languages. Fifty-six percent 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 which in turn drives continuous quality improvement for the entire PACE organization. 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). It is then reviewed and approved by the CalOptima Board of Directors Quality Assurance Committee (QAC) and then approved by the CalOptima Board of Directors annually. The written 2017 PACE QAPI Plan was reviewed and approved by the PQIC on Feb 7, 2017.

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 CalOptima 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 Quality Improvement (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 2017**

In 2017, overall CalOptima PACE accomplishments include:

- 1) Successful DHCS Level of Care Audits (Spring and Fall 2017).

- 2) Met 17 of the 21 QAPI element goals
- 3) Program growth to 236.
- 4) 100% of participants completed a Physician Orders for Life-Sustaining Treatment (POLST).
- 5) 100% of participants were up to date on the Pneumococcal and Influenza immunization rates (CMS goal is >80%).
- 6) Infection Control: Rate of skin and urinary infections in the elderly were lower than national benchmarks.
- 7) 100% of participants had completed a Physician's Order for Life-sustaining Treatment (POLST).
- 8) Quality of Care HEDIS metrics
  - a) 100% of participants had their medications reviewed.
  - b) 91% of diabetic participants completed the annual diabetic eye exam.
  - c) 100% of participants had a pain screening.
  - d) The rate of participants with dementia who were taking a tricyclic antidepressant, or an anticholinergic medication went from 50% down to 9% during the year. This was within the 90<sup>th</sup> percentile of the 2016 Medicare HEDIS Quality Compass.
  - e) The rate of participants with chronic kidney disease who was on a nonsteroidal anti-inflammatory was zero. This was within the 90<sup>th</sup> percentile of the 2016 Medicare HEDIS Quality Compass.
- 9) Utilization
  - a) One long-term care placement 12/25/17 or 0.5% of the PACE participants.
  - b) Establish relationships with hospitalist and nursing home physicians
  - c) Implementation of the concurrent review program and the addition of a new utilization management nurse.
- 10) Transportation
  - a) Only 4 1-hr violations, all which occurred in Q1, 2017.
  - b) 95% on time performance
- 11) Participant Satisfaction
  - a) Better than CalPACE average in 9 of 10 domains
  - b) Better than national averages in 9 of 10 domains
  - c) Overall program satisfaction greater than both CalPACE and national averages.
- 12) Hired and recruited staff to meet the needs of our Participants. As such, 72 of 80 staff members (or 90%) are bilingual or multilingual. Staff speak 12 unique languages including Arabic, Mandarin Chinese, Cambodian, Spanish, Mien, Farsi, Arabic, Korean, Tagalog, Vietnamese, Samoan, and English.
- 13) 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.

#### **IV. STRATEGIC GOALS AND OBJECTIVES OF THE 2017 PACE QAPI PROGRAM**

1. The QAPI program is organized to identify and analyze significant opportunities for improvement in clinical services, care and utilization.
  - a. Accomplished as evidenced by the ongoing HPMS and QAPI individual metric data collection and analysis.
  - b. Accomplished as evidenced by the ongoing PACE QAPI activities.

- c. Accomplished as evidenced by the population health techniques implemented in 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 the ongoing HPMS and QAPI individual metric data collection and analysis.
  - b. Accomplished as evidenced by the ongoing PACE QAPI activities.
  - c. Accomplished as evidenced by monitoring of member grievances and complaints, and regular review of delegated entities.
  - d. Accomplished by the monthly meeting with the transportation vendor.
  - e. Accomplished as evidenced by the daily morning inpatient and nursing facility clinical rounds.
  - f. Accomplish by the ongoing infection control activities.
  - g. Collaboration with the Compliance Department for identification of potential quality issues that may involve 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 as evidenced by the daily morning inpatient and nursing facility clinical rounds.
  - c. Accomplished by adding the hospital and nursing home attendings to the IDT.
  - d. Accomplished by the addition of preferred specialists who agree to participate in IDT.
- 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 86% of specialty appointments which were scheduled within 7 business days of IDT authorization.
  - c. Accomplished by the Podiatrist, Psychiatrist and the Dentist coming to the PACE center to see and treat the PACE participants.
  - d. Accomplished by the Podiatrist, Psychiatrist and the Dentist participating in the IDT meetings.
- 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 the 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 which 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 monthly.
  - b. Accomplished by the weekly PACE management team meetings.
  - c. Accomplished by the participation in the CalOptima Quality Improvement, Utilization Management, and Credentialing and Peer Review Committee meetings.
  - d. Accomplished by the participation in the CalOptima Board of Directors and the Board of Directors Quality Improvement committee meetings.

## **V. SUMMARY OF ACCOMPLISHMENTS, BARRIERS AND ACTIONS**

### **2017 QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT WORK PLAN - ELEMENTS BY CATEGORY**

#### ***Quality of Care***

**QAPI17.01 PACE QAPI Plan and Work Plan will be reviewed and updated annually**  
Received and filed by the CalOptima Board of Directors on March 2<sup>nd</sup>, 2017.

**QAPI17.02 PACE QAPI Plan and Work Plan will be evaluated annually.**  
Approved by the CalOptima Board of Directors on March 2<sup>nd</sup>, 2017.

**QAPI17.03 Increase Influenza immunization rates for all eligible PACE participants**

**Goal:** > 90% of members will have influenza vaccination

**Data/Analysis:** 100% of members received the influenza vaccination by year end.

**Summary:** Continue metric in 2018 work plan for oversight of HPMS required monitoring.

#### **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. All the Participants who initially 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 monthly basis during the months of October – March.
  - b. Utilize EMR's quality analytics for tracking of missed opportunities for immunization.
  - c. QI will give immunization reports bimonthly during the months of October – March.
  - d. Follow-up with all participants who refused influenza immunization monthly during the months of October – March.

**QAPI14.04** Increase Pneumococcal immunization rates for all eligible PACE participants

**Goal:** > 90% of members will have pneumococcal vaccination

**Data/Analysis:** 100% of members received the Pneumococcal immunization by year end.

**Summary:** Continue metric in 2018 work plan for oversight of HPMS required monitoring.

**Key Findings/Opportunities for Improvement**

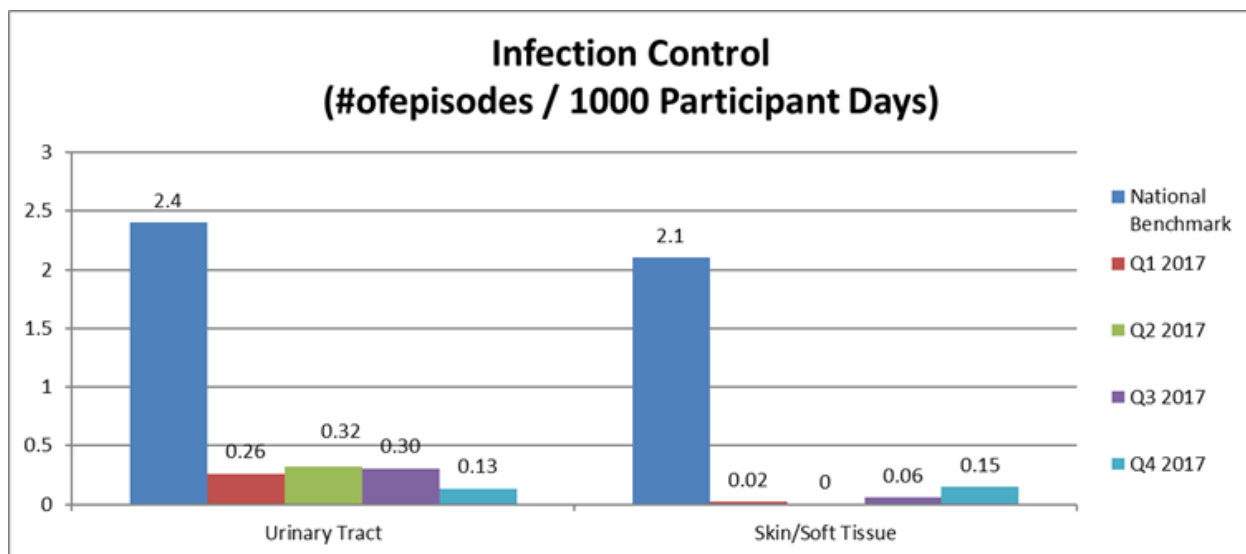
- 1. Barriers
  - a. Inability to get previous medical records when participants reported prior immunization.
  - b. Lack of consistently following immunization procedures for new participants between April – September.
- 2. Interventions
  - a. Implemented new immunization procedure if medical records 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.

**QAPI17.05** 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 2017.

**Data Analysis:** (see charts below)

**Common Infections in PACE Participants by Quarter 2017**



**Summary:** Overall, rates were consistently below benchmarks. We did experience an outbreak of Influenza A in December 2018. 100% of participants had their 2017 influenza vaccination. All participants were treated prophylactically with Tamiflu and all high-risk participants were kept home. IDT ensured that all participants were delivered and completed the Tamiflu course and that all participants kept home had all the needed services coordinated.

**Key Findings/Opportunities for Improvement**

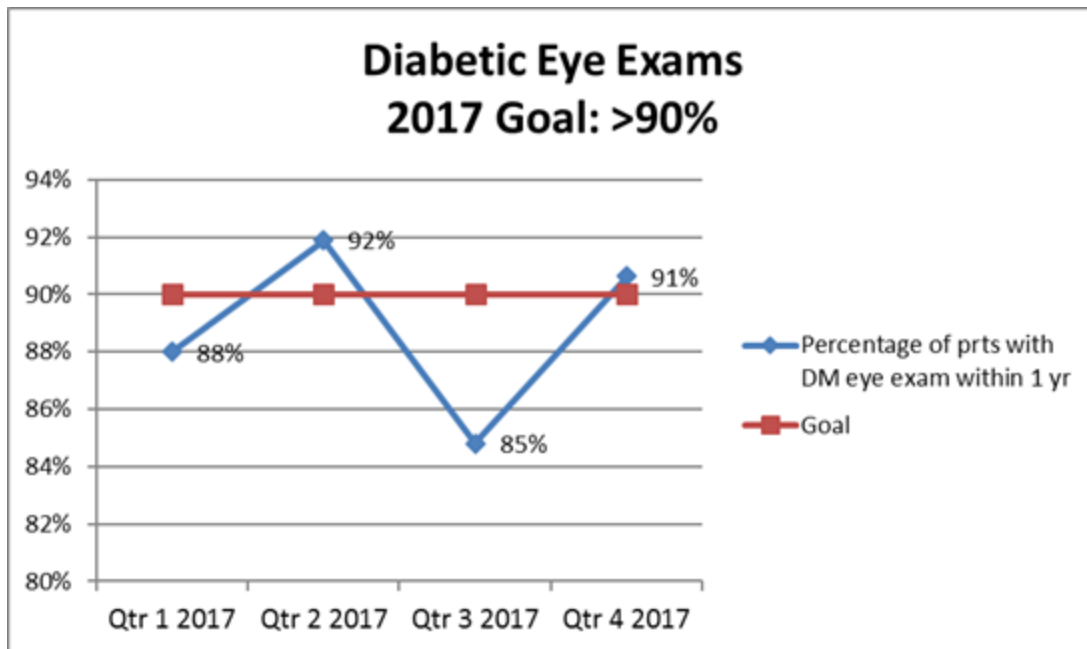
1. Barriers
  - a. Because respiratory infections had been below national averages between 2014-2016, we had removed it from the QAPI elements in 2017.
2. Interventions
  - a. Implemented the new infection identification module built into the EMR.
  - b. Add Respiratory Infections back to QAPI elements in 2018.

**QAPI17.06 Increase the percentage of PACE participants with diabetes who completed their annual diabetic eye exam.**

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

**Data/Analysis**

Quarter 2017	Completion Rate
Q1	88%
Q2	92%
Q3	85%
Q4	91%



Comprehensive Diabetes Care: Annual Diabetic Eye Exam					
		Quality Compass 2016 HEDIS Percentiles			
MY 2017 PACE Rate	MY 2016 OCC	25 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	75 <sup>th</sup> Percentile	90 <sup>th</sup> Percentile
91%	75.93%	61.13	68.95%	77.19%	<b>83.10%</b>

Comprehensive Diabetes Care: Annual Diabetic Eye Exam					
		2018 Star Rating Measure Cut Points			
MY 2017 PACE Rate	MY 2016 OCC	2 Stars	3 Stars	4 Stars	5 Stars
<b>91%</b>	<b>75.93%</b>	<b>47% to 59%</b>	<b>59% to 72 %</b>	<b>72% to 81%</b>	<b>&gt;81%</b>

**Summary:** Significant improvement in this rate year over year. Met target goal of >90%. Greater than 90<sup>th</sup> based on the 2016 Quality Compass 2016 HEDIS Percentiles and is a 5 Star Rating based on 2018 Star Rating Measure Cut Points.

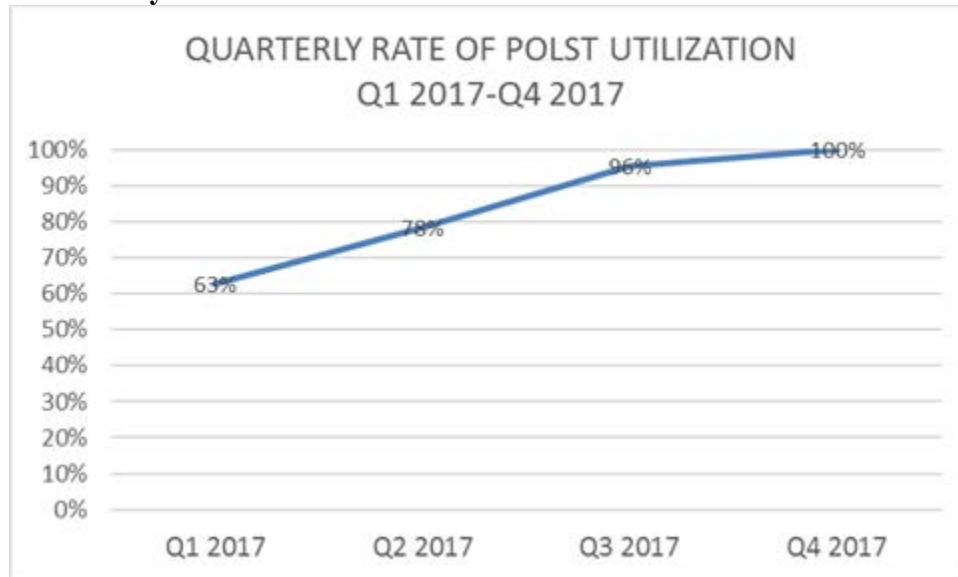
#### Key Findings/Opportunities for Improvement

1. Barriers
  - a. Availability of specialists. The dip in Q3 was found to be related to Ophthalmology appointment availability.
2. Interventions
  - a. Contracted with a new Ophthalmology group.
  - b. Looking to contract with an Optometrist who can come to the PACE center monthly.

**QAPI17.07 Increase the % of participants who have completed a Physician Orders for Life Sustaining Treatment (POLST).**

**Goal:** >75% of members will have a POLST

**Data/Analysis:** 2017 final rate was 100%.



Care for Older Adults: Advance Care Planning					
		Quality Compass 2016 HEDIS Percentiles			
2017 PACE Rate	MY 2016 OCC	25 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	75 <sup>th</sup> Percentile	90 <sup>th</sup> Percentile
100%	41.20%	N/A	N/A	N/A	N/A

**Summary:** At the end of 2017, 100% of PACE participants had a completed POLST on file. This had been one of the programs key initiative to ensure that we understood and delivered the end of life care which is consistent with the participants wishes.

**Key Findings/Opportunities for Improvement**

1. Barriers
  - a. Participant's and their families are reluctant to discuss end of life care.
  - b. Participant's and their families are unfamiliar with the POLST.
2. Interventions
  - a. The POLST is introduced during the initial evaluation and is then addressed at the 6-month and annual evaluations.
  - b. One clinic staff member is assigned the responsibility of tracking the POLST completion status of all participants.
  - c. Providers and Social Work Supervisor are coordinating in-person meetings with participant, and family if necessary, upon enrollment and reassessment.

**QAPI17.08 Increase the percentage of PACE participants who have their medications reviewed.**

**Goal:** 100% of participants will have their medication reviewed within the last 6 months.

**Data/Analysis:** 2017 final rate was 100%.

Medication Review	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Charts with Med Review	196	205	225	236
Census at End of Quarter	196	207	226	236
Rate	100%	99%	100%	100%

Care for Older Adults: Medication Review					
Quality Compass 2016 HEDIS Percentiles					
2017 PACE Rate	MY 2016 OCC	25 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	75 <sup>th</sup> Percentile	90 <sup>th</sup> Percentile
100%	74.54%	N/A	N/A	N/A	N/A

Care for Older Adults: Functional Status Assessment					
2018 Star Rating Measure Cut Points					
2017 PACE Rate	MY 2016 OCC	2 Stars	3 Stars	4 Stars	5 Stars
100%	74.54%	59% to 79%	79% to 88%	88% to 93%	>93%

**Summary:** 100% of our participants have had their medications reviewed within the past 6 months in all but Q2. This is a 5 Star Rating based on 2018 Star Rating Measure Cut Points. Since this is the first year we have had this element, we will continue it in 2018.

**Key Findings/Opportunities for Improvement**

1. Barriers
  - a. No standardized tracking reports existed.
2. Interventions
  - a. Reports developed and analyzed by the QI department quarterly.
  - b. Reports shared with the clinical team to address deficiencies.
  - c. Continue to monitor in 2018.

**QAPI17.09 Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS.**

**Goal:** 100% completion.

**Data/Analysis:** Although, the goal was not reached, we had significant improvement from the beginning 2016 moving from 84% in Q1 to 95% in Q4. This element was a new addition to the 2017 QAPI work plan and tracking this metric revealed opportunities for improvement.

Functional Status Assessment	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Charts with All Assessments	164	195	209	224
Census at End of Quarter	196	207	226	236
Rate	84%	94%	92%	95%

Care for Older Adults: Functional Status Assessment					
		Quality Compass 2016 HEDIS Percentiles			
2017 PACE Rate	MY 2016 OCC	25 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	75 <sup>th</sup> Percentile	90 <sup>th</sup> Percentile
95%	55.32%	N/A	N/A	N/A	N/A

Care for Older Adults: Functional Status Assessment					
		2018 Star Rating Measure Cut Points			
2017 PACE Rate	MY 2016 OCC	2 Stars	3 Stars	4 Stars	5 Stars
95%	55.32%	46% to 67%	67% to 78%	78% to 92%	>92%

**Summary:** Continued improvement was seen quarter over quarter with a final rate of 95%. Although this is a 5 Star Rating based on 2018 Star Rating Measure Cut Points., CMS requires 100% of PACE participants to have the functional assessments completed on time.

**Key Findings/Opportunities for Improvement**

1. Barriers
  - a. Lack of ownership for staff responsible for scheduling assessments.
  - b. Limited reporting functionality in current EMR.
2. Interventions
  - a. QI is providing monthly reports to IDT with assessments due dates based on previous assessment.
  - b. QI is working with EMR project manager to fix broken report. Currently report is scheduled to work with next EMR upgrade in Mid-March 2018.

**QAPI17.10 Increase the percentage of PACE participants who are screened regularly for pain.**

**Goal:** 100% of participants will have a pain assessment completed at least every 6 months.

**Data/Analysis:** Improvement was seen quarter over quarter and 100% of participants had this completed by the end of 2017.

Pain Screening Assessment	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Charts with Pain Screening	178	201	221	236
Census at End of Qrt	196	207	226	236
Rate	91%	97%	98%	100%

Care for Older Adults: Pain Screening					
		Quality Compass 2016 HEDIS Percentiles			
2017 PACE Rate	MY 2016 OCC	25 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	75 <sup>th</sup> Percentile	90 <sup>th</sup> Percentile
100%	78.70%	N/A	N/A	N/A	N/A

Care for Older Adults: Pain Screening					
		2018 Star Rating Measure Cut Points			
2017 PACE Rate	MY 2016 OCC	2 Stars	3 Stars	4 Stars	5 Stars
100%	78.70%	40% to 62%	62% to 80%	80% to 94%	>94%

**Summary:** This element was a new addition to the 2017 QAPI work plan. Tracking this metric revealed an opportunity for improvement and we saw an improvement month over month. By Q4, 100% of our participants were screened for pain. This is a 5 Star Rating based on 2018 Star Rating Measure Cut Points. Since this is the first year we have had this element, we will continue it in 2018.

#### Key Findings/Opportunities for Improvement

1. Barriers
  - a. Limited reporting functionality in current EMR.
  - b. Required manual chart review.
2. Interventions
  - a. QI developed reports for the clinical team based on the participants up for their 6-month or annual evaluation.

#### **QAPI17.11 Reduce potentially harmful drug-disease interactions involving participants with a diagnosis of dementia and taking a tricyclic antidepressant or an anticholinergic agent.**

**Goal:** <38.82% of participants or better than the 90 percentile of the 2015 Quality Compass

#### **Data Analysis:**

DEMENTIA	Q1 2017	Q2 2017	Q3 2017	Q4 2017
#of Drug + Disease Combinations	24	15	27	7
#of Participants with dx	48	63	67	77
Rate	50%	24%	40%	9%

Potential Harmful Drug-Disease Interactions in the Elderly: Dementia + Tricyclic Antidepressants or Anticholinergic Agents (lower is better)					
		Quality Compass 2016 HEDIS Percentiles			
2017 PACE Rate	MY 2016 OCC	25 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	75 <sup>th</sup> Percentile	90 <sup>th</sup> Percentile
9%	40.05%	51.95%	46.51%	41.88%	37.50%

**Summary:** This was the first year that this element was in the plan and we saw significant

improvement from the beginning of the.

### **Key Findings/Opportunities for Improvement**

1. Barriers
  - a. Communication with the Psychiatrist
  - b. No previous visibility.
2. Interventions
  - a. QI is providing quarterly reports to both the Psychiatrist and the PACE PCP's
  - b. Increase in the meetings between the Psychiatrist and the PACE PCP's

### **QAPI17.12 Reduce potentially harmful drug-disease interactions involving participants with a diagnosis of Chronic Renal Failure and taking a Nonaspirin NSADIS or Cox2 Selective NSAIDS**

**Goal:** <3.93% of participants or better than the 90 percentile of the 2015 Quality Compass

**Data Analysis:** PACE had no participants who were on this potential drug-disease combination.

CKD	Q1 2017	Q2 2017	Q3 2017	Q4 2017
# of Drug-Disease Combinations	0	0	0	0
# of Participants with Chronic Kidney Disease	20	22	29	38
Rate	0%	0%	0%	0%

<b>Potential Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure + Nonaspirin NSAIDs or Cox2 Selective NSAIDs Agents (lower is better)</b>					
		Quality Compass 2016 HEDIS Percentiles			
2017 PACE Rate	MY 2016 OCC	25 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	75 <sup>th</sup> Percentile	90 <sup>th</sup> Percentile
0%	25.24%	13.33%	9.21%	6.22%	<b>3.70%</b>

### **Findings/Opportunities for Improvement**

1. Barriers
  - a. No previous visibility.
2. Interventions
  - a. QI is providing quarterly reports to the PACE PCP's
  - b. Will continue to monitor in 2018

Summary: This was the first year this element was in the plan and the final rate was 0%.

### ***Access and Availability***

### **QAPI17.13 Improve access to specialty practitioners**

**Goal:** >80% of specialty care authorizations will be scheduled within 7 business days.

**Data/Analysis:** This goal was met as the overall average rate for scheduling specialty care appointments in 2017 was 83%.



### Key Findings/Opportunities for Improvement

#### 1. Barriers

- a. Some specialty practitioner offices had limited knowledge of the PACE model of care.
- b. Inconsistent process for scheduling appointments confounded by staff shortages.
- c. PACE is reliant on the UC Irvine callback to make appointments with a UCI specialist.
- d. Scheduling a specialty appointment requires coordination with:
  - The specialist office
  - The participants family
  - Transportation
  - Interpreter (if needed)
  - Escort (if needed)

#### 2. Interventions

- a. 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.
- b. We initiated a PACE clinic corrective action plan to address specialty appointment scheduling in January 2017, including:
  - i. Revised 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

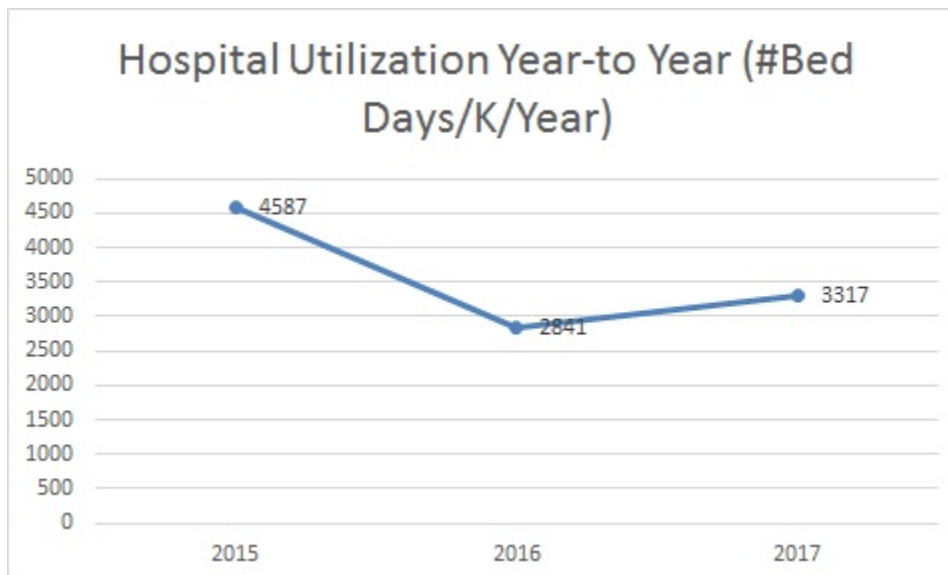
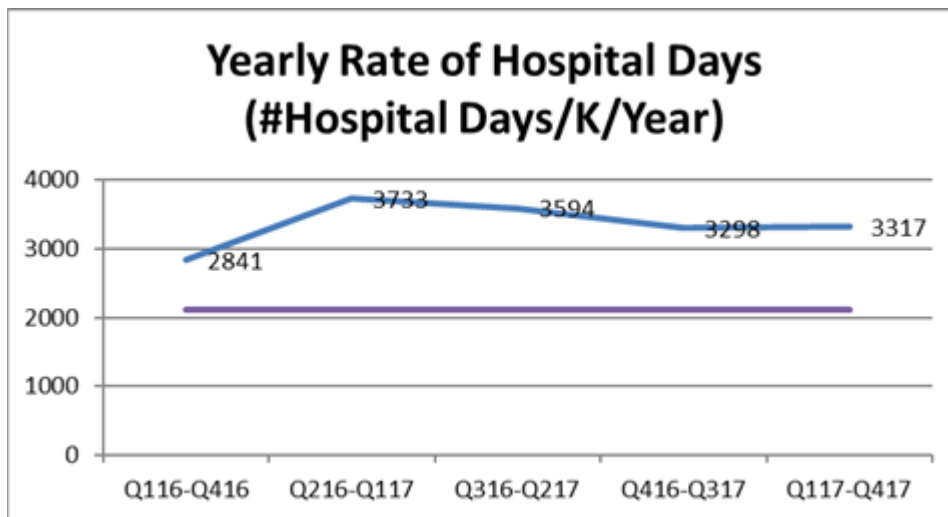
- iii. Implementation of Specialty Care Calendar in new HER.
- c. Identified and have an ongoing dialogue with a few preferred specialists for them to better understand the PACE model of care.
- d. Many the identified specialists will start coming to the PACE center and participate in the IDT meetings on a regular basis

### *Utilization Management*

#### **QAPI17.14 Reduce the rate of acute hospital bed days by PACE participants**

**Goal:** Less than 2,104 hospital bed days per 1000 per year (2015 CalPACE average).

**Data/Analysis:** The 2017 final rate was 3,317 hospital bed days per 1000 per year. This was an increase in the 2016 rate of 2,841 bed days/K/Y and over the 2017 goal.



**Summary:** The CalOptima Concurrent Review Department was fully integrative with the PACE

team this year. As with previous years, a few participants can increase the rate dramatically due to the small overall membership. To meet the utilization goal in 2017, PACE needed to have an average of 1.3 participants in the hospital at any one time. The final rate reflects an average bed day of about 2.3 or 1 additional member in the hospital on average throughout the year. Five participants accounted for almost 30% of the total bed days utilized in 2017. Four of the five participants would have benefited from a formal palliative care program with acute home visit evaluations and/or hospice-like services (for those participants who did not want to disenroll in PACE and enroll in hospice. This would have substantially prevented most of their hospital bed day utilization. The 5<sup>th</sup> participant had end stage heart failure and was on the heart transplant list. Finally, we saw an increase in hospital bed days in Q4, 2017 as compared to Q4 of 2016 due to the influenza outbreak which affected the entire county and PACE.

### **Key Findings/Opportunities for Improvement**

#### **1. Barriers**

- a. Communication and coordination of care with the hospitals and nursing facilities.
- b. Difficulty getting real time utilization management reports.
- c. Case management staffing shortages throughout the year.
- d. Five participants accounted for almost 30% of the bed days in 2017.
- e. Palliative and Hospice-like programs availability.

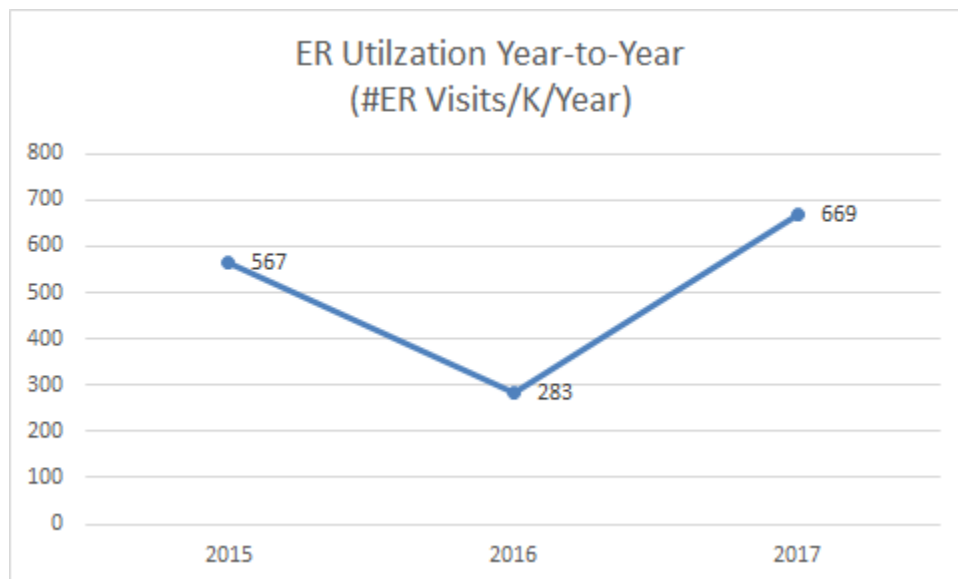
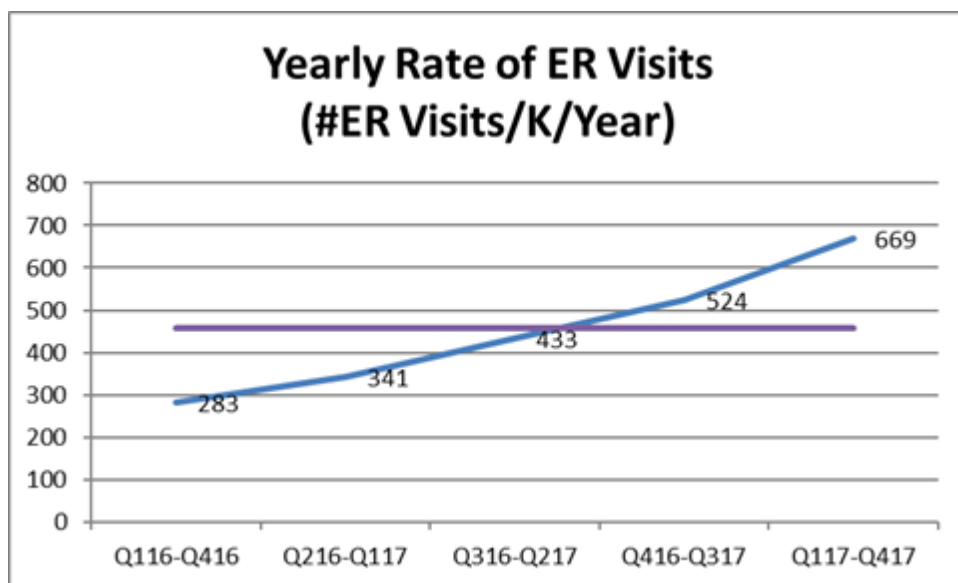
#### **2. Interventions**

- a. Fully implemented the Concurrent Review process with support from the CalOptima concurrent review department.
- b. 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.
- c. Integrated the hospitalist and nursing facility physician into IDT and to the PACE PCP team.
- d. Develop and implement an ER Diversion in 2018. Although called “ER Diversion”, the program will begin with afterhours call and will allow for home visit evaluation as well as skilled nursing facility diversion.
- e. Move after-hours call to the provider group who will be implementing the ER Diversion Program in 2018.
- f. Add one additional PACE RN Case Management/Utilization Management nurse in 2018 which will increase the number of complex cases which can be managed.
- g. Expand Complex Case Management program in 2018.
- h. A Palliative care and hospice-like program will be developed and implemented in 2018. The hospice-like program will provide care for those participants who want to enroll in hospice, but do not want to disenroll in PACE.

### **QAPI17.15 Reduce the rate of ER utilization by PACE participants**

**Goal:** Less than 458 Emergency Room visits per 1000 per year (2015 CalPACE average)

**Data/Analysis:** The 2017 final rate was 669 emergency room only visits per 1000 per year. The graphs below illustrate the trends.



**Summary:** There was a significant increase each quarter of 2017. As stated above, a few participants can increase the rate dramatically due to the small overall membership. The same five participants accounted for almost 20% of the total ER visits utilized in 2017. Four of the five participants would have benefited from a formal palliative care program with acute home visit evaluations and/or hospice-like services (for those participants who did not want to disenroll in PACE and enroll in hospice. This would have substantially prevented most of their ER visits. The 5<sup>th</sup> participant had end stage heart failure and was on the heart transplant list. Although we do expect an increase in the rate over in the winter months, the year over year trends also sees an increased. We did see a substantial increase in both ER visits in Q4 due to the influenza outbreak in the county and at PACE.

## **Key Findings/Opportunities for Improvement**

### **1. Barriers**

- a. After-hours UCI provider call group are not familiar with our participants.
- b. Several members contributed to a significant percentage of the utilization.
- c. Not utilizing the two preferred Urgent Care centers
- d. A formal Palliative Care and Hospice-like program is not fully implemented.
- e. Case management staffing shortages throughout the year.
- f. Five participants accounted for almost 20% of the ER visits in 2017.
- g. Palliative and Hospice-like programs availability.

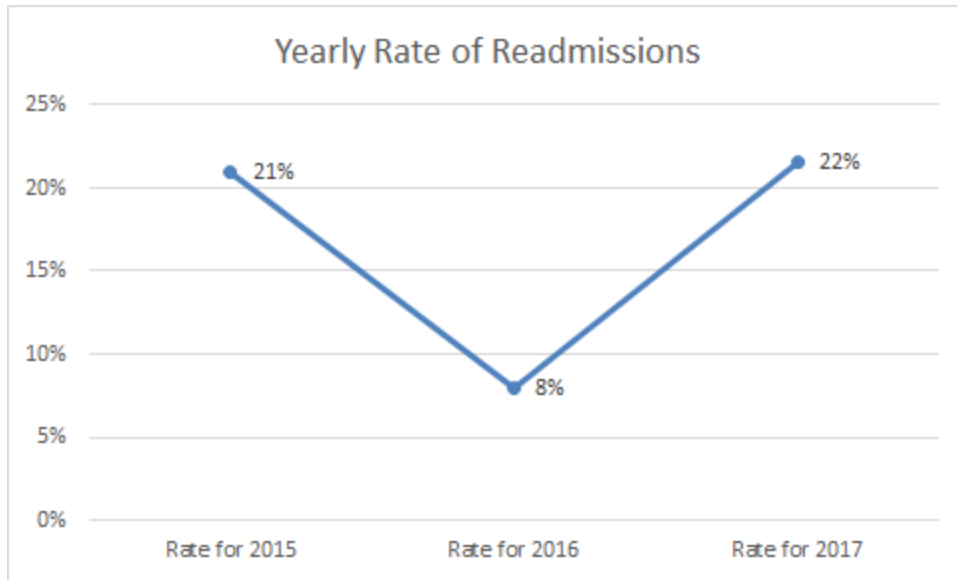
### **2. Interventions**

- a. Retrained staff to utilize the two-identified preferred urgent care center who are open evenings and weekend and can perform X-Rays, Ultrasounds, Splinting and minor procedures.
- b. Integrated the hospitalist and nursing facility physician into IDT and to the PACE PCP team.
- c. Develop and implement an ER Diversion in 2018. Although called “ER Diversion”, the program will begin with afterhours call and will allow for home visit evaluation as well as skilled nursing facility diversion.
- d. Move after-hours call to the provider group who will be implementing the ER Diversion Program in 2018.
- a. Add one additional PACE RN Case Management/Utilization Management nurse in 2018 which will increase the number of complex cases which can be managed.
- e. Expand Complex Case Management program in 2018.
- f. A Palliative care and hospice-like program will be implemented in 2018. The hospice-like program will provide care for those participants who want to enroll in hospice, but do not want to disenroll in PACE.

## **QAPI17.16 Reduce the 30-day all cause readmission rates by PACE participants**

**Goal:** Less than 10% (CalOptima PACE utilization in 2015)

**Data/Analysis:** The 2017 Final Rate was 22%.



**Summary:** The final rate was 22%. The most recent CalPACE average was 12.4% as opposed to the 10% cited in the goal. Regardless, we were higher than either average. Again, a few participants can increase the rate dramatically. The five participants accounted for almost 30% of the readmissions in 2017. Four of the five participants would have benefited from a formal palliative care program with acute home visit evaluations and/or hospice-like services (for those participants who did not want to disenroll in PACE and enroll in hospice. This would have substantially prevented most of the readmissions. The 5<sup>th</sup> participant had end stage heart failure and was on the heart transplant list. Finally, we saw an increase in the readmission seen in Q4 year over year which appears to have been caused by the influenza A outbreak which affected the entire county and the PACE center.

## Key Findings/Opportunities for Improvement

### 2. Barriers

- a. Admission notifications from hospitals.
- b. Case management staffing shortages throughout the year.
- c. Communication and coordination of care with the hospitals and nursing facilities.
- d. Difficulty getting real time utilization management reports.
- e. Five participants accounted for almost 30% of the readmissions in 2017.
- f. Palliative and Hospice-like programs availability.

### 3. Interventions

- a. 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.
- b. Integrated the hospitalist and nursing facility physician into IDT and to the PACE PCP team.

- c. Develop and implement an ER Diversion in 2018. Although called “ER Diversion”, the program will begin with afterhours call and will allow for home visit evaluation as well as skilled nursing facility diversion.
- d. Move after-hours call to the provider group who will be implementing the ER Diversion Program in 2018.
- e. Add one additional PACE RN Case Management/Utilization Management nurse in 2018 which will increase the number of complex cases which can be managed.
- f. A Palliative care and hospice-like program will be developed and implemented in 2018. The hospice-like program will provide care for those participants who want to enroll in hospice, but do not want to disenroll in PACE.

**QAPI17.17 Decrease the percentage of participants who are placed in long-term care facility.**

**Goal:** Less than 4% (2015 CalPACE average).

**Data/Analysis:** We had one participant who was transferring to Long Term Care on 12/25/17.

**Summary:** This was the first year this element was measured in the PACE QAPI work plan and PACE did not have any participants in Long Term Care for most of the year. Part of the success may be attributed to the appropriate utilization of Residential Care Facilities for the Elderly (RCFEs). As of the end of 2017, PACE had 11 participants in RCFE’s. The LTC rate was significantly lower than most PACE programs, but may increase as our program matures. In the most recent CalPACE quality report, CalOptima had the third youngest population with an average age of 73 years old. The CalPACE average was 76 years old.

**Key Findings/Opportunities for Improvement**

1. Barriers
  - a. Finding Board and Care facilities who can care for participants with special needs like dementia.
  - b. Family and/or caregiving burnout
2. Interventions
  - a. Authorizing respite care.
  - b. Establish preferred nursing facilities who could provide skilled and custodial services.
  - c. Integrated the nursing facility physician into IDT and to the PACE PCP team.

***Participant Satisfaction***

**QAPI17.19** Improve the overall satisfaction of participants and their families with the CalOptima PACE program

**Goal:** Greater than or equal to 90% of participants will answer Good, Very Good or Excellent 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 program showed significant improvement in both the overall satisfaction and the individual satisfaction domains.

Improvement was seen in 6 domains versus a decrease in 3 domains. Additionally, the satisfaction rate in 9 of the 10 domains was higher than the CalPACE average and higher than the national averages in 8 of the 10 domains. Finally, the overall satisfaction of 90% was higher than the CalPACE and national PACE averages.

### 2017 Annual Participant Satisfaction Survey

Domain	2015	2016	2017	2017 CalPACE	2017 National Averages
Transportation	92%	98%	98%	93%	95.5%
Center Aids	89%	92%	96%	93%	91.7%
Home Care	88%	92%	93%	87%	87.8%
Medical Care	83%	86%	92%	88%	89.5%
Health Care Specialist	80%	85%	92%	87%	87.4%
Social Worker	92%	96%	95%	94%	95.5%
Meals	58%	71%	63%	71%	73.1%
Rehabilitation Therapy and Exercise	94%	98%	97%	95%	93.2%
Recreational Therapy	85%	82%	86%	84%	82.7%%
Other Indicators	91%	92%	94%	89%	89.4%
Overall Satisfaction	84%	89%	90%	88%	88.4%

*\*Source: 2017 CalPACE Participant Satisfaction Survey conducted by Vital Research*

**Summary:** The medical care domain had a notable increase from 86% to 92% and the Health Care Specialist domain saw an increase from 85% to 92%. The increase in both domains may be attributed to increased PACE provider hours and CalOptima's PACE 2017 focus to improve access to specialty practitioners. Additionally, many of these increases may have been a result of the PACE programs updated communication/messaging plan which was implemented in the middle of 2017.

### Key Findings/Opportunities for Improvement

#### 1. Barriers

- Meals: Meals served at PACE are in accordance to participant's health needs (i.e. cardiac diet, low sodium, diabetic etc.).
- Meals: Cultural preferences in meals vary.
- Specialty Care: Coordination of care between specialists and IDT.
- Home Care, Medical Care, Recreational Therapy, and Social Work: Staffing shortages.

#### 2. Interventions

- Meals: Condiments are offered for participants when requested such as: salt packets, low sodium soy sauce, hot sauce.
- Meals: Meal substitutes are given to participants when requested.
- Specialty Care: PACE-wide specialty initiative.

- d. Home Care, Medical Care, Transportation, Recreational Therapy, and Social Work staffing shortages:
  - i. Contracted with new nursing, home care and physician locum's agencies.
  - ii. Transportation vendor contracted with vendor to support their PACE operations.

### *Transportation*

**QAPI17.20** Improve the response time to transportation incidents reported by staff and participants.

**Goal:** >90% of incidents are resolved within 48 hours

**Data/Analysis:** Overall average rate for 2017 was 88% of incidents were resolved within 48 hours. Although this goal was not met we had significant progress in Quarter 4 totaling 92% of incidents that were resolved within 48 hours.

Transportation Incident Log		Q1 2017	Q2 2017	Q3 2017	Q4 2017
#of Incidents		0	117	97	38
Resolved within 48 hours		0	91	69	35
	Files with Error	0	13	0	0
	Rate of Error	0	11.11	0	0
	Rate of 48-Hour Resolution	0	88%	71%	92%

### **Summary:**

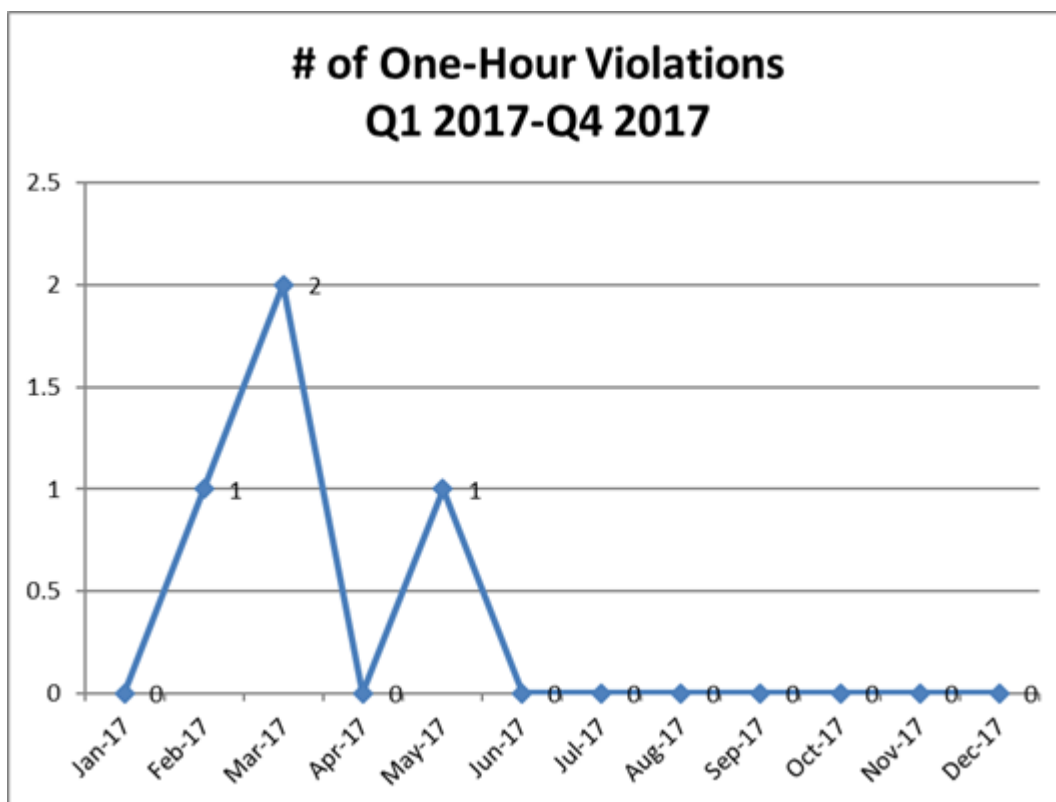
This element was added to address the issues related to transportation which occurred in 2016 with the goal of resolving the situation within 48 hours and improve participant satisfaction with the transportation services. In Quarter 1, there were no incidents reported as staff may have not been documenting the incidences in the log. Quarter 2 to Quarter 4 is more reflective of the transportation incidents reported to staff and the turnaround time to resolve the incidences. Although this goal was not met, the actual number of incidences that were reported drastically reduced from 117 reported incidences in Q2 to 38 reported incidences in Q4. The improvement appears to be reflected in the annual participant satisfaction survey where transportation had the highest score of any domain at 98%.

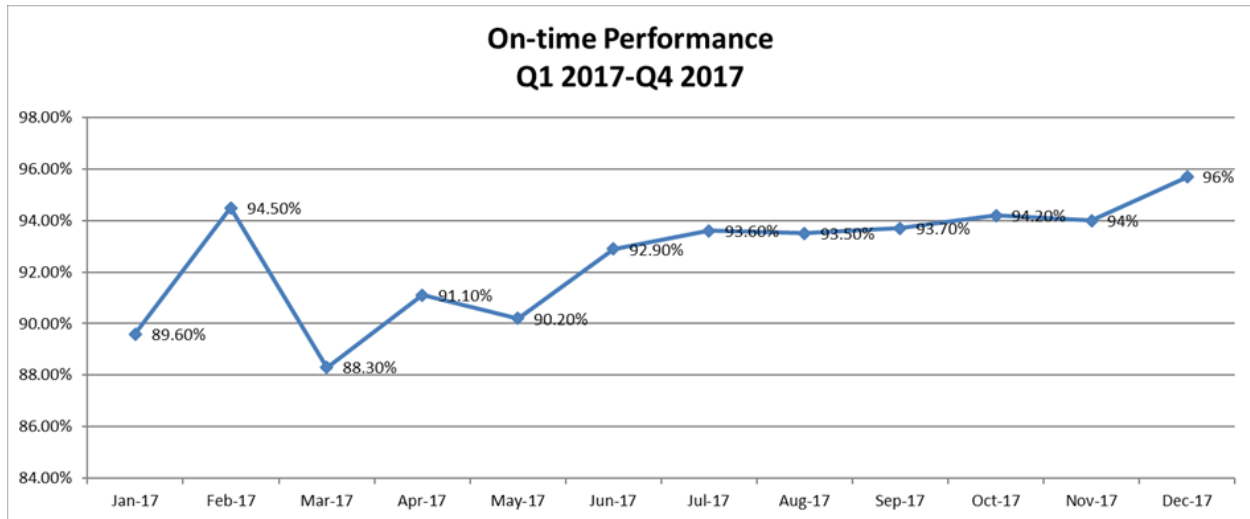
1. Barriers
  - a. Split shifts were implemented in June 2017 which resulted in transportation delays and timeliness issues.
  - b. Difficulty tracking transportation requests outside of EMR.
2. Interventions
  - a. Fleets were re-configured to improve on time performance and participants satisfaction.

- b. Quality Improvement team completed a full review of participant's schedules and identified scheduling errors which were communicated to Secure Transportation for correction.
- c. Quality Improvement developed a workflow to track transportation requests and orders in EMR.
- d. Close transportation monitoring was established in 2016 and continued throughout 2017.

**QAPI17.21 and QAPI17.22:** Ensure PACE transportation ride times are less 60 minutes per trip with a **goal:** 0 trips > 60minutes in duration and improve participant experience by providing timely transportation services with a goal of > 90% on-time performance

**Data/Analysis:** There were a total of 4 one-hour violations that occurred in 2017 all within Quarter 1 and Quarter 2. Although this goal was not met, there has been positive improvements in the 2017 trends for Quarter 3 and Quarter 4. This goal was met as the overall average rate for on-time performance in 2017 was 93%.





### Summary:

In July 2017, CMS released the 2016 transportation CAP. The release of this CAP is reflective of the improvements the transportation vendor has made since the numerous violations discovered in 2016. Although the vendor appears to have resolved their technical reporting abilities, we will continue to closely monitor. The improvement appears to be reflected in the annual participant satisfaction survey where transportation had the highest score of any domain at 98%.

### Key Findings/Opportunities for Improvement

#### 1. Barriers

- c. Implementation of split-shift schedules which resulted in a significant number of participant transportation schedule changes.
- d. Capacity challenges when there is a significant number of additional urgent rides requested.

#### 2. Interventions

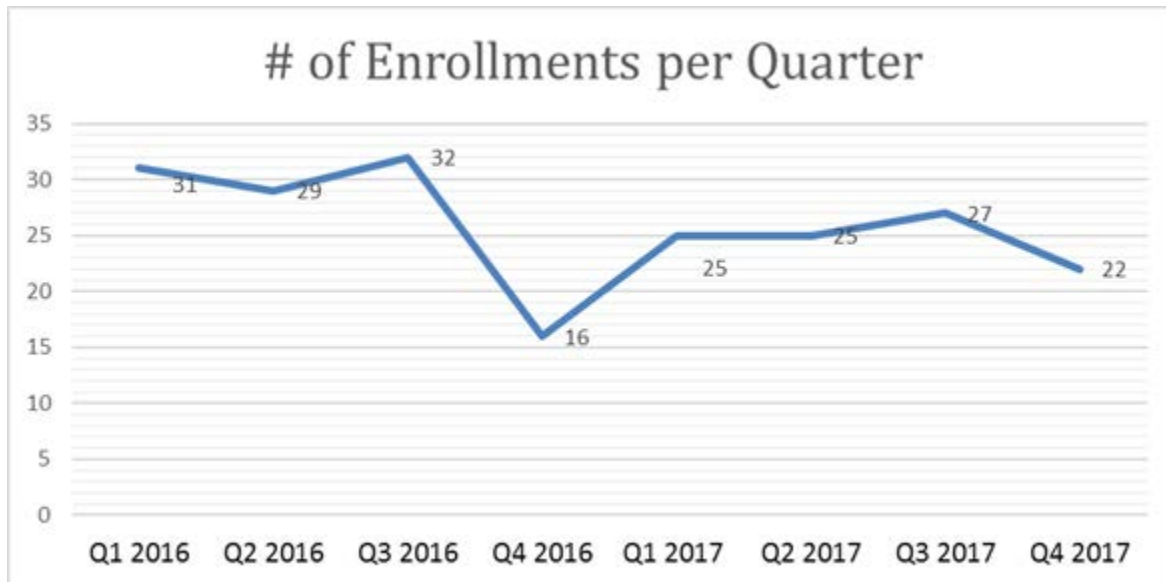
- a. RFI and RFP was completed to find alternative vendors. Ultimately, the same vendor, Secure Transportation, was awarded the contract. However, a second, alternative vendor was contracted with in case Secure ran into issues as the number of participants increased.
- b. Monetary sanctions have been placed on transportation vendors for any future 1-hour violations.
- c. Unannounced monthly ride-along to ensure accuracy of transportation vendor reports continued.
- d. Transportation vendor continued to submit weekly and monthly reports to PACE Director for review, analysis and discussion
- e. Fleets were re-configured to improve on time performance and participants satisfaction.
- f. Workflow to track transportation requests and orders in EMR was implemented.

## **Enrollment & Disenrollment**

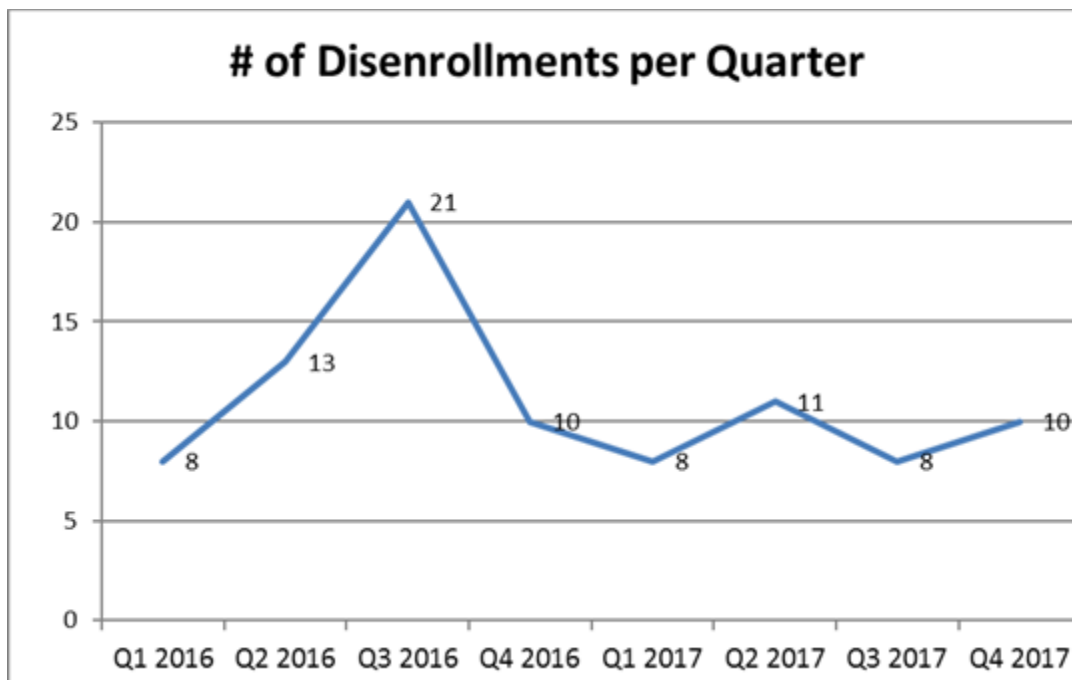
### **Summary:**

1. CalOptima PACE's enrollment has remained close to budgeted goal with a dip in the summer and in December. While enrollment remained fairly the same most of the year, the decrease in disenrollment's led to the growth pattern. The programs emphasis on improving participant satisfaction played a key role in this decrease. As the program continues to grow and mature, the number of involuntary disenrollments will naturally increase and we will need to see growth in the number of enrollments per month while holding the voluntary disenrollments to a minimum. PACE is looking to expand its service area and make PACE available to all Orange County residents by requesting a service area expansion, a community physician waiver and utilizing the Alternative Care Model. This will allow prospective participants to keep their own PCP and allows for more flexibility and choice. The implementation of these three initiatives should lead to an increase in the number of enrollments per month.

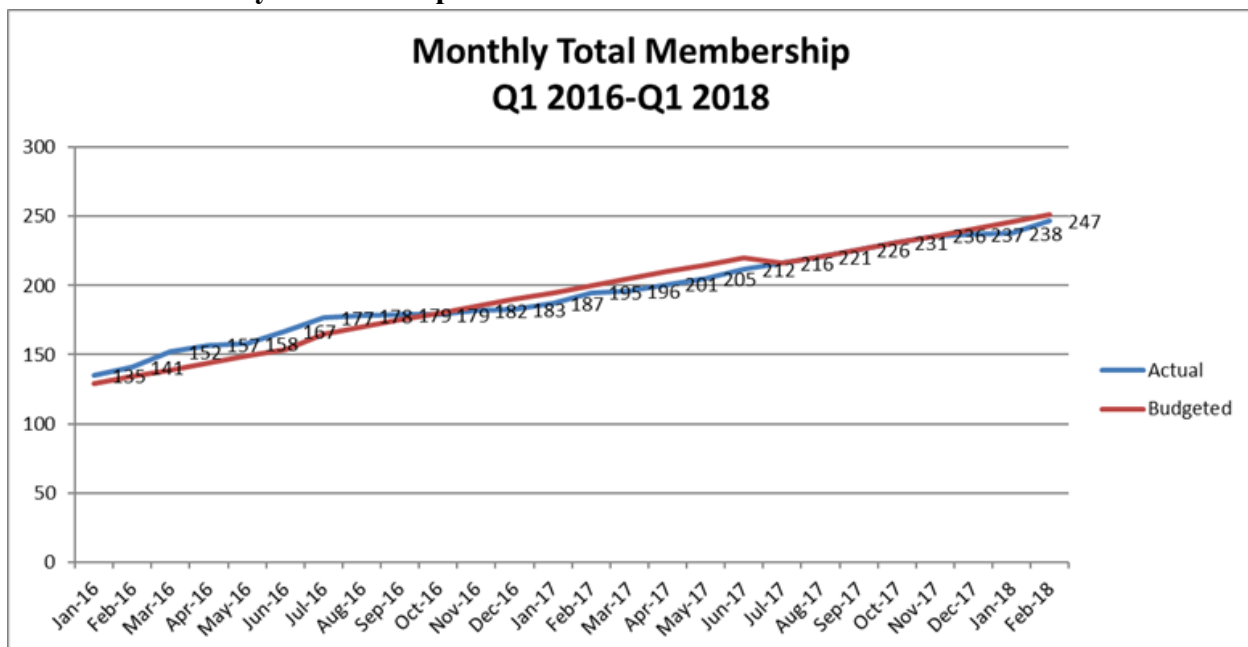
### **2016-2017 Enrollment Trends:**



### **2016-2017 Disenrollment Trends**



#### 2016-2017 Monthly Membership Trends



#### Key Findings/Opportunities for Improvement

##### 1. Barriers

- a. Enrollment Team operated with new staff members including a New Manager of Marketing and Intake and a new enrollment coordinator. Replacing staff on the Enrollment Team is a lengthy process due to the DHCS marketing exam requirement.
- b. Enrollment Team operated without an Outreach Specialist in Quarter 3 and 4.

- c. The number of involuntary disenrollments will continue to increase as the program continue to grow and expand.

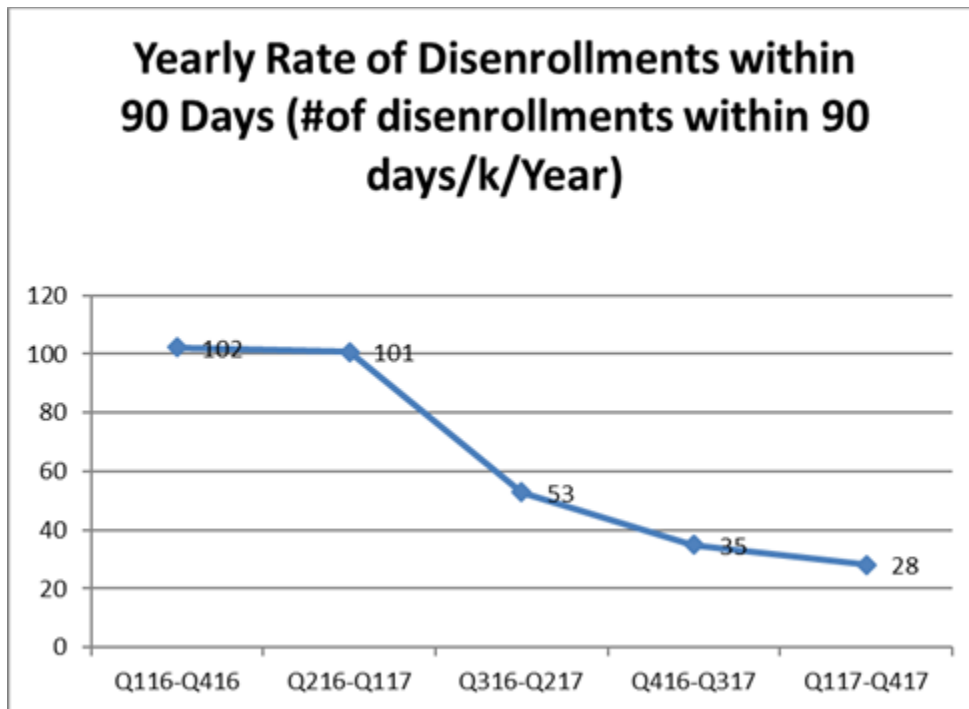
## 2. Interventions

- a. Completed the ACS RFI and RFP for ACS expansion in 2017.
- b. PACE staff participated in the development of an overarching communication/messaging plan which was implemented. The plan included how to explain the PACE model of care to potential and current participants.
- c. The Customer Service Workgroup was implemented to focus efforts to increase participant satisfaction.
- d. All enrollment staff complete the marketing exam, enabling the enrollment process to continue in times of staff transition.
- e. A new process to track referral sources and prospective participant milestones via the new EHR was implemented.
- f. Implement the Alternative Care Setting expansion in 2018.
- g. Submit the Community Physician Waiver in 2018.
- h. Submit a service area expansion request in 2018.
- i. Implement new and improved marketing tools in 2018 to include:
  - i. Business reply cards
  - ii. Scheduled mass mailings
  - iii. Local newspaper advertising
  - iv. Hyperlocal campaigns

### **QAPI17.18 Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment.**

**Goal:** Reduce the annualized rate below 50/K/year (20 % reduction from 2016)

**Data/Analysis:** This goal was met as there were only 7 controllable disenrollment's within the first 90 days in 2017. The final rate was 28 controllable disenrollment's per thousand per year compared with 102 in 2016.



**Summary:** Of the total 7 disenrollments within 90 days in 2017, one was due to leaving the service area for more than 30 consecutive days. The remaining 6 disenrollments were due to dissatisfaction with the PACE program, wanting to return to their previous PCP and/or wanting to access services out of PACE's network.

### **Key Findings/Opportunities for Improvement**

1. Barriers:
  - a. Participants not fully understanding the PACE model of care which led to dissatisfaction when they were unable to continue to see their PCP or their specialist at the same visit frequency.
  - b. Enrollment team not communicating the same information as it related to which previously authorized specialty visits they would be authorized.
2. Interventions:
  - a. The entire PACE staff participated in the development of an overarching communication/messaging plan which was implemented. The plan included how to explain the PACE model of care to potential and current participants.
  - b. A clinic team member is now a part of the initial enrollment conference to ensure that potential participants understand which of the specialty appointments which had been authorized prior to joining PACE would be honored.
  - c. CalOptima's Process Excellence Team help review, revise and implement a new specialty appointment workflow.
3. The Customer Service Workgroup was implemented to focus efforts to increase participant satisfaction.

## 2017 HEALTH PLAN MANAGEMENT SYSTEM (HPMS)

### – NOT COVERED IN THE QAPI WORK PLAN

**2017 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):

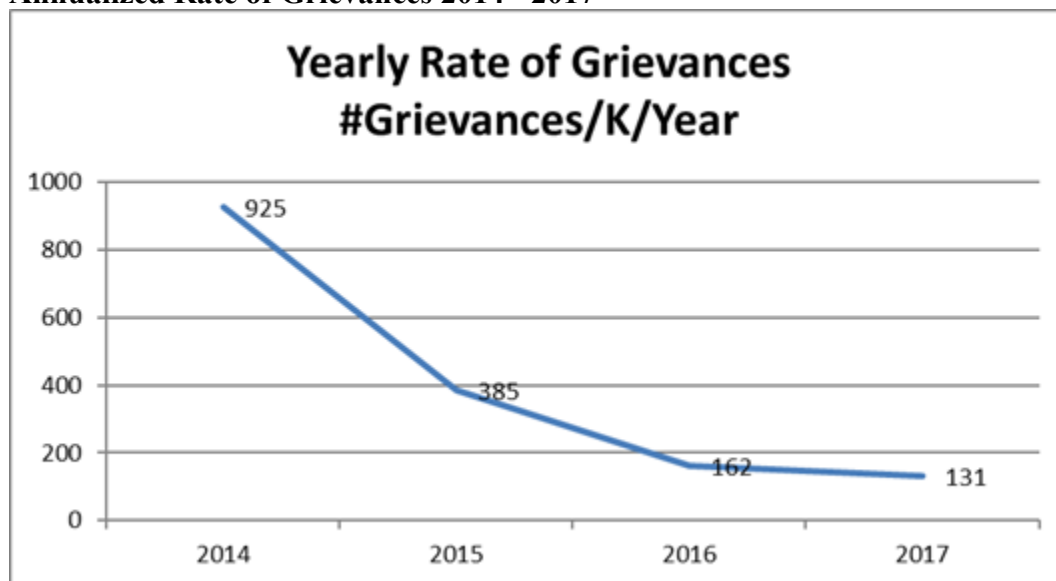
1. Grievances
2. Appeals
3. Level II events, formerly known as sentinel events, are reported as they occur.
4. Burns
5. Medication Errors
6. Immunizations (evaluated in the Quality of Care section of this report)
7. Enrollment/Disenrollment (evaluated previously in this report)
8. Falls without Injury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

### Grievances

**Summary:** Overall grievance rates continued to improve in 2017 which was supported by the significant improvement in the Annual Participant Satisfaction survey. Most of the grievances were related to transportation (timeliness and participant-driver interaction) and clinical services (dissatisfaction with services, timeliness and scheduling). A detailed breakdown is below.

	CENTER							CLINIC			
	# Grievances	Other	Food	Home Care	Transportation			Clinical Care/ Service/ Treatment		Comm- unication about care	Scheduling/ Communication
					Timeliness	Prt-Driver	Escort	Dissatisfaction	Timeliness		
Q4 2014	2	0									
Q1 2015	0	0									
Q2 2015	7	0	1	1	1	0	0	1	1	1	1
Q3 2015	17	0	0	0	4	1	2	3	4	1	1
Q4 2015	13	0	0	0	1	1	1	8	1	0	1
Q1 2016	1	0	0	0	0	0	0	0	0	0	1
Q2 2016	7	0	0	0	4	0	0	2	0	0	1
Q3 2016	6	0	0	0	2	1	0	1	0	0	2
Q4 2016	4	0	0	0	0	2	0	0	2	0	0
Q1 2017	9	0	0	1	0	0	0	3	1	1	3
Q2 2017	2	0	0	0	2	0	0	0	0	0	0
Q3 2017	10	0	0	0	7	0	0	2	1	0	0
Q4 2017	6	1	0	0	2	1	0	1	0	0	1

## Annualized Rate of Grievances 2014 - 2017



### Appeals

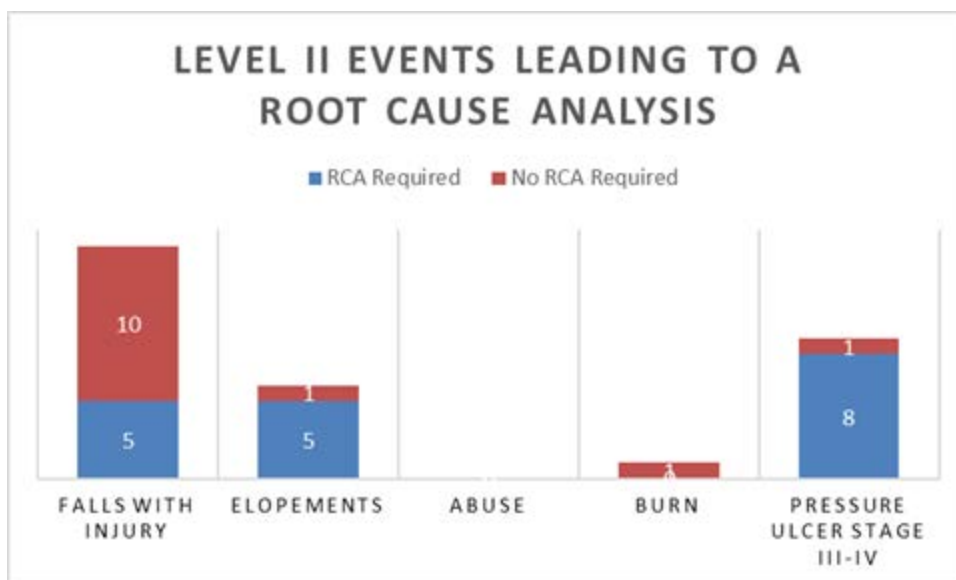
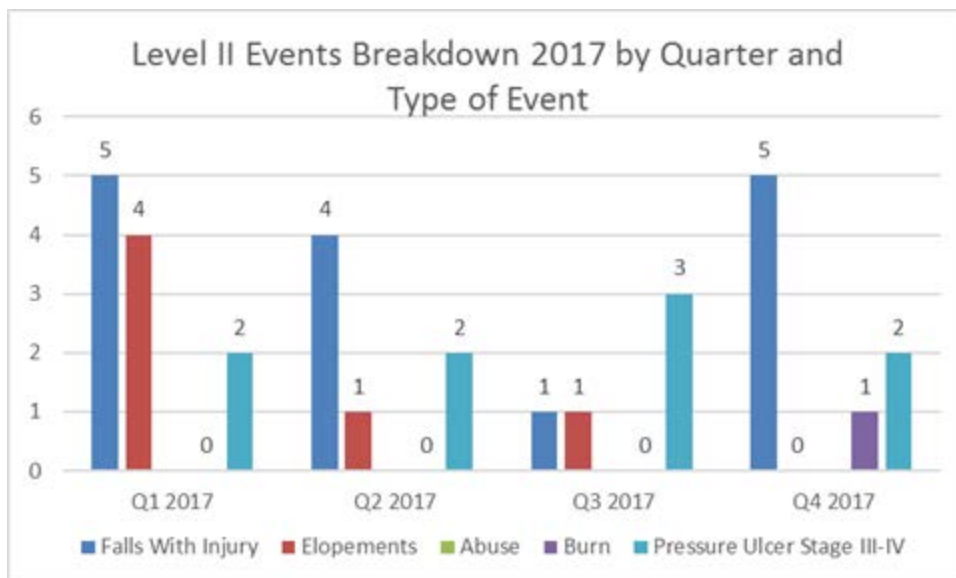
Appeals by participants continue to be minimal in 2017. A total of 9 appeals were submitted, the majority concerning requests for increased center day attendance. Explanations for this could be contributed to effective/over-utilization and/or effective communication from interdisciplinary team members 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.

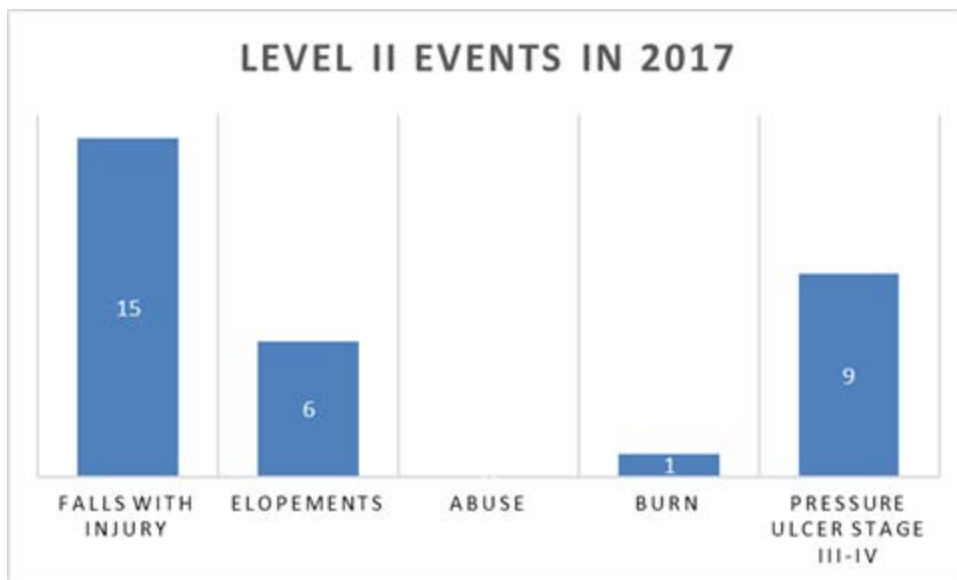
### Level II Events

**Summary:** In 2017, CalOptima PACE reported 31 level II events, an increase from 21 in 2016. Most frequently reported were (1) Fall with fracture or requiring hospitalization and (2) Pressure Ulcer Stage III-IV. Because of the Root Cause Analysis done on some of these events, the following process changes were implemented:

1. A 'Falls Anonymous' group for participants that have been identified as high fall risk was developed and implemented. In this group, participants are encouraged to share barriers and experiences with past falls and practice/demonstrate fall recovery.
2. A falls workgroup committee consisting of PACE MD, PACE Pharmacist, PACE Clinic Manager and QI Specialist was developed and meet ongoing to address participants with high falls.
3. A wound care committee was developed and implemented to identify high risk participants and provide early interventions to prevent pressure ulcers.

The charts below provide additional trends in 2017 Level II reporting.





### **Burns**

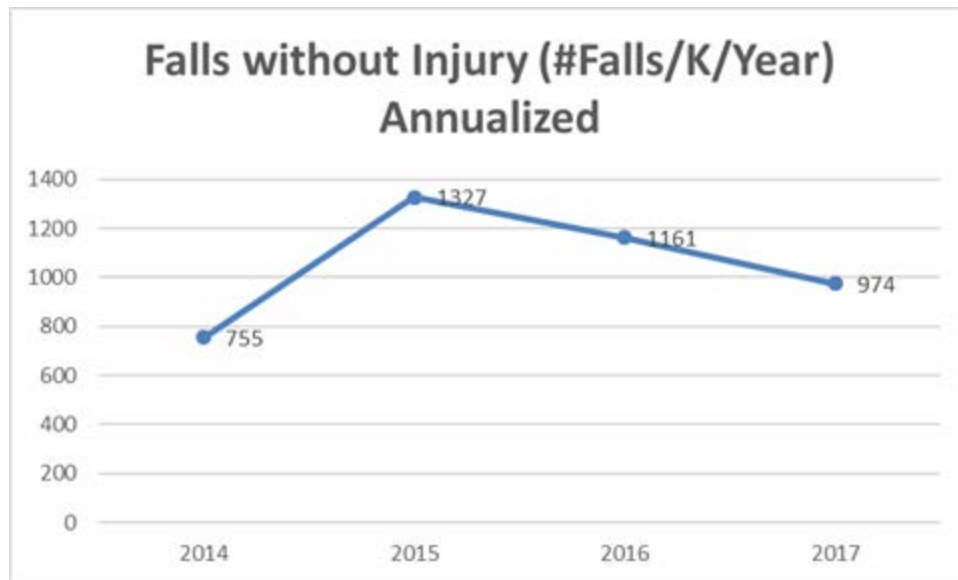
A total of 1 burn (first degree or less) was reported in 2017. This burn occurred in the home environment. It is expected that this element is under-reported, as participants may not consider burns of first degree or less reportable to their primary care provider or day health center staff.

### **Medication Errors**

A total of 2 medication errors were reported in 2017 which has decreased from 8 medication errors reported in 2016. Both errors were attributed to pharmacy error and/or specialist error. A CAP was provided from the contracted pharmacy and the prescribing specialist was educated. In each incident, there was no participant harm because of the medication error.

### **Falls Without Injury**

**Summary:** Calculated as a rate utilizing member months. There have been some progressive improvements from the number of reported falls without injury from 2015 onwards. Most falls are continuing to occur in the community, specifically in the participant's home environment. CalOptima PACE has spearheaded two groups discussed below with the goal to continue the decrease in the numbers of falls in 2018. The 'Falls Anonymous' group has started for participants that have been identified as high fall risk. In this group, participants are encouraged to share barriers and experiences with past falls and practice/demonstrate fall recovery. In addition, a falls workgroup committee consisting of PACE MD, PACE Pharmacist, PACE Clinic Manager and QI Specialist has been established to address participants with high falls.



## **VI. OPPORTUNITIES FOR IMPROVEMENT IN 2017**

### **1. Utilization Management**

#### **a. Inpatient Utilization**

- i. The hospitalist and nursing facility physician will be fully integrated within IDT and to the PACE PCP team.
- ii. Develop and implement an ER Diversion in 2018.
- iii. Move after-hours call to the provider group who will be implementing the ER Diversion Program in 2018.
- iv. A Palliative care and hospice-like program will be developed and implemented in 2018. The hospice-like program will provide care for those participants who want to enroll in hospice, but do not want to disenroll in PACE.
- v. The complex case management program will be expanded with the addition of the new PACE RN Case Management/Utilization Management nurse.
- vi. The new PACE RN Case Management/Utilization Management nurse will be trained on how to use Milliman Care Guidelines (MCG) to review high cost specialist procedures.

#### **b. ER Utilization**

- i. Develop and implement an ER Diversion in 2018.
- ii. Move after-hours call to the provider group who will be implementing the ER Diversion Program in 2018.
- iii. The complex case management program will be expanded with the addition

- of the new PACE RN Case Management/Utilization Management nurse.
    - iv. A Palliative care and hospice-like program will be developed and implemented in 2018. The hospice-like program will provide care for those participants who want to enroll in hospice, but do not want to disenroll in PACE.
    - v.
  - c. 30-Day All-Cause Readmissions.
    - i. The hospitalist and nursing facility physician will be fully integrated within IDT and to the PACE PCP team.
    - ii. A Palliative care and hospice-like program will be developed and implemented in 2018. The hospice-like program will provide care for those participants who want to enroll in hospice, but do not want to disenroll in PACE.
    - iii. The complex case management program will be expanded with the addition of the new PACE RN Case Management/Utilization Management nurse.
  - 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. Preferred specialists will be identified and trained in the PACE Model of Care. They will attend some IDT meetings and if possible, will see participants at the PACE center
    - ii. The new PACE RN Case Management/Utilization Management nurse will be trained on how to use Milliman Care Guidelines (MCG) to review high cost specialist procedures.
    - iii. PACE will leverage CalOptima's Provider Relations department to ensure that the specialist network meets the needs of PACE.
  - f. Pharmacy
    - i. Increase the % of specialty medications which are reviewed in real time.
    - ii. Retrospective quarter reviews of medication utilization will be analyzed and shared with IDT and the PACE PCP's.
  - g. Update the Operational/Utilization dashboard to reflect the oversight needed as PACE expands beyond the Garden Grove center.
2. Participant Satisfaction
- a. Continue to reinforce the mission, vision and values of the CalOptima PACE program as revised in 2017.
    - i. Improve communication between the Participants and staff to ensure appropriate levels of Participant expectations.
    - ii. Improve the community's understanding of the PACE program.
    - iii. Improve our health delivery partners understanding of PACE.
  - b. Participants will be updated on the Satisfaction Survey process.

- c. 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.
  - d. A Customer Service workgroup will continue 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. Continue to focus on improving communication and participant satisfaction to decrease voluntary disenrollments.
  - b. Review and refine the current marketing strategy to support the implementation of Alternative Care Setting expansion model.
  - c. 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.
- 4. Quality of Care (QOC) Metrics
  - a. New QOC HEDIS metrics will be added to the 2018 QI work plan.
  - b. These metrics will allow the program to compare the care being delivered against other like populations.
- 5. Delegation Oversight
  - a. 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.
  - b. The operational/utilization monthly report will be updated to reflect the oversight required as we implement the Alternative Care Settings expansion.
  - c. The grievances and potential quality issues involving downstream vendors will be track and trended to assure no service or clinical trend is emerges.

Proposed 2017 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan														
QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion	Q1 Results	Q2 Results	Q3 Results	Q4 Results	EOY Total	MET/NOT MET
QAPI17.01	Quality of Care	2016 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, 2017	Pending	Completed	Completed	Completed	N/A	Met
QAPI17.02	Quality of Care	2017 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, 2017	Completed	Completed	Completed	Completed	N/A	Met
QAPI17.03	Quality of Care	Influenza Immunization Rates	Increase Influenza immunization rates for all eligible PACE participants	Improve compliance with influenza immunization recommendations	> 90% of members will have influenza vaccination	Clinical Operations Manager	Quarterly	12/31/2017	96%	N/A	N/A	100%	100%	Met
QAPI17.04	Quality of Care	Pneumococcal Immunization Rates	Increase Pneumococcal immunization rates for all eligible PACE participants	Improve compliance with pneumococcal immunization recommendations	> 90% of members will have pneumococcal vaccination	Clinical Operations Manager	Quarterly	12/31/2017	93%	90%	94%	100%	100%	Met
QAPI17.05	Quality of Care	Infection Control	Reduce common infections in PACE participants (Urinary and Skin)	Monitor and analyze the incidence of Urinary and Skin infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement	Maintain common infection rates less than the following national benchmarks: Urinary Tract 0.46-4.4 episodes/1000 participant days; Skin and Soft Tissue 0.1-2.1 episodes/1000 participant days	Clinical Operations Manager	Quarterly	12/31/2017	Urinary Tract 0.26; Skin/Soft Tissue 0.02	Urinary Tract 0.32; Skin/Soft Tissue 0.00	Urinary Tract 0.30; Skin/Soft Tissue 0.06	Urinary Tract 0.13; Skin/Soft Tissue 0.15	Urinary Tract 0.26; Skin/Soft Tissue 0.06	Met
QAPI17.06	Quality of Care	Diabetes: Annual 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 QI 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	12/31/2017	88%	92%	85%	91%	91%	Met
QAPI17.07	Quality of Care	Care for Older Adults: Advance Directive Planning	Increase POLST utilization for PACE participants	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST	>75% of members will have a POLST	PACE Center Manager	Quarterly	12/31/2017	63%	78%	96%	100%	100%	Met
QAPI17.08	Quality of Care	Care for Older Adults: Medication Review	Increase the percentage of PACE participants who have their medications reviewed	Ensure all PACE participants have a medication review	100%	PACE Center Manager	Quarterly	12/31/2017	100%	99%	100%	100%	100%	Met
QAPI17.09	Quality of Care	Care for Older Adults: Functional Status Assessment	Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	Ensure all PACE participants have a functional status assessment completed every 6 months	100%	PACE Center Manager	Quarterly	12/31/2017	84%	94%	92%	95%	95%	Met
QAPI17.10	Quality of Care	Care for Older Adults: Pain Screening	Increase the percentage of PACE participants who are screened regularly for pain	Ensure all PACE participants have a pain screening	100%	PACE Center Manager	Quarterly	12/31/2017	91%	97%	98%	100%	100%	Met
QAPI17.11	Quality of Care	Potentially Harmful Drug/Disease Interactions in the Elderly (DAE): Dementia + tricyclic antidepressant or anticholinergic agents	Reduce potentially harmful drug-disease interactions	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	>38.82% (2016 MEDICARE HEDIS 90th Percentile Rate)	PACE Pharmacist	Quarterly	12/31/2017	50%	24%	40%	9%	9%	Met
QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion	Q1 Results	Q2 Results	Q3 Results	Q4 Results	EOY Total	MET/NOT MET
QAPI17.12	Quality of Care	Potentially Harmful Drug/Disease Interactions in the Elderly (DAE): Chronic Renal Failure + Nonaspirin NSAIDs or Cox2 Selective NSAIDs	Reduce potentially harmful drug- disease interactions	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	>3.93% (2016 MEDICARE HEDIS 90th Percentile Rate)	PACE Pharmacist	Quarterly	12/31/2017	0%	0%	0%	0%	0%	MET
QAPI17.13	Access and Availability	Specialty Care	Improve access to specialty practitioners	Appointments for specialty care will be scheduled within 7 business days to improve access to specialty care for initial consultations	> 80% of specialty care authorizations will be scheduled within 7 business days	PACE Clinical Operations Manager	Quarterly	12/31/2017	62%	93%	92%	86%	84%	MET
QAPI17.14	Utilization Management	Acute Hospital Day Utilization	Reduce the rate of acute hospital days by PACE participants	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	< 2,104 hospital days per 1000 per year (CalPACE avg in 2015)	PACE Medical Director	Quarterly	12/31/2017	3733 days/K/Year	3594 days/K/Year	3298 days/K/Year	3317 days/k/year	3317 days/k/year	NOT MET
QAPI17.15	Utilization Management	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 QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative	< 458 emergency room visits per 1000 per year (CalPACE avg in 2015)	PACE Medical Director	Quarterly	12/31/2017	341 Visits/K/Y	433 Visits/K/Y	524 Visits/K/Y	669 Visits/k/year	669 Visits/k/year	NOT MET
QAPI17.16	Utilization Management	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 QI department who will work with the PACE interdisciplinary and clinical teams to find opportunities for quality improvement	<10% 30-day all cause readmission (CalOptima PACE avg in 2015)	PACE Medical Director	Quarterly	12/31/2017	38%	17%	16%	10%	22%	NOT MET
QAPI17.18	Utilization Management	Long Term Care Placement	Decrease the percentage of participants who are placed in a long term care facility	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	<4% of members (CalPACE Average Utilization in 2015) will reside in long term care	PACE Center Manager	Quarterly	12/31/2017	0	0	0	0.4%	0.4%	MET

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion	Q1 Results	Q2 Results	Q3 Results	Q4 Results	EOY Total	MET/NOT MET
QAPI17.17	Participant Satisfaction	Disenrollments	Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment.	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Reduce the annualized rate below 50/k/year (20% reduction from 2016)	PACE Center Manager	Quarterly	12/31/2017	101/k/year	53/k/year	35/k/y	28/k/y	28/k/y	MET
QAPI17.18	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 Good, Very Good or Excellent on this question	PACE Director	Annually	12/31/2017	N/A	N/A	N/A	90%	90%	MET
QAPI17.19	Participant Satisfaction	Transportation	Improve response time to transportation incidents reported by staff and participants	Monitor and analyze incidents reported in the Transportation Incident Log to identify opportunities for improvement to resolve issues within 48 hours of report	>90% of incidents are resolved within 48 hours	PACE Center Manager	Quarterly	12/31/2017	100%	88%	71%	92%	88%	NOT MET
QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion	Q1 Results	Q2 Results	Q3 Results	Q4 Results	EOY Total	MET/NOT MET
QAPI17.20	Delegation Oversight	Transportation	Improve PACE transportation ride times to less than 60 minutes per trip	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	0 trips > 60 minutes in duration	PACE Director	Quarterly	12/31/2017	3 Rides Over 60 Minutes	4 rides over 60 minutes	0	0	4	NOT MET
QAPI17.21	Delegation Oversight	Transportation	Improve participant experience by providing timely transportation services	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports by sampling GPS records and monthly ride-along	>90% on-time performance	PACE Director	Quarterly	12/31/2017	88.30%	91.40%	93.60%	95.00%	93%	MET

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken February 20, 2018** **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

#### **Report Item**

7. Consider Recommending Board of Directors' Approval of the 2018 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan

#### **Contact**

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

#### **Recommended Action**

Recommend Board of Directors' approval of the 2018 CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan.

#### **Background**

The Board of Directors first authorized the Chief Executive Officer to submit CalOptima's application to become a PACE Provider on October 7, 2010. The CalOptima PACE program opened its doors for operation in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents and continues to grow. As of December 31st, 2017, CalOptima PACE had 236 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes.

#### **Discussion**

PACE organizations are required to have a written Quality Assessment and Performance Improvement (QAPI) Plan that is reviewed and approved annually by the PACE governing body and, if necessary, revised. The QAPI Plan reflects the full range of services furnished by CalOpima PACE. The goal of the 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.

The 2018 CalOptima PACE QAPI Plan is based on CalOptima's first four full years of data collection, review and analysis with specific data driven goals and objectives. The work plan elements were developed based on the opportunities for quality improvement that were revealed in the 2017 CalOptima PACE QAPI Plan Evaluation. For the 2018 QAPI work plan, five new elements were added, and one element removed. The added elements are HEDIS and/or STAR measures whose focus are on diabetes care, potentially harmful drug-disease interactions in the elderly and transitions of care. These elements allow the quality of care being delivered at PACE to be compared against

other state and national programs. The one element removed was not found to be useful in ongoing oversight and management of the PACE program. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

**Fiscal Impact**

The recommended action to approve the 2018 CalOptima PACE QAPI Plan does not have a fiscal impact.

**Rationale for Recommendation**

PACE organizations are required to establish a Quality Assessment and Performance Improvement (QAPI) program. Through 42 CFR §460.132(b), the Centers for Medicare & Medicaid Services (CMS) requires PACE Organizations to have their QAPI plan reviewed annually by the PACE governing body and, if necessary, revised. As per 42 CFR §460.132(a) and (b), the PACE organization leadership presents their QAPI plan and any revisions to their governing body for annual approval to assure effective organizational oversight. CMS and the State will review the plan during subsequent monitoring visits.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Proposed 2018 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Plan and QAPI Work Plan
2. PowerPoint Presentation – 2018 PACE QAPI Description and Work Plan

/s/ Michael Schrader  
**Authorized Signature**

2/12/2018  
**Date**

**CALOPTIMA PACE**

**QUALITY ASSESSMENT**

**PERFORMANCE IMPROVEMENT PLAN**

**2018**

*Quality Improvement Subcommittee Chairperson:*

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

\_\_\_\_\_  
**Date**

*Board of Directors' Quality Assurance Committee Chairperson:*

\_\_\_\_\_  
**Paul Yost, M.D.**

\_\_\_\_\_  
**Date**

*Board of Directors Chairperson:*

\_\_\_\_\_  
**Paul Yost, M.D.**

\_\_\_\_\_  
**Date**

## **Introduction**

The Quality Assessment Performance Improvement Plan (QAPI) at CalOptima's Program of All Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous quality improvement for all the PACE organizations' services. It is designed and organized to support the mission, values, and goals of CalOptima PACE.

## **Overview**

- 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.
- The CalOptima PACE QAPI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima's governing body, the Board of Directors has the final authority to review, approve and, if necessary, revise the QAPI Plan annually. (See Appendix A) It is comprised of both the Program Description and specific goals and objectives described in the Work Plan. (See Appendix B)
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QAPI Plan. The PACE QI Coordinator will ensure timely collection and completeness of data.
- CalOptima PACE QAPI Committee will complete an annual evaluation of the approved QAPI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QAPI Plan goals and objectives for the following year.

## **Goals**

- To provide quality health care services for all CalOptima PACE participants through comprehensive service delivery leading to improved clinical outcomes
- To coordinate all QAPI activities into a well-integrated system that oversees quality of care services
- To achieve a coordinated ongoing and effective QAPI Program that involves all providers of care
- To ensure that all levels of care are consistent with professionally recognized standards of practice
- To assure compliance with regulatory requirements of all responsible agencies.
- To promote continuing education and training of staff, practitioners, administration and the executive board
- To analyze data and studies for outcome patterns and trends
- To annually assess the effectiveness of the QAPI Plan and enhance the program by finding opportunities to improve the CalOptima PACE QAPI Plan

## Objectives

- Improve the quality of health care for participants
  - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima PACE Staff will be measured against those outlined by their respective licensing agency in the State of California (i.e. The State Board of Nursing of California).
  - Implement population health management techniques for specific participant populations, such as immunizations.
  - Identify and address areas for improvement that arise from unusual incidents, sentinel events, and annual death review.
  - Meet or exceeds minimum levels of performance on standardized quality measures as established by CMS and the SAA which includes achieving an immunization rate for both influenza and pneumococcal vaccinations of 80% for the participant population that is appropriate.
- Improve on the patient experience
  - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
  - Provide education to staff on the multiple dimensions of patient experience.
  - Identify and implement ways to better engage participants in the PACE experience, i.e., menu selection, PACE Member Advisory Committee (PMAC).
- Ensure appropriate use of resources
  - Review and analyze utilization data regularly including hospital admissions, hospital readmissions, ER visits, and hospital 30-day all-cause readmission.
- Provide oversight of contracted services
  - Meet or exceed community standards for credentialing of licensed providers and perform due diligence in assuring that contracted facilities meet community and regulatory standards for licensure.
  - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
  - Review documentation and coordination of care for participants receiving care in institutional settings and perform site visits on an ongoing-basis.
  - Monitor staff and contractors to ensure that appropriate standards of care are met.
- Communication of Quality and Process Improvement Activities and Outcomes
  - Communicate all QAPI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee, and the Board of Directors.
  - Results of QAPI-identified benchmarks are shared with staff and contracted providers at least annually.

- Reduce potential risks to safety and health of PACE participants through ongoing Risk Management
  - Every member of the PACE staff organization has responsibility for risk assessment and management.
  - Monitor, analyze and report the aggregated data elements required by CMS via the Health Plan Management System in order to identify areas needing of quality improvement.
  - Monitor, report and perform a Root Cause Analysis on all participant-involved events, resulting in a significant adverse outcome for the purpose of identifying areas for quality improvement.

### **Organizational and Committee Structure (See Appendix A for Organizational Chart)**

CalOptima Board of Directors provides oversight and direction to CalOptima

PACE Organization. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QAPI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the quality improvement programs at CalOptima. This includes the CalOptima PACE QAPI Program, to the CalOptima Board of Director's Quality Assurance Committee (QAC), which performs the functions of the Quality Improvement Committee (QIC) described in CalOptima's State and Federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The CalOptima Board of Director's QAC is a subcommittee of the Board and consists of currently active Board members. The CalOptima Board of Director's QAC reviews the quality and utilization data that are discussed during the PACE Quality Improvement Committee (PQIC). The CalOptima Board of Director's QAC provides progress reports, reviews the annual PACE QAPI Plan and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

### **CalOptima PACE Quality Improvement Committee (PQIC)**

#### Purpose

This committee provides oversight for the overall administrative and clinical operations of the organization. The PQIC may create new committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. [Twice a quarter, ~~On a quarterly basis,~~](#) the PQIC will review all QAPI Plan initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods in order to address quality problems in any clinical or administrative process. It will also discuss Level One data and Level Two incidents. Potential areas for improvement will be identified through analysis of the data and through Level Two root cause analysis. This meeting will be facilitated by the PACE Medical Director who will report its activities up to the CalOptima Board of Director's QAC, who will then report up to the Board. The PACE Director or the PACE QA Coordinator may report up to the CalOptima Board of Director's QAC if the PACE Medical Director is not available.

### Membership

Membership shall be comprise of the PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, [PACE Clinical Medical Director](#), [PACE QA Manager and the QA](#) Coordinator, and Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing Chair of the committee. See Appendix C for QI Committee Minutes Template.

### **CalOptima PACE Focused Review Committees**

#### Purpose

These committees will be formed to respond to or to proactively address specific quality issues which rise to the level of warranting further study and action. Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

### Membership

Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, [PACE Clinical Medical Director](#), [PACE QA Manager](#), PACE Program Director, [PACE](#) Center Manager, [PACE](#) Clinical Operations Manager, [PACE](#) QA Coordinator, and Intake/Enrollment Coordinator or direct care staff. The Committee will be chaired by the PACE Medical Director, [PACE Clinical Medical Director](#), [PACE Director or PACE QA Manager](#). ~~If the PACE Medical Director is not a member of the committee, then the committee will be chaired by the PACE Director.~~ The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC. This Committee will be responsible for managing all peer review activities performed by independent reviewers related to adverse outcomes.

### **CalOptima PACE Member Advisory Committee (PMAC)**

#### Purpose

This committee provides advice to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to both the PQIC and the CalOptima Board of Directors' QAC, which then will be reported to the Board.

### Membership

The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing Chair and will facilitate for the committee.

### ~~CalOptima PACE Ethics Advisory Committee~~

#### ~~Purpose~~

~~The purpose of this committee is to provide a forum to discuss ethical dilemmas in the provision of care and to respond to participant, family member or staff requests for information on ethical aspects of participant care. It allows for a case review and non-binding recommendations to the Interdisciplinary Team (IDT). The committee or consultants will report and advise the IDT and the~~

~~PQIC. In addition, it can advise the Board on policy development related to ethics.~~

### Membership

~~It will be composed of five members. The PACE Director will act as the standing Chair of the committee. Community professionals with expertise in geriatrics and long term care, and who do not have a significant affiliation with CalOptima PACE, will compose at least one half of the membership Committee seats. At least 3 members will constitute a quorum of the Ethics Committee.~~

## **Quality and Performance Improvement Activities, Outcomes and Reporting**

### Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate the CalOptima PACE population are identified on analysis and trending of data related to the care and services provided at PACE. Other indicators and opportunities for performance improvement are identified through:

- Utilization of Services
  - CalOptima PACE will collect, analyze and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:
    - Hospital Bed Days
    - ER Visits
    - 30-Day All-Cause Readmissions
    - ☐ Participants residing in Long Term Care
  - Data analysis will allow for analyzing both over and under utilization for areas of quality improvement
- Participant and Caregiver Satisfaction
  - The organization shall survey the participants and their caregivers on at least an annual basis. Additionally, we will continue to look for other opportunities for feedback in order to improve quality of services.
  - Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
  - The PACE Member Advisory Committee shall provide direct feedback on satisfaction to both the PACE leadership staff and the CalOptima Board of Directors, Quality Assurance Committee.
- Outcome Measures From the QAPI work plan elements as well as the clinically relevant HPMS data. Data Collected During Patient Assessments
  - This will include the CMS mandated immunization elements
  - HEDIS metrics relevant to the PACE population including:
    - Comprehensive Diabetes Care (CDC)
    - Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)
    - ☐ Medication Reconciliation Post Discharge (MRP) would include evaluations from all Interdisciplinary Team Members.
  - Physiological and clinical well-being, functional status, cognitive functioning, and emotional and mental health status assessments may be used. Standardized, evidenced based assessments will be used whenever available.
- Effectiveness and safety of staff-provided and contract-provided services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team with each reassessment, review of medical records, and success of infection control efforts
- All clinical and certain non-clinical positions have competency profiles specific to their positions
- CalOptima PACE staff will monitor providers by methods such as review of providers' quality improvement activities, medical record review, grievance investigations, observation of care, and interviews
- Unannounced visits to inpatient provider sites will be made by CalOptima PACE staff as necessary
- Non-clinical areas
  - The PACE PQIC has oversight to all activities offered by PACE
  - Member Grievances will be forwarded to the QA Coordinator for tracking, trending and data gathering. These results will be forwarded to the PACE Director ~~and PACE Medical Director~~ for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of decisions and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
  - Member Appeals will be forwarded to the QA Coordinator for tracking, trending and data gathering ~~and the~~. ~~This will be forwarded to the~~ PACE Director ~~and PACE Medical Director~~ for review. If the PACE Director determines that the appeal is for clinical services, it will be forwarded to the PACE Medical Director for review. If the PACE Director or PACE Medical Director disagrees with decision made by the IDT, they will approve the service and communicate this decision to IDT. If the PACE Director or PACE Medical Director agrees with IDT's decision, the case will be forwarded to a third party for review. -The third party review's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediately and decision implementation and shared with the Interdisciplinary Team who will inform caregivers and participants of ~~the~~ decisions and assist them with furtherment of the process as needed.
  - Transportation services will continue to be monitored through monthly metrics, ~~and~~ grievance trending, and a transportation incident log. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be -and reported via quarterly to the PQIC meetings. The PACE QI department will validate the transportation data by comparing the raw GPS data and unannounced ride along data against the reports submitted.
  - Meal quality will be monitored through daily checks of food temperatures as well as comments solicited by the CalOptima PACE Member Advisory Committee.
  - Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills as well as regulatory agency inspections.
  - Plans of correction on problems noted will be implemented by center staff and reviewed by the PACE Program Director, PACE Medical Director or the PACE QA Manager and will be presented to the PQIC.-
  - The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

### Priority setting for performance improvement initiatives is based on

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life
- Potential impact on participant access to necessary care or services
- Potential impact on participant safety
- Participant, caregiver, or other customer satisfaction
- Potential impact on efficiency and cost-effectiveness
- Potential mitigation of high risk, high volume, or high frequency events
- Relevance to the mission and values of CalOptima PACE

### External Monitoring and Reporting

CalOptima PACE will report both aggregate and individual-level data to CMS and State Administering Agencies to allow them to monitor CalOptima's PACE performance. This includes Level One and Level Two Reporting, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported up through the PACE monitoring module of the Health Plan Management System (HPMS). ~~CMS implemented changes to the level I event reporting structure. On a quarterly basis, the~~ The following Level One events are reported to CMS via the Health Plan Management System (HPMS):

- Grievances
- Appeals
  - Level II events, formerly known as sentinel events, are reported as they occur.
- Burns
- Medication Errors
  - Immunizations (evaluated in the Quality of Care section of this report)
- Enrollment/Disenrollment (evaluated previously in this report)
- Falls without Injury
  - ER Visits (evaluated in the Utilization Management section of this report)
- Kennedy Terminal Ulcer (not implemented)
- Level One Reporting Indicators
  - Routine Immunizations
  - Grievances and Appeals
  - Enrollments
  - Disenrollments
  - Prospective Enrollees
  - Readmissions
  - Emergency (Unscheduled) Care
  - Unusual Incidents
  - Deaths

### Level Two Reporting Indicators

- When unusual incidents reach specified thresholds, CalOptima must notify CMS and the State Administering Agency in the required timetables, complete a Root Cause Analysis and

present the results of the analysis on a conference call with both agencies as well as internally at the PACE QIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Level Two Events are:

- Deaths related to suicide or homicide, unexpected and with active coroner investigation
- Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall
- Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame
- Pressure ulcer acquired while enrolled in the PACE Program
- Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function
- Any elopement
- Health Outcomes Survey-Modified (HOS-M)
  - CalOptima PACE will participate in the annual HOS-M to assess the frailty of the population in our center
- Other External Reporting Requirements
  - Suspected elder abuse shall be reported to appropriate state agency
  - Equipment failure or serious adverse reaction to any administered medications will be reported to the FDA
  - Any infectious disease outbreak will be reported to the CDC

#### Corrective Action Plans

- When opportunities for improvement are identified, a corrective plan will be created.
- Each corrective plan will include an explanation of the problem, the individual who is responsible for implementing the corrective plan, the time frame for each step of the plan, and an evaluation process to determine effectiveness
- Corrective Action Plans from contracted providers will be requested by the QA Manager or other member of the PQIC, as appropriate

### Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the CalOptima PACE Medical Director and the CalOptima PACE Director
- The QA Manager or QA Coordinator will consult with relevant CalOptima PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately

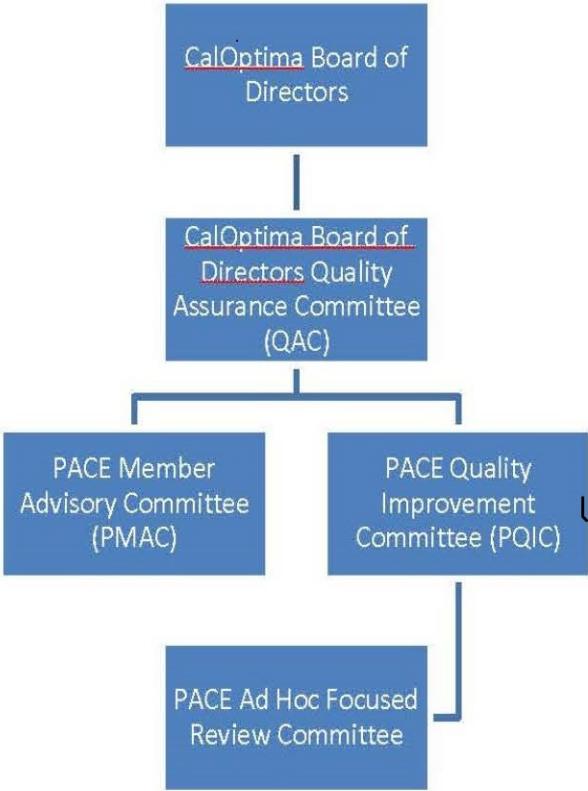
### Re-Evaluation and Follow-up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
  - Severity of the problem
  - Frequency of occurrence
  - Impact of the problem on participant outcomes
  - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

### Annual Review of PACE QAPI Plan

- The PACE QAPI Plan will be assessed annually for effectiveness
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QAPI Plan
- The CalOptima Board of Directors will review, revise and approve the CalOptima PACE QAPI Plan to assure organizational oversight and commitment

Appendix A: 20186 CalOptima PACE QAPI Program Reporting Structure



Proposed 2018 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion	Q1 Results	Q2 Action	Q3 Results	Q4 Action	Q4 Results	EOY Total	ME/NO T MET
QAPI18.01	Quality of Care	2017 PACE QAPI Plan and Work Plan Annual Evaluation	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis.	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation	PACE Medical Director	Annua ly	March, 2018							
QAPI18.02	Quality of Care	2018 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 signed on an annual basis.	Annual Adopt on	PACE Medical Director	Annua ly	March, 2018							
QAPI18.03	Quality of Care	Influenza Immunization Rates	Increase Influenza immunization rates for all eligible PACE participants	Improve compliance with Influenza immunization recommendations	> 80% of members will have influenza vaccination	Clinical Operations Manager	Quarterly	12/31/ 2018							
QAPI18.04	Quality of Care	Pneumococcal Immunization Rates	Increase Pneumococcal immunization rates for all eligible PACE participants	Improve compliance with pneumococcal immunization recommendations	> 80% of members will have pneumococcal vaccination	Clinical Operations Manager	Quarterly	12/31/ 2018							
QAPI18.05	Quality of Care	Infection Control	Reduce common infections in PACE participants (Respiratory and Skin)	Monitor and analyze the incidence of Respiratory and Skin infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Maintain common infection rates less than the following national benchmark: Respiratory Tract 0.1% episodes/1000 participant days Skin 0.2% episodes/1000 participant days	Clinical Operations Manager	Quarterly	12/31/ 2018							
QAPI18.06	Quality of Care	Care for Older Adults: Advance Directive Planning	Increase POLST utilization of PACE participants	Ensure all PACE members who have been sponsored meet and every six months until they have one completed in order to improve POLST utilization	>70% of members who have been enrolled in the PACE program for 6 months will have a POLST completed	PACE Center Manager	Quarterly	12/31/ 2018							
QAPI18.07	Quality of Care	Care for Older Adults: Medication Review (COA)	Increase the percentage of PACE participants who have their medications reviewed	Ensure all PACE participants have a medication review	>85% (2018 Star Ratings Cut Point)	PACE Center Manager	Quarterly	12/31/ 2018							
QAPI18.08	Quality of Care	Care for Older Adults: Functional Status Assessment (COA)	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months by CMS.	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months	100% (CMS Requirement)	PACE Center Manager	Quarterly	12/31/2018							
QAPI18.09	Quality of Care	Care for Older Adults: Pain Screening (COA)	Increase the percentage of PACE participants who are screened regularly for pain.	Ensure all PACE participants have a pain screening	>9 % (2018 Star Ratings Cut Point)	PACE Center Manager	Quarterly	12/31/ 2018							
QAPI18.10	Quality of Care	Comprehensive Diabetes Care (CDC): Diabetic Eye Exams	Increase the percentage of PACE participants who have diabetic eye exam completed annually if diabetic eye exam completed	PACE Participants w/in diabetes will be monitored by the PACE QI department who will work with the interdiscplinary and clinical teams to develop strategies for improvement	>83.15% (MEDICARE Quality Company - 2016 HEDIS 50th percentile)	PACE Medical Director	Quarterly	12/31/ 2018							
QAPI18.11	Quality of Care	Comprehensive Diabetes Care (CDC): Nephropathy Monitoring	Increase the percentage of PACE participants who have nephropathy monitoring.	PACE Participants w/in diabetes will be monitored by the PACE QI department who will work with the interdiscplinary and clinical teams to develop strategies for improvement	58.35% (MEDICARE Quality Company - 2016 HEDIS 50th percentile)	PACE Medical Director	Quarterly	12/31/ 2018							
QAPI18.12	Quality of Care	Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg)	Increase the percentage of PACE participants w/in diabetes who have controlled blood pressured (<1 090 mm Hg)	PACE Participants w/in diabetes will be monitored by the PACE QI department who will work with the interdiscplinary and clinical teams to develop strategies for improvement	>79.32% (MEDICARE Quality Company - 2016 HEDIS 50th percentile)	PACE Medical Director	Quarterly	12/31/ 2018							
QAPI18.13	Quality of Care	Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus Tricyclic Antidepressants or Anticholinergics	Reduce potentially harmful drug-drug-disease interactions	PACE Participants w/in a history of falls will be monitored by the PACE QI department who will work with the interdiscplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	<8.91% (MEDICARE Quality Company - 2016 HEDIS 50th percentile)	PACE Pharmacist	Quarterly	12/31/ 2018							
QAPI18.14	Quality of Care	Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	Reduce potentially harmful drug-drug-disease interactions	PACE Participants w/in a diagnosis of Dementia will work w/in the interdiscplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	<37.55% (MEDICARE Quality Company - 2016 HEDIS 50th percentile)	PACE Pharmacist	Quarterly	12/31/ 2018							
QAPI18.15	Quality of Care	Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDs or COX2 Selective NSAIDs	Reduce potentially harmful drug-drug-disease interactions	PACE Participants w/in a diagnosis of Chronic Renal Failure will work w/in the interdiscplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	<3.75% (MEDICARE Quality Company - 2016 HEDIS 50th percentile)	PACE Pharmacist	Quarterly	12/31/ 2018							
QAPI18.16	Quality of Care	Medication Reconciliation Post Discharge (MRP)	Increase the percentage of participants for whom medications were reconciled within 30 days of hospital discharge	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	>80%	PACE Pharmacist	Quarterly	12/31/ 2018							
QAPI17.17	Access and Availability	Specialty Care	Improve access to specialty providers	Appointments for specialty care will be scheduled for the next business day or as soon as possible for initial consultations	> 80% of specialty care appointments scheduled within 10 days	PACE Clinical Operations Manager	Quarterly	12/31/ 2018							
QAPI17.18	Utilization Management	Acute Hospital Day Utilization	Reduce the rate of acute hospital days by PACE participants	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the interdiscplinary and clinical teams to develop strategies to lower that rate through preventative care and education	< 2.10 hospital days per 1000 per year (2016 CalPACE Average)	PACE Medical Director	Quarterly	12/31/ 2018							
QAPI17.19	Utilization Management	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 QI department who will work with the interdiscplinary and clinical teams to develop strategies to lower that rate through preventative care and education	< .58 emergency room visits per 1000 per year (2016 CalPACE Average)	PACE Medical Director	Quarterly	12/31/ 2018							

Proposed 2018 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QAPI17.20	Utilization Management	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 QI department who will work with PACE inter disciplinary and clinical staff to develop strategies for quality improvement.	<12.5% 30-day all cause readmission (2018 CalPACE Average)	PACE Medical Director	Quarterly	12/31/2018										
QAPI17.21	Utilization Management	Long Term Care Placement	Decrease the percentage of participants who are placed in a long term care facility	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE inter disciplinary and clinical teams to develop strategies for quality improvement through preventative care and education.	< 1% of members (2018 CalPACE Average) will reside in long term care	PACE Center Manager	Quarterly	12/31/2018										
QAPI17.22	Participant Satisfaction	Disenrollments	Reduce the percentage of participants who disenroll from the PACE program within the first 90 days of enrollment.	Review and analyze the participants who disenroll from the PACE program to determine reasons for disenrollment, including deaths and withdrawals, to develop strategies for improvement.	Reduce the annualized rate below 0%/year (20% reduction from 2017 Goal)	PACE Center Manager	Quarterly	12/31/2018										
QAPI17.23	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 to determine areas for improvement and implement interventions to improve the participant and their families' satisfaction with the PACE program.	>88% will answer "Good, Very Good or Excellent" on this question (2017 CalPACE average)	PACE Director	Annually	12/31/2018										
QAPI17.24	Delegation Oversight	Transportation	Improve PACE transportation ride times to less than 60 minutes per trip	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour variations, define areas for improvement, and implement interventions to maintain compliance with regulation.	0 trips > 60 minutes in duration	PACE Director	Quarterly	12/31/2018										
QAPI17.25	Delegation Oversight	Transportation	Improve participant experience by providing timely transportation services	Review and analyze transcripts on records to determine areas for improvement and implement interventions to improve participant experience by sampling GPS records and monthly ride-along	>90% on-time performance	PACE Director	Quarterly	12/31/2018										

## Appendix C: PACE QAPI Committee Meeting Minutes Template

<p align="center"><b>PACE Quality Improvement Committee Meeting Minutes</b></p> <p align="center">Date _____</p> <p align="center">Time: _____</p> <p align="center">Place: PACE conference Room 109</p>		
<p>Meeting Attendees: PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QA Coordinator, and the PACE Intake/Enrollment Manager.</p>		
<p>Meeting Notes Taker: QA Coordinator</p>		
Topic	Presentation/Discussion	Recommendation/Action
Roll Call and Introduction		
Review and Approval of Last PQIC Meeting Minutes		
<b>Old Business:</b>		
<b>New Business:</b>		
Level II Issues		
HPMS Data Analysis		
Standing Agenda Item		
Clinical Logs and Updates		
Operational Logs and Updates		
Site Logs and Updates		
PMAC Update Report		



**CalOptima**  
Better. Together.

# **2018 PACE Quality Assurance Performance Improvement (QAPI) Plan**

**Board of Directors' Quality Assurance Committee Meeting  
February 20, 2018**

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

# 2018 Program Description

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- Encompasses all clinical care, clinical services & organizational services provided to our members
- Aligns with our vision and mission
- Focuses on optimal health outcomes for our members
- Uses evidence-based guidelines, data and best practices tailored to our populations

# 2018 PACE QAPI Work Plan Elements

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- Preventative Care
- Quality Of Care
- Infection Control
- Access & Availability
- Utilization Management
- Delegation Oversight
- Patient Satisfaction/Member Experience

# Opportunities for Improvement Identified in 2017 QAPI Plan Evaluation

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- Hospital and ER Utilization
- Specialty Care Utilization
- Participant Satisfaction
- Additional Quality/HEDIS Elements
  - 2016: 14 Elements
  - 2017: 21 Elements
  - 2018: 25 Elements

# 2018 QAPI **New** Work Plan Elements

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- Comprehensive Diabetes Care (CDC)
  - HbA1c Testing
  - Nephropathy Monitoring
  - Blood Pressure Control (<140/90)
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)
  - Fall + Tricyclic Antidepressants or Antipsychotics (lower is better)
- Medication Reconciliation Post-Discharge (MRP)

# Recommended Action

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- Recommend Board of Directors' approval of the 2018 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment Performance Improvement (QAPI) Plan

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken February 20, 2018** **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

#### **Report Item**

8. Consider Recommending Board of Directors' Ratification of Increased Payment to Primary Care Physicians for the Depression Screening Incentive Program Funded by Intergovernmental Transfer (IGT) 1

#### **Contact**

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

Greg Hamblin, Chief Financial Officer, (714) 246-8400

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

#### **Recommended Actions**

Recommend the Board of Directors:

1. Ratify a \$20 increase per depression screening to \$50 for all screens completed by physicians for eligible member retroactively to May 1, 2017; and
2. Authorize incentive payments of \$50 per depression screening for members prospectively through May 2019, or until available funding has been exhausted, whichever comes first.

#### **Background**

In 2015, CalOptima identified five health needs based on inputs and recommendations from CalOptima's internal and external stakeholders as to the areas of greatest concerns to CalOptima members in the community. They are adult mental health, children mental health, childhood obesity and diabetes, strengthening the safety net and improving children's health. Staff began to develop IGT funded initiatives to address these areas including a program to address depression in adolescents.

Around the same time, Kaiser Permanente had implemented a screening program for 11 year olds aimed at identifying adolescents at risk for depression, anxiety, and dysthymia. CalOptima staff met with Kaiser to learn more about the scope of their program. Kaiser screening process consists of four components: completion of the screening tool, use of mental health resources, parental inputs, and discussion concerning the results of the screen. All four parts need to be documented to ensure the screening is completed appropriately. Based on Kaiser's input, staff believed that the physician's role in screening for depression is extensive and requires additional training and support.

As CalOptima staff moved forward with the development of the program, new requirements regarding depression screening for adolescent continue to emerge. In February 2016, the U.S. Preventive Services Task Force (USPSTF) published a final recommendation for screening depression in children and adolescents. USPSTF concluded with moderate certainty that screening for Major Depression Disorder in adolescents aged 12 to 18 years has a moderate net benefit. In 2017, the Healthcare Effectiveness Data and Information Set (HEDIS) introduced the Depression Screening and Follow-up for Adolescents and Adults (DSF) measure. This measure requires members to be screened for clinical depression using a standardized tool and, if screened positive, to receive follow-up care. The Department of Health Care Services (DHCS) has also selected DSF as part of the External Accountability Set (EAS) to evaluate the quality of care delivered by CalOptima to its members.

On December 1, 2016, CalOptima staff presented to the Board a proposed physician incentive program aimed to increase the rate of depression screenings conducted during annual wellness visits for members ages 12 to 18. The Board authorized the reallocation of \$1,000,000 from 2010-11 IGT 1 funds to support the program. At that time, \$30 per screening was approved as the incentive payment amount to be made directly to primary care physicians (PCPs).

### **Discussion**

Internally, the Behavioral Health Integration (BHI) Department, in collaboration with the Provider Relations Department, began the implementation of the depression screening incentive program in January 2017. To maximize the potential impact of the program, staff recommended to start the program by focusing on members turning 12 in 2017 (16,670 members). Approximately 641 PCPs were identified as serving these members, with 40 of them serving over 100 members. An informational packet was developed to educate PCPs about the program and the expected additional role. The packet included a cover letter describing the program, the Patient Health Questionnaire (PHQ-9) Adolescent version, scoring instruction, instructions on coding and interpreting the results with recommended next steps, and a CalOptima Outpatient Mental Health Services flyer.

Leveraging the experience of working with PCPs on previous incentive programs, Staff communications with providers from the outset was that the incentive payments would be \$50 per depression screening under the program, rather than \$30 as had been approved. This rate was intended to encourage provider participation and to provide adequate funding to support depression screening within their practice.

In April 2017, Staff distributed the depression screening informational packet to 641 PCPs. The Provider Relations Department followed up with visits to the office of 40 PCPs with the highest number of eligible members to provide additional training on utilization of the screening tool and claim processing. The program was also highlighted in the provider newsletters and email campaigns. Staff launched the program in May 2017, and CalOptima began to process claims for completed depression screenings (at the \$50 level) with date of service starting in May.

Between May and December 2017, 1,948 incentive payments were paid to PCPs at \$50 per screen totaling \$97,400.00. Of these members, 307 were screened positive for depression. When the result is positive, PCPs are advised to take additional steps that include watchful waiting, supportive counseling, consider medication management, and referral to mental health providers. Based on the current utilization pattern, we anticipate the annual screening rate will be approximately 20% (3,300 depression screenings). CalOptima staff is encouraged by the early findings. The incentive encourages PCPs to evaluate their patients for depression and has the potential to make a significant impact on children's mental and overall health. Response to the program from PCPs has been overwhelmingly positive.

In January 2018, the discrepancy between the Board approved \$30 per screen amount and the actual \$50 per incentive payment per screen gained broader visibility within the organization. Based on the screenings completed to date, the rate change has resulted in an increase in payment of \$38,960, or 66% through December 2017. The annual increase in payment is projected to be \$66,000. With an annual utilization rate of approximately 20%, the \$50 incentive payment per screen will only use approximately 33% of the \$1,000,000 allotted to the program within a two-year period. While one option would be to

attempt to recoup the \$20/screening paid above the amount authorized by the Board, staff believes that ratifying the higher incentive payments and authorizing payments at the higher level going forward, will enable CalOptima to build on the momentum created during the first eight months of the program.

Staff will continue to monitor the volume of screenings and depression diagnosis, and will keep the Board updated on the program, and return with further recommendations. In addition, Staff will implement internal validation and control measures to ensure that system and process implementations are consistent with Board-approved actions.

### **Fiscal Impact**

As of December 2017, total actual expenses for Depression Screening Incentive Program payments was \$97,400. Staff estimates the projected annual cost for the incentive payments at \$50 per depression screening is \$165,000. Pursuant to the recommended action, incentive payments will continue through May 2019, or until available IGT funding is exhausted, whichever comes first. If additional unexpended funds remain at that time, staff will return to the Board with further recommendations. Since the recommended action is funded by IGT 1 funds authorized by the Board at the December 1, 2016, meeting, the recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

### **Rationale for Recommendation**

Staff recommends approval of the proposed recommendation to maintain the early success of the program and to support increased needs for mental health screening in primary care setting. CalOptima will provide QAC an update of the program in Q3 2018.

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachments**

1. Board Action dated December 1, 2016, Consider Authorization of the Expenditure Plan for Available Intergovernmental Transfer (IGT) Funds, Including Reallocation of Dollars from IGT 1, IGT 2, and IGT 3, and Allocation of Dollars from IGT 4 and IGT 5
2. Depression Screening Informational Packet
3. Depression Screening Incentive Program 2017 Quarterly Status Reports

/s/ Michael Schrader  
**Authorized Signature**

2/12/2018  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

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

#### **Report Item**

15. Consider Authorization of the Expenditure Plan for Available Intergovernmental Transfer (IGT) Funds, Including Reallocation of Dollars from IGT 1, IGT 2 and IGT 3, and Allocation of Dollars from IGT 4 and IGT 5

#### **Contact**

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

#### **Recommended Actions**

1. Approve expenditure plan for reallocation of IGT 1-3 funds in the amount of \$5,820,020 and allocation of IGT 4 and 5 funds in the amount of \$21,966,208 to include projects consistent with the original CMS-approved expenditure categories, and that support CalOptima Board-approved funding categories;
2. Authorize the CEO to execute agreements as necessary to distribute IGT funds for Board approved projects and initiatives supporting the approved funding priorities;
3. Authorize a timeline extension for the expenditure of \$50,000 in IGT 1 funds for OneCare Personal Care Coordinators (PCC) through June 30, 2017 or until funds have been exhausted, whichever occurs earlier; and
4. Direct staff to return to the Board with further IGT expenditure recommendations as they are developed; all IGT specific programs and initiatives remain subject to Board approval.

#### **Background/Discussion**

CalOptima began participating in the rate range IGT program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. Including the estimated amount of the currently pending IGT 5 transaction, CalOptima's share of the five IGT transactions will total approximately \$48 million. Numerous Board-approved projects have been launched with IGT 1-3 funds within the regulator-approved categories, and most have been completed or are on track for completion. There are a small number of projects that have been postponed or eliminated and these dollars are available for the Board's reallocation. Allocations for IGT 4 and IGT 5 funds have yet to be approved by the Board.

1. Staff has developed recommendations to reallocate \$5.8 million in unspent funds from IGTs 1-3. Recommendations have also been developed for expenditure of the \$22 million in available funds from IGT 4 and IGT 5.
2. The proposed \$27.8 million in recommended expenditures will be utilized to support one or more of the original CMS-approved and CalOptima Board-approved expenditure categories (see Attachment 2. IGT 1 – 5 Summary Tables of Expenditures by CMS/DHCS (and CalOptima Board) Approved Funding Categories) as appropriate.

### IGT Ad Hoc Committee

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on November 14, 2016, to review the IGT expenditure plan as recommended by staff. The ad hoc committee consists of Supervisor Do, Director Nguyen, and Director Schoeffel. Recommendations from the Ad Hoc committee include the following:

1. Approve \$12.8 million for projects within the approved funding categories as listed below, to improve services and quality of care for Medi-Cal member, support providers, and make infrastructure investments for the benefit Medi-Cal members.
2. Complete a comprehensive Member Health Needs Assessment, results of which will be used to inform development of Community Grant RFPs.
  - a. Member Health Needs Assessment to be conducted within a 3-6 month timeframe, with the assistance of a consultant (procured according to appropriate policy and RFP processes).
3. Staff will return with recommendations for Board approval on specific programs and initiatives on the expenditure of an additional \$15 million in IGT funds following completion of the Member Health Needs Assessment;

### Funding Allocations and Projects to be Supported

The table below illustrates the recommended funding reallocations from IGTs 1-3 projects and allocation of IGT 4 and 5 funds:

FROM (Project/IGT)	Amount to be (Re)allocated	TO Recommended Projects	Project Funding Amount
Telemedicine/ IGT 1 (Enhance provider reimbursement rates)	\$1,000,000	Depression Screenings	\$1,000,000
Telemedicine/ IGT 1 (Strengthen delivery system)	\$69,190	Provider Portal Communications & Interconnectivity	\$1,500,000
IGT 4	\$1,430,810		
IGT 4	\$250,000	Member Health Homes	\$250,000
IGT 4	\$750,000	UCI Observation Stay Payment Pilot	\$750,000
IGT 4	\$500,000	Member Health Needs Assessment	\$500,000
IGT 4	\$3,550,000	Personal Care Coordinators (PCCs)	\$7,000,000
Pay-for-Performance for PCPs/ IGT 3 (Care Coordination)	\$3,450,000		
Pay-for-Performance for PCPs/ IGT 3 (Improve information services infrastructure)	\$750,000	Data Warehouse Expansion	\$750,000
Case Management System/ IGT1 (Strengthen delivery system)	\$3,620	Facets System Upgrade and Reconfiguration	\$506,620
Provider Network Management Solution/	\$500,000		

FROM (Project/IGT)	Amount to be (Re)allocated	TO Recommended Projects	Project Funding Amount
IGT 2 (Enhance information technology infrastructure)			
Security Audit Remediation/ IGT2 (Enhance information technology infrastructure)	\$3,000		
Additional Unallocated Funds/ IGT 1	\$28,231	IGT Program Administration (Grants Management Software, staffing and administrative costs)	\$529,608
Additional Unallocated Funds/ IGT 2	\$427		
Additional Unallocated Funds/ IGT 3	\$15,552		
IGT 4	\$485,398		
Subtotal			\$12,786,228
IGT 5 (Anticipated amount)	\$15,000,000	Community Grants (pending completion of Member Health Needs Assessment)	\$15,000,000
Total			\$27,786,228

The details of the above recommended projects are as follows:

- Depression Screenings (up to \$1,000,000): Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members ages 12-18 over two years. Subject to regulator approval, as applicable, incentive payments per screening will be \$30 and made directly to primary care providers. Beginning with Year 2 of the project, and again, subject to regulator approval as appropriate, a sufficient process/infrastructure must be in place to collect depression screening scores in addition to the claims from providers in order for incentive payment to be made. This project addresses the “Children’s Mental Health” funding category.
- Provider Portal Communications and Interconnectivity (up to \$1,500,000): Develop and implement a web-based provider portal strategy that will support real time bi-directional electronic communication between CalOptima and community partners/providers. Project includes an initial pilot with designated community agencies to evaluate and incorporate feedback prior to implementation with CCN Network Providers. This project addresses the “Pilot Program Planning and Implementation” funding category, as bi-directional data sharing and exchange between CalOptima and providers is a required component of the Whole Person Care pilot in which CalOptima is a key participant, and will be an important asset to the upcoming Health Homes Program.
- Health Homes Program (HHP) (up to \$250,000): CalOptima is implementing the "Health Homes for Patients with Complex Needs Program” (HHP), a new DHCS program for Medi-Cal and Cal Medi-Connect plans. This program requires plans to engage Community-Based

Care Management Entities (CB-CMEs) to provide HHP services. DHCS requires plans to assess organizations in the community that may offer HHP services and use this information in development of the local delivery model. Health Homes Program payments do not cover the cost of such activities, and IGT funds will be used to complete this one-time environmental assessment and development of tools to select, contract and determine readiness of organizations to provide HHP services. These activities may be conducted by a consultant, temporary staff or other resource (procured according to appropriate policy and RFP processes). This project addresses the “Pilot Program Planning and Implementation” funding category.

- UCI Observation Stay Payment Pilot (up to \$750,000): Assuming terms and can be reached with UCI within 90 days, funds will support a pilot project with UC Irvine Health to test cost effectiveness of emergency department observation unit (EDOU) care and demonstrate potential return on investment for such care. This project will include tracking of specific CalOptima member information, including diagnosis, protocol, time in ED OU, discharge diagnosis, discharge status and readmission rates. UCI and CalOptima will conduct monthly utilization review. If terms cannot be reached within this time period, staff will return to the Board with further recommendations. This project addresses the “Pilot Program Planning and Implementation” funding category.
- Member Health Needs Assessment (up to \$500,000): Conduct a county-wide Medi-Cal member health needs assessment. Funds will support assistance from a consultant (procured according to appropriate policy and RFP processes) and associated costs for assessment activities such as surveys, focus group meetings and survey completion incentives etc. Results and recommendations from the completed assessment will inform RFP development of targeted Community Grant funding to support the needs of Medi-Cal beneficiaries in Orange County. This project addresses the “Strengthening the Safety Net” funding category by providing information that will more effectively align funding investments with the needs of our Medi-Cal members.
- Personal Care Coordinators (PCCs) (up to \$7,000,000): Funds will support Health Network and CalOptima PCCs to assist members in navigating the health care system. Funding covers PCCs for the following member populations: duals (OneCare and OneCare Connect), Medi-Cal Seniors and Persons with Disabilities, and other vulnerable populations (e.g. homeless, those with serious and persistent mental illness, transitioning from Regional Center services, etc.). Funding includes support for the cost of services to complete an evaluation of the PCC program, to be completed no later than June 2018. Evaluation activities may be conducted by a consultant, temporary staff or other resource (procured according to appropriate policy and RFP processes). This project addresses the “Strengthening the Safety Net” funding category as PCCs assist members in navigating the health care system.
- Data Warehouse Expansion (\$750,000): Integrate various data sources (e.g. pharmacy, claims, case management system, accounting and budget data) into the Clinical Data Warehouse to provide the capability to build complete member claims and pharmacy histories, analyze data

and produce an integrated performance/financial impact analysis package. This project is anticipated to be completed in two years or less and may include the use of contract services and information systems upgrades procured according to appropriate policy and RFP processes. This project addresses the “Pilot Program Planning and Implementation” funding category, as data integration is a fundamental component of the Whole Person Care pilot, Health Homes Program, and Whole Child initiatives.

- Facets System Upgrade and Reconfiguration (up to \$506,620): Improve operational efficiencies of Facets claims and member management system with additional hardware and vendor service purchases. This work supports optimizing data storage requirements and prevents data loss, adding test environments for program implementation to mitigate negative impact to production, system load balancing to support growth in membership and claims data, and improving performance and batch processing to optimize server distribution. This project addresses the “Enhance core data analysis and exchange systems” funding category, being continued from IGT 2.
- IGT Program Administration (up to \$529,608): Funds will support purchase and ongoing maintenance of Grant Administration software (procured according to appropriate policy and RFP processes) to facilitate management and oversight of IGT projects and community grants. Funding will also support staffing and administrative costs to manage the IGT transaction process, and provide IGT project and expenditure oversight over two years. Administrative functions are an allowable use of IGT funds and support the funding category of “Strengthening the Safety Net” by providing oversight of the entire IGT process and ensuring that funding investments are effectively aligned with the needs of our members.
- Addressing Gaps and Barriers facing Orange County Medi-Cal members (approximately \$15,000,000): \$15,000,000 in anticipated funds from IGT 5 to be allocated for targeted community needs in one or more of the funding priority areas above after completion of a Member Health Needs Assessment. Staff will return to the Board with recommendations following completion of the Health Needs Assessment.

#### IGT 1 Project Timeline Extension

As part of this expenditure plan recommendation, staff also requests a timeline extension for an expenditure of \$50,000 in IGT 1 funds for OneCare Personal Care Coordinators (PCC) which was authorized through December 31, 2016 (see Attachment 14, Board Action dated March 3, 2016 - Authorize Extension and Reallocation of OneCare PCC Funds for CY 2016). Extension for use of these funds is requested through June 30, 2017 or until funds have been exhausted, whichever occurs earlier.

#### Fiscal Impact

The recommended action has no fiscal impact to CalOptima’s operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

**Rationale for Recommendation**

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. PowerPoint Presentation: IGT Update and Expenditure Plan
2. IGT 1 – 5 Summary Tables of Expenditures by CMS/DHCS (and CalOptima Board) Approved Funding Categories
3. Board Action dated March 7, 2013: Approve Proposed Use of \$12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2011-12 IGT Funds and Execute Required IGT Documents
4. Board Action dated June 6, 2013: Approve Work Plan and Timeline for Implementation of FY 2010-11 Intergovernmental Transfer (IGT) Funds
5. Board Action dated March 6, 2014: Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents
6. Board Action dated September 4, 2014: Authorize and Direct the Chairman of the Board of Directors to Enter into the Necessary Agreements with the University of California at Irvine (UCI) and the California Department of Health Care Services (DHCS) to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2012-13, Including Approval of Proposed Funding Categories; Recommend Board of Directors Approval of an Updated Expenditure Plan for FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of \$900,000 of IGT 2 Funds and Authorize Procurement Process for School-Based Vision and Dental Wraparound Services
7. Board Action dated October 2, 2014: Approve Grant Awards to Designated Organizations in Support of New and Prospective Federally Qualified Health Centers (FQHCs)
8. Board Action dated December 4, 2014: Authorize Grant Awards in Support of Prospective Federally Qualified Health Centers (FQHCs) and Funding for Expert Consultation to Manage and Ensure Satisfactory Progress on Clinic Grants
9. Board Action dated December 4, 2014: Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
10. Board Action dated April 2, 2015: Authorize Reallocation of OneCare Personal Care Coordinator (PCC) Funding to Cover the Cost of the Program
11. Board Action dated April 2, 2015: Approve the Allocation of Intergovernmental Transfer (IGT) Funds for Personal Care Coordinators (PCC) for the OneCare Connect (OCC) Program Including for OCC Members in the CalOptima Community Network

12. Board Action dated May 7, 2015: Authorize Agreements Necessary to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2013-14 (IGT 4); Consider Approval of a Modification of Eligible Use for IGT 2 Funds Allocated to Support Federally Qualified Health Centers (FQHCs)
13. Board Action dated October 1, 2015: Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects
14. Board Action dated March 3, 2016: Authorize Extension of Expenditures of Fiscal Year 2010-11 Intergovernmental Transfer Funds for OneCare Personal Care Coordinators (PCC) through December 31, 2016; and Authorize the Reallocation of OneCare Connect PCC Funding to Cover the Cost of the OneCare PCC Program through Calendar Year 2016

/s/ Michael Schrader  
**Authorized Signature**

11/23/2016  
**Date**



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# **IGT Update & Expenditure Plan**

**Board of Directors Meeting  
December 1, 2016**

**Cheryl Meronk  
Director, Strategic Development**

# Intergovernmental Transfers (IGT)

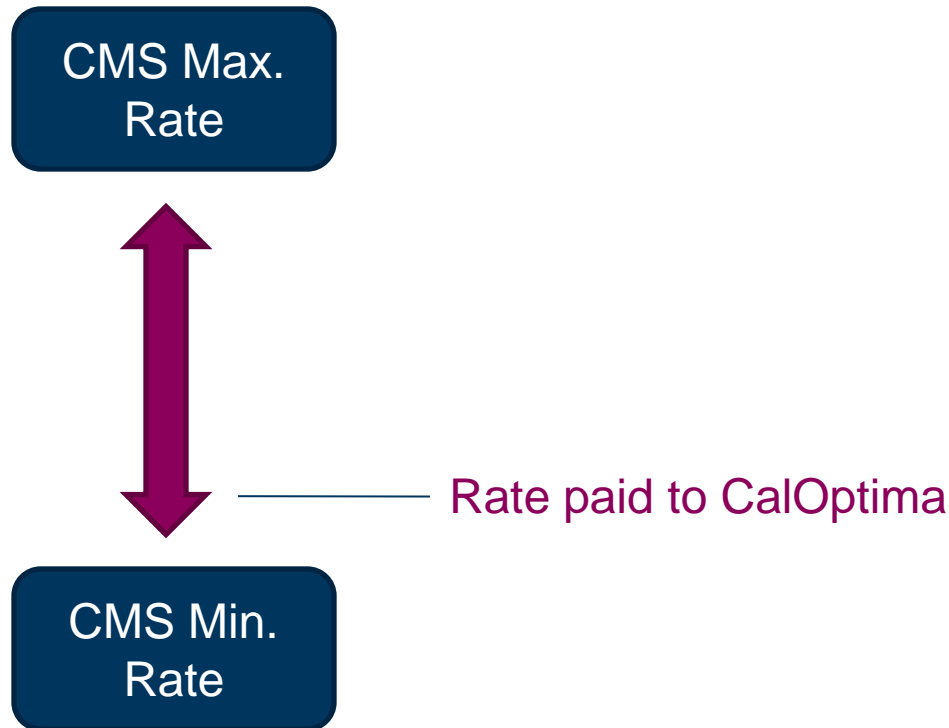
## Background

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- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

# Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



# IGT Funds Availability and Process

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- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

# CalOptima Share Totals for IGT 1–5

IGTs	CalOptima Share
IGT 1	\$12.52 M
IGT 2	\$8.60 M
IGT 3	\$4.88 M
IGT 4	\$7 M
IGT 5	≈\$15 M
<b>Total</b>	<b>\$48 M*</b>

*\*Estimated total*

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# IGT 1 Status\*

Project	Budget	Balance	Notes
Personal Care Coordinators	\$3,850,000	\$110,000	Complete by 2/28/2017
Case Management System	\$2,099,000	\$3,500	Completed
Strategies to Reduce Readmissions	\$533,585	\$443,000	Complete by 12/1/2016
Program for High-Risk Children	\$500,000	\$500,000	Complete by 10/31/2018
Telemedicine	\$1,100,000	\$1,100,000	To be reallocated
Case Management System Consulting	\$866,415	\$218,000	Complete by 12/31/2017
OCC PCC Program	\$3,550,000	\$2,085,000	Complete by 2/28/2017
<b>Total</b>	<b>\$12.5 M</b>	<b>\$4.4 M</b>	<b>Total Reallocation Amount: \$1.1 M</b>

\*As of 8/31/2016 – balance figures rounded

# IGT 2 Status\*

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	\$1,250,000	\$265,000	Complete by 12/31/2016
Security Audit Remediation	\$101,000	\$0	Completed
Continuation of COREC	\$1,000,000	\$517,000	Complete by 6/30/2017
OCC PCC Program	\$2,400,000	\$2,400,000	Complete by 3/31/2018
Children's Health/ Safety Net Services	\$1,300,000	\$126,000	Complete by 5/31/2017
Wraparound Services	\$1,400,000	\$487,000	Complete by 11/1/2017
Recuperative Care	\$500,000	\$318,500	Complete by 3/1/2017
Provider Network Management Solution	\$500,000	\$500,000	To be reallocated
Project Management	\$100,000	\$17,000	Complete by 9/30/2016
PACE EHR System	\$50,000	\$1,000	Complete by 12/31/2016
<b>Total</b>	<b>\$8.6 M</b>	<b>\$4.6 M</b>	<b>Total Reallocation Amount: \$0.5 M</b>

\*As of 8/31/2016 – balance figures rounded

# IGT 3 Status\*

Project	Budget	Balance	Notes
Pay for Performance for PCPs	\$4,200,000	\$4,200,000	To be reallocated
Recuperative Case (Phase 2)	\$500,000	\$500,000	Complete by 6/30/2018
Project Management	\$165,000	\$165,000	Complete by 12/31/2017
<b>Total</b>	<b>\$4.8 M</b>	<b>\$4.8 M</b>	<b>Total Reallocation Amount: \$4.2 M</b>

\*As of 8/31/2016 – balance figures rounded

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# IGT 4 Status\*

Project	Budget	Balance	Notes
Unallocated Funds	\$7,000,000	\$7,000,000	To be allocated
Total	\$7 M	\$7 M	Total Allocation Amount: \$7 M

*\*As of 8/31/2016 – balance figures rounded*

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# IGT 5 Status\*

Project	Budget	Balance	Notes
Unallocated Funds	≈\$15,000,000	≈\$15,000,000	To be allocated
Total	≈\$15 M	≈\$15 M	Total Allocation Amount: ≈\$15 M

*\*Not yet received*

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# Total Funds to Reallocate or Allocate

IGT	Funds Available
IGT 1	\$1.1 M
IGT 2	\$0.5 M
IGT 3	\$4.2 M
IGT 4	\$7 M
IGT 5	≈\$15 M
<b>Total</b>	<b>\$27.8 M*</b>

*\*Estimate dependent on total IGT 5 amount*

# IGT Approved Funding Categories\*

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Adult Mental Health

Children's Mental Health

Childhood Obesity

Strengthening the Safety Net

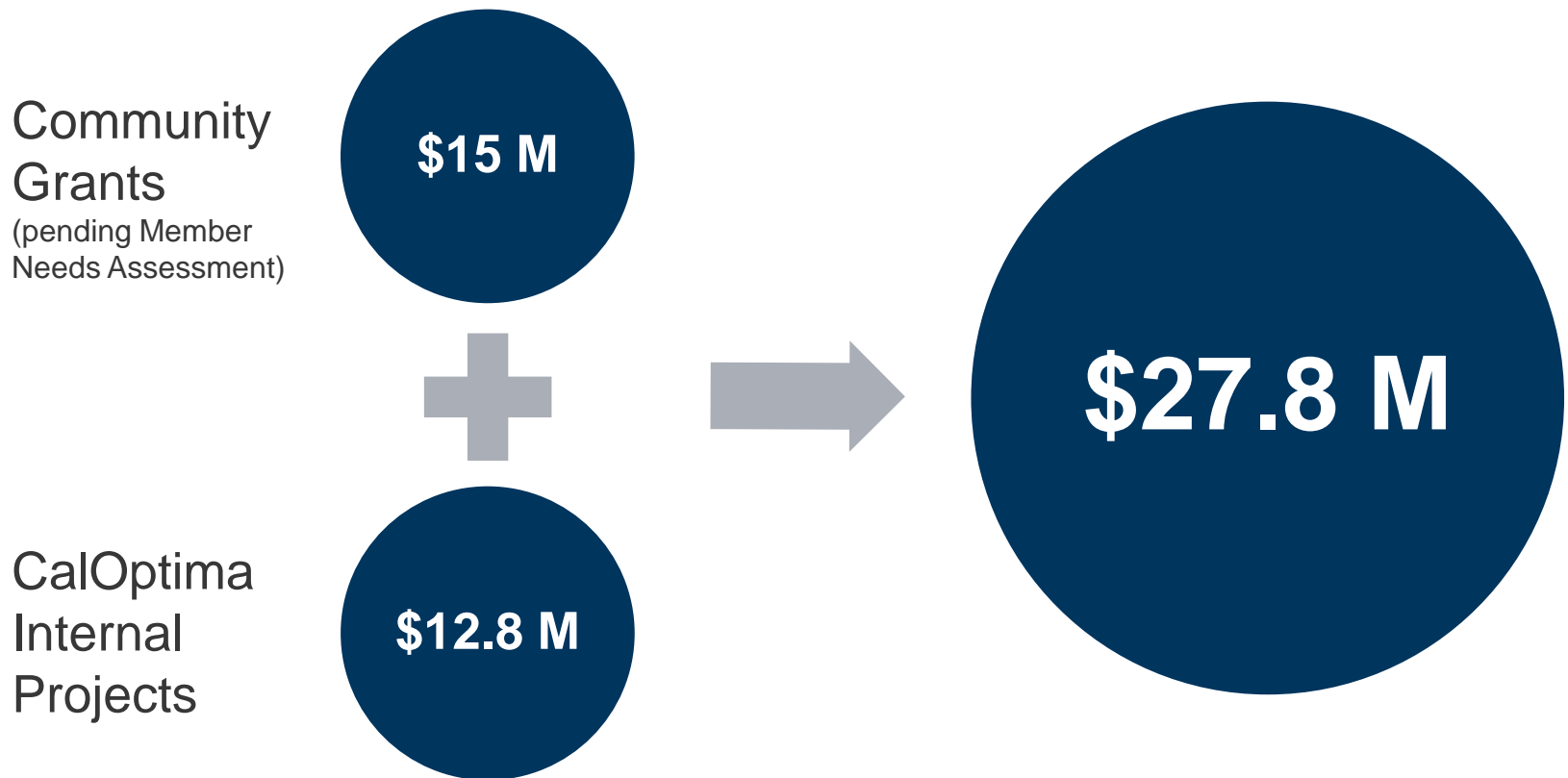
Improving Children's Health

Pilot Program Planning & Implementation

*\*IGTs 4 and 5 only*

# Purpose of IGT Funds

- Funds must be used to deliver enhanced services for the Medi-Cal population



# Recommended Internal Expenditures

Expenditures	Funding Amount
Data Warehouse Expansion	\$750,000
Depression Screenings Ages 12–18	\$1,000,000
Facets System Upgrade and Reconfiguration	\$500,000
Health Homes Program	\$250,000
Health Needs Assessment	\$500,000
IGT Program Administration (grant management software, staff and administrative costs over two years)	\$530,000
Personal Care Coordinators (PCCs) <ul style="list-style-type: none"> <li>• Duals (OneCare and OneCare Connect)</li> <li>• Medi-Cal Seniors and Persons with Disabilities</li> <li>• Other Populations (Homeless/SPMI, RCOC, etc.)</li> </ul>	\$7,000,000
Provider Portal Communications and Interconnectivity	\$1,500,000
UCI Observation Stay Payment Pilot	\$750,000
<b>Total</b>	<b>\$12,780,000</b>

# External Community Grant Support

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- Comprehensive Member Health Needs Assessment to inform Grant RFP development
  - Fill gaps in services and improve health outcomes for CalOptima members
  - Improve access to services
  - Address social determinants of health
- Orange County's Medi-Cal delivery system relies heavily on safety net system
  - Community health centers
  - Community-based organizations

# IGT Timeline

Date	Activity
September 15	FAC Update and Review
September 21	QAC Update and Review
November 10 and 17	PAC/MAC/OCC MAC Review
November 14	IGT Ad Hoc
December 1	Board of Directors Presentation
January – June 2017	Conduct Member Health Needs Assessment
Fall 2017	Development and Release of Community Grant RFPs

## IGT 1-5 Summary Tables of Expenditure by CMS/DHCS (and CalOptima Board) Approved Funding Categories

### **IGT 1 Funding Categories:** (CalOptima Board Approved on March 7, 2013)

- Enhance provider reimbursement rates based on rewards for increased access, which includes, but is not limited to, the following:
  - Open access scheduling
  - Same day appointment availability
  - Participation in medical homes
  - Specialist recruitment for increased access
- Strengthen the delivery system to include, but no be limited to, increased member education and previously unused or underused resources such as the following:
  - 24/7 clinical call center
  - Minute clinics
  - Telemedicine
  - E-consults
  - Complex case management

<b>Project</b>	<b>Amount</b>	<b>Funding Category</b>
OneCare Personal Care Coordinators	\$3,850,000	Strengthen the delivery system
Case Management System	\$2,099,000	Strengthen the delivery system
Strategies to Reduce Re-admissions	\$533,585	Strengthen the delivery system
Program for High Risk Children	\$500,000	Strengthen the delivery system
Telemedicine	\$1,100,000	Enhance provider reimbursement rates
Case Management System Consulting	\$866,415	Strengthen the delivery system
OCC PCC Program	\$3,550,000	Strengthen the delivery system
<b>Total Allocation</b>	<b>\$12.5 M</b>	

### **IGT 2 Funding Categories:** (CalOptima Board Approved on March 6, 2014)

- Enhance CalOptima's core data analysis and exchange systems and management information technology infrastructure to facilitate improved coordination of care for Medi-Cal members;
- Continue and/or expand on services and initiatives developed with 2010-11 IGT funds;
- Provided wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health integration, preventative dental services and supplies, and incentives to encourage members to participate in initial health assessment and preventative health programs.

<b>Project</b>	<b>Amount</b>	<b>Funding Category</b>
Facets System Upgrade & Reconfiguration	\$1,250,000	Enhance information technology infrastructure
Security Audit Remediation	\$101,000	Enhance information technology infrastructure
Continuation of COREC	\$1,000,000	Enhancement to core data systems
OCC PCC Program	\$2,400,000	Strengthen the delivery system
Children's Health/Safety Net Services	\$1,300,000	Strengthen the delivery system
Wraparound Services	\$1,400,000	Wraparound services
Recuperative Care	\$500,000	Strengthen the delivery system
Provider Network Management Solution	\$500,000	Enhancement to core data systems
Project Management	\$100,000	Administration
PACE EHR System	\$50,000	Enhance information technology infrastructure
<b>Total Allocation</b>	<b>\$8.6 M</b>	

**IGT 3 Funding Categories:** (CalOptima Board Approved on September 4, 2014)

- Services related to care coordination and case management for CalOptima members;
- Expansion of optional benefits for CalOptima members potentially including but not limited to vision, dental, and prevention and treatment of chronic disease;
- Innovation and enhancement of the health care delivery model
- Continuing improvements to information services infrastructure and applications to enhance services to CalOptima members.

<b>Project</b>	<b>Amount</b>	<b>Funding Category</b>
Pay for Performance for PCPs	\$4,200,000	Care coordination
Recuperative Case (Phase 2)	\$500,000	Strengthen the delivery system
Project Management	\$165,000	Administration
<b>Total Allocation</b>	<b>\$4.8 M</b>	

**IGT 4 Funding Categories:** (CalOptima Board Approved on May 7, 2015)

- Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health;
- Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver initiatives. This would be one-time funding allocation for planning and implement pilot programs as required.

<b>Project</b>	<b>Amount</b>	<b>Funding Category</b>
Unallocated Funds	\$7,000,000	To be distributed across categories
<b>Total Allocation</b>	<b>\$7 M</b>	

**IGT 5 Funding Categories:** (CalOptima Board Approved on April 7, 2016)

- Adult Mental Health
- Childhood Obesity
- Children's Mental Health
- Improving Children's Health
- Strengthening the Safety Net
- Pilot Program Planning and Implementation

Project	Amount	Funding Category
Unallocated Funds	\$15,000,000	To be distributed across categories
<b>Total Allocation</b>	<b>\$15 M</b>	

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken March 7, 2013** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

VII. A. Approve Proposed Use of \$12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2011-12 IGT Funds and Execute Required IGT Documents

#### **Contact**

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

#### **Recommended Actions**

1. Approve proposed use of \$12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds; and
2. Authorize the CEO to initiate the required process for FY 2011-12 IGT funds and execute required IGT documents.

#### **Background**

On March 3, 2011, the CalOptima Board approved staff to enter into agreements to secure an IGT with the Regents of the University of California/University of California, Irvine (UCI) for Fiscal Year (FY) 2010-11. CalOptima retained \$12.4 million through the IGT transaction. The funds were received in late August 2012, and UCI's portion was disbursed in September.

IGTs are transfers of public funds between governmental entities. The revenue generated through IGTs is potentially non-recurring since there is no guarantee of future IGT agreements. Thus, funds are best suited for one-time investments or as seed capital for new services or initiatives. Ultimately, IGT-funded programs or services must be self-sustaining and not reliant on IGT funds for ongoing operation.

In approving the IGT, the Centers for Medicare & Medicaid Services (CMS) authorized the use of IGT funds to fulfill one or more of the options under the following categories, as approved by the CalOptima Board of Directors:

Category 1: Enhance provider reimbursement rates based on rewards for increased access, which includes, but is not necessarily limited to, the following:

- a. Open access scheduling
- b. Same day appointment availability
- c. Participation in medical homes
- d. Specialist recruitment for increased access

Category 2: Strengthen the delivery system to include, but not be limited to, increased member education and previously unused or underused resources such as the following:

- a. 24/7 clinical call center
- b. Minute clinics
- c. Telemedicine

- d. e-Consult
- e. Complex case management

### **Discussion**

CalOptima sought input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the relative priority of each potential use. In response to a request from both committees for a cost analysis of the CMS-approved uses, Manatt, an interdisciplinary policy and business advisory consultancy firm, was engaged to research and prepare the requested analyses within an accelerated timeframe. A copy of Manatt's analysis is attached.

The MAC and the PAC met twice and formed ad hoc groups to review Manatt's analysis and provide recommendations for use of the funds. Based on this input, staff developed a proposal that is presented in the attached presentation.

Prior to moving forward, staff will return to the Board for approval of a proposed implementation plan.

<b>Proposed Uses</b>	<b>Recommended Allocation</b>
Complex Case Management – Part 1 <ul style="list-style-type: none"><li>Case management for high-risk members across various care settings</li></ul>	Year 1: \$5.1M Year 2: \$4.2M
Complex Case Management – Part 2 <ul style="list-style-type: none"><li>Improved health network documentation of clinical needs</li></ul>	Year 1: \$1.8M Year 2: \$200K
Expanded Access Pilots <ul style="list-style-type: none"><li>Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points</li></ul>	Year 1: \$450K Year 2: \$650K
<b>Total Budget</b>	<b>\$12.4 M</b>

UCI has indicated interest in entering into an agreement for a second IGT for FY 2011-12. As proposed, CalOptima plans to begin working with UCI on the required process.

### **Fiscal Impact**

FY 2010-11 IGT funding provides \$12.4 million to improve the quality of care and cost effectiveness of CalOptima and its delegated network. Potential funds for FY 2011-12 are unknown at this time.

### **Rationale for Recommendation**

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

CalOptima Board Action Agenda Referral  
Approve Proposed Use of \$12.4 Million in FY 2010-11 IGT  
Funds; Authorize the CEO to Initiate Required Process for  
FY 2011-12 IGT Funds and Execute Required IGT Documents  
Page 3

**Concurrence**

Gary Crockett, Chief Counsel  
Michael Ewing, Chief Financial Officer

**Attachments**

FY 2010-11 IGT Recommendations Presentation  
Manatt Cost Analysis dated January 10, 2013

/s/ Michael Schrader  
**Authorized Signature**

3/1/2013  
**Date**



# CalOptima

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## Recommendations for FY 2010-11 Intergovernmental Transfer (IGT) Funds

**Board of Directors Meeting**

**March 7, 2013**

**Ilia Rolon, MPH  
Manager, Strategic Operations**

# Planning Process

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- Engaged Manatt Consulting to:
  - Estimate upfront costs, costs to sustain
  - Identify implementation barriers and opportunities
- Presented analysis to Provider Advisory Committee (PAC) and Member Advisory Committee (MAC) in January 2013
- C and MAC
  - Held ad hoc meetings in January to review analysis in more depth and receive staff input
  - Met in February to vote on priority of options and finalize recommendations to CalOptima Board
  - Consensus reached between PAC and MAC regarding top four priorities

# Options

Previous Name	New Name
Complex case management	•Complex case management
Open access scheduling	•Extended hours
Same day appointment availability	•Combined with above
Participation in medical homes	•Medical home infrastructure support
Specialist recruitment	•Specialist recruitment and retention
24/7 clinical call center	•Clinical call center
Minute clinics	•Alternative access points
Telemedicine	•Remote visits •Telemonitoring
E-Consults	•Specialty Care Consults

# Comparison of Recommendations

Priority	Provider Advisory Committee	Member Advisory Committee
1	<b>Complex Case Management</b>	<b>Complex Case Management</b>
2	<b>Specialty Care Access -- Planning &amp; Pilots</b>	<b>Extended Hours</b>
3	<b>Extended Hours Access</b>	<b>Alternative Access Points</b>
4	<b>Alternative Access Points – Planning and Pilots</b>	<b>Specialty Care Access – Planning &amp; Pilots</b>
5		Remote Visits
6		Medical Home Infrastructure Support
7		Telemonitoring

\* Bold type indicates consensus

# Staff Recommendations

Proposed Uses	Recommended Allocation
<b>Complex Case Management – Part 1</b> <ul style="list-style-type: none"> <li>Case management for high-risk members across various care settings</li> </ul>	Year 1: \$5.1M Year 2: \$4.2M
<b>Complex Case Management – Part 2</b> <ul style="list-style-type: none"> <li>Improved health network documentation of clinical risk</li> </ul>	Year 1: \$1.8M Year 2: \$200K
<b>Expanded Access Pilots</b> <ul style="list-style-type: none"> <li>Pilot selected strategies with documented ROI, such as e-consults, telemonitoring and alternative access points</li> </ul>	Year 1: \$450K Year 2: \$650K
<b>Total Budget</b>	<b>\$12.4 M</b>

# Complex Case Management – Part 1

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- Recommended Allocation: \$9.3 Million
- Description
  - Case management and care coordination services for high-need members across various provider settings (e.g., primary and specialty care, inpatient, skilled nursing)
  - A platform for IGT-funded services: Case Management team determines which other services the member needs
- Pricing Elements
  - Approximately 15 positions (HIT staff, RNs, data analysis, patient navigators)
  - New or enhanced technology for:
    - care coordination
    - clinical decision support
    - data repository
    - electronic health record (EHR) integration
    - predictive modeling

# Complex Case Management – Part 2

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- Recommended Allocation: \$2 Million
- Description
  - Improvement of Health Networks' ability to accurately document clinical need
- Pricing Elements
  - Gap analysis
  - Risk documentation software
  - Staffing for provider technical assistance and education

# Expanded Access Pilots

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- Proposed Allocation: \$1.1 Million
- Objectives
  - Reduction in visits to emergency departments
  - Decreased wait times for specialty care
  - Improved member satisfaction
- Potential Pilots
  - E-Consultation: Enables PCP to meet and share information with specialist via web connection and refer electronically for treatment, thus reducing need for specialty care
  - Incentivizing providers to see patients during evening and weekend hours
  - Developing alternative access points
  - Telemonitoring

# Next Steps

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- Approve Staff Recommendation for use of IGT funds
- Receive implementation plan in April / May 2013

**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

**Action To Be Taken June 6, 2013**  
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

VII. E. Approve Work Plan and Timeline for Implementation of FY 2010-11 Intergovernmental Transfer (IGT) Funds

**Contact**

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

**Recommended Action**

Approve work plan and timeline for proposed use of \$12.4 million of FY 2010-11 Intergovernmental Transfer (IGT) funds.

**Background**

On March 3, 2011, the CalOptima Board authorized staff to enter into agreements to secure an IGT with the Regents of the University of California/University of California, Irvine (UCI) for Fiscal Year (FY) 2010-11. CalOptima retained \$12.4 million through the IGT transaction.

Subsequent to receiving the funds in late August 2012, CalOptima sought input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the relative priority of each CMS-approved potential use. In response to a request from both committees for a cost analysis of the potential uses, Manatt, an interdisciplinary policy and business advisory consulting firm, was engaged to research and prepare the requested analyses. The MAC and the PAC reviewed Manatt's analysis and provided recommendations for use of the funds. Based on this input, staff developed a proposal for best use of the funds.

On March 7, 2013, the CalOptima Board approved three main uses of the funds to improve the quality of care and cost effectiveness of CalOptima and its delegated network, as shown in the table below. The approved uses are expected to generate the most positive impact on members, CalOptima and its delegated networks, while also providing a sustainable return on investment for the future.

<b>Approved Uses</b>	<b>Allocation</b>
Complex Case Management – Part 1 <ul style="list-style-type: none"><li>• Case management for high-risk members across various care settings</li></ul>	Year 1: \$5.1M Year 2: \$4.2M
Complex Case Management – Part 2 <ul style="list-style-type: none"><li>• Improved health network documentation of clinical needs</li></ul>	Year 1: \$1.8M Year 2: \$200K
Expanded Access Pilots <ul style="list-style-type: none"><li>• Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points</li></ul>	Year 1: \$450K Year 2: \$650K
<b>Total Budget</b>	<b>\$12.4 M</b>

### **Discussion**

The largest portion of FY 2010-11 IGT funds is allocated to the enhancement of complex case management services for high-risk members across various care settings. Per the medical literature, the success of such programs is highly dependent on who is targeted, the program's design, and how success is measured. To derive maximum benefit from its investment in disease and case management services, CalOptima will first seek to strengthen the existing infrastructure in the following two areas: 1) improvement of data integrity and completeness; and, 2) implementation of predictive modeling to further inform the enrollment of members in disease and complex case management programs. In Phase Two, staff will use improved data to design complex case management program enhancements and determine the optimal delegation arrangement for these services.

IGT funds were also earmarked for pilot projects that expand access to healthcare services, particularly for medically vulnerable members. In FY 2013-14, CalOptima will implement a pilot to enhance communication between primary and specialty care providers through electronic referrals and consultations. The goals of the pilot are to mitigate specialty care service capacity issues and increase the ease and efficiency with which members who need specialty care services are able to access those services.

A more detailed work plan and timeline is included in the attached presentation. Staff will provide quarterly reports on the implementation progress.

### **Fiscal Impact**

Implementation plan is consistent with previously approved IGT for FY 2010-11.

### **Rationale for Recommendation**

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

### **Concurrence**

Gary Crockett, Chief Counsel  
Michael Ewing, Chief Financial Officer

### **Attachment**

FY 2010-11 Intergovernmental Transfer (IGT) Implementation Plan

/s/ Michael Schrader  
**Authorized Signature**

5/31/2013  
**Date**



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# **FY 2010-11 Intergovernmental Transfer (IGT) Implementation Plan**

**Board of Directors Meeting  
June 6, 2013**

**Ilia Rolon, MPH  
Director, Strategic Development**

# Background

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## March 2013 Board Actions

- Approved use of IGT funds as follows:
  - Complex Case Management (CCM) 1: Case management for high-risk members across various care settings
    - Year 1: \$5.1M
    - Year 2: \$4.2M
  - CCM 2: Improved health network documentation of clinical risk
    - Year 1: \$1.8M
    - Year 2: \$200K
  - Pilot selected expanded access strategies such as e-consults, telemonitoring, and alternative access points
    - Year 1: \$450K
    - Year 2: \$650K
- Directed staff to return with implementation plan

# Key Planning Assumptions

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- Success of case and disease management programs is highly dependent on who is targeted, how program is designed and how success is measured\*
- Allocation of funding should be data-driven
  - Begin by strengthening CalOptima's ability to accurately identify patients that fall within targeted risk score range
- Resources should follow the critical mass of at-risk members

\* Source: "Complex Puzzle: How Payers are Managing Complex and Chronic Care," Issue Brief, California Healthcare Foundation, April 2013

# Work Plan and Timeline

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- **Strengthen complex case management infrastructure**

- Improve data integrity and completeness

- **Q3 2013** Assess current CalOptima data integrity; Issue RFP for vendor to provide technical assistance to health networks (HN) and providers for improved documentation of risk (CCM 1 & 2)
- **Q4 2013** Upon selection of vendor, enroll interested HNs and conduct assessments (CCM 2)
- **Q1 2014** Based on assessment results, identify opportunities for improvement and offer consultative assistance to HNs (CCM 2)
- **Q2 2014** Use improved data to design, implement CCM program enhancements and determine delegation arrangement (CCM1)

- Implement predictive modeling to further inform enrollment in complex case management programs (CCM 1)

- **Q2 2014** Issue RFP
- **Q3 2014** Select vendor and begin implementation and training
- **Q4 2014** Implement enhancements to member enrollment

# Work Plan and Timeline (Cont.)

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- **Enhance referral and consultation communication between primary and specialty care providers**
  - **Q3 2013** Assess current health information exchange capabilities (CalOptima web portal, OCPRHIO\*) and determine buy or build
  - **Q4 2013** Issue RFP for e-consult platform, if needed
  - **Q1 2014** Install components
  - **Q2 2014** Pilot with 1 health network and select CCN providers
  - **Q2-Q3 2014** Enroll other interested health networks and CCN providers

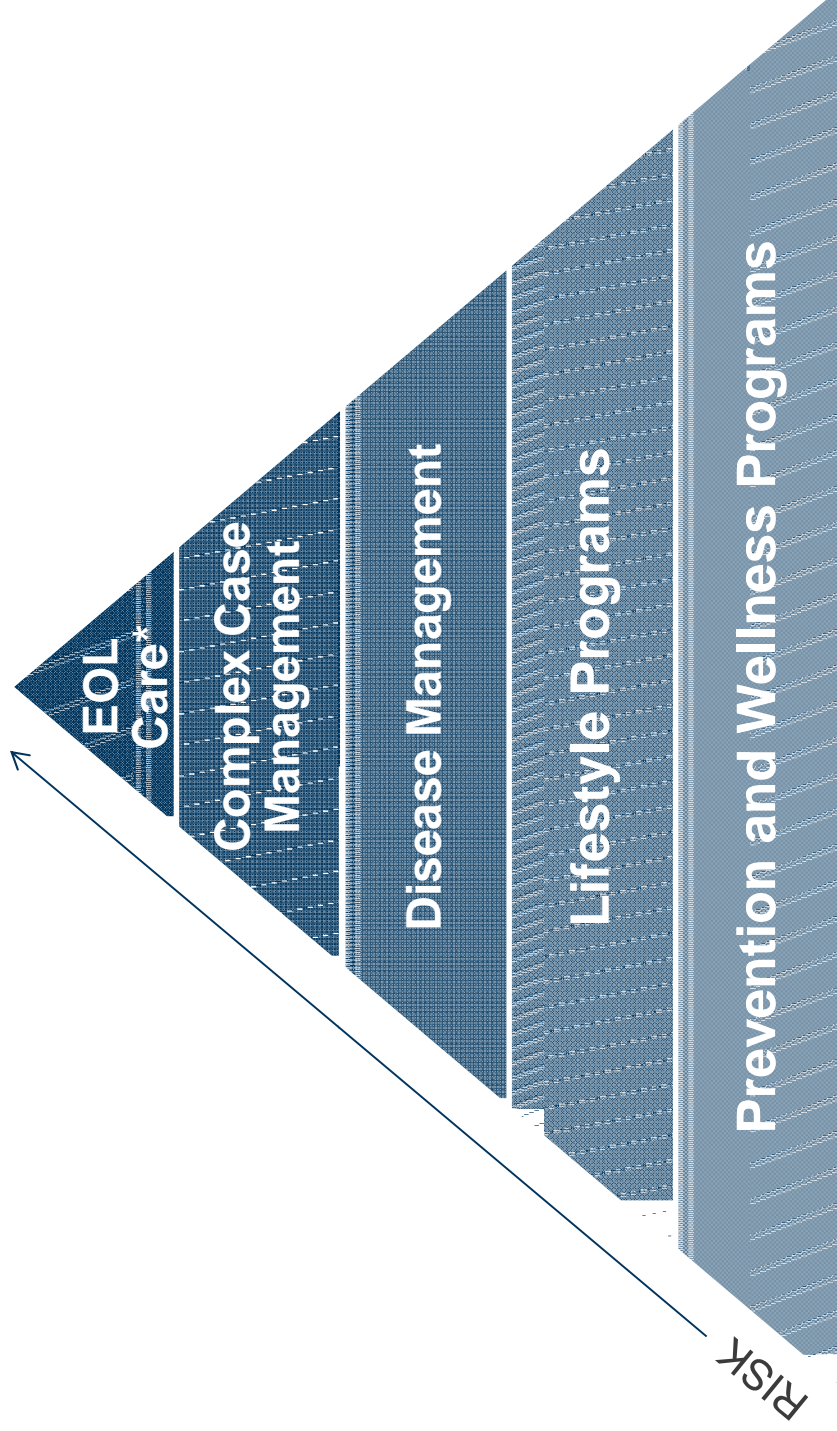
\* Orange County Partnership Regional Health Information Organization

# Appendix

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- Types of Care Management Programs
- California Healthcare Foundation Recommendations

# Types of Care Management Programs



\* End-of-life care (may be considered part of complex case management or may be separate program)

Source: Booz Allen Hamilton, 2012

# California Healthcare Foundation

## Recommendations

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- Use analytic tools to better identify the population that would most benefit from interventions
  - *Predictive modeling*: Statistical technique of analyzing data to predict which members may be at greater risk for high-cost care, esp. hospitalization
- Adjust program design to engage and activate the patient by experimenting with a wide range of tools
  - “Low-touch”: Tech solutions such as mobile apps, text messaging
  - “High-touch”: Coaching or case management
- Better integrate disease management and complex case management programs with the treating provider or PCP
  - Use contracting arrangements to better align financial incentives and outcome measurement
  - Test a range of provider engagement tools, such as health information exchanges (HIEs), provider portals and embedding of care managers

Source: “Complex Puzzle: How Payers are Managing Complex and Chronic Care,” Issue Brief, California Healthcare Foundation, April 2013



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# Intergovernmental Transfers (IGT)

**Board of Directors Meeting**  
**March 7 6, 2014**

**Ilia Rolon**  
**Director, Strategic Development**



**CalOptima**  
Better. Together.

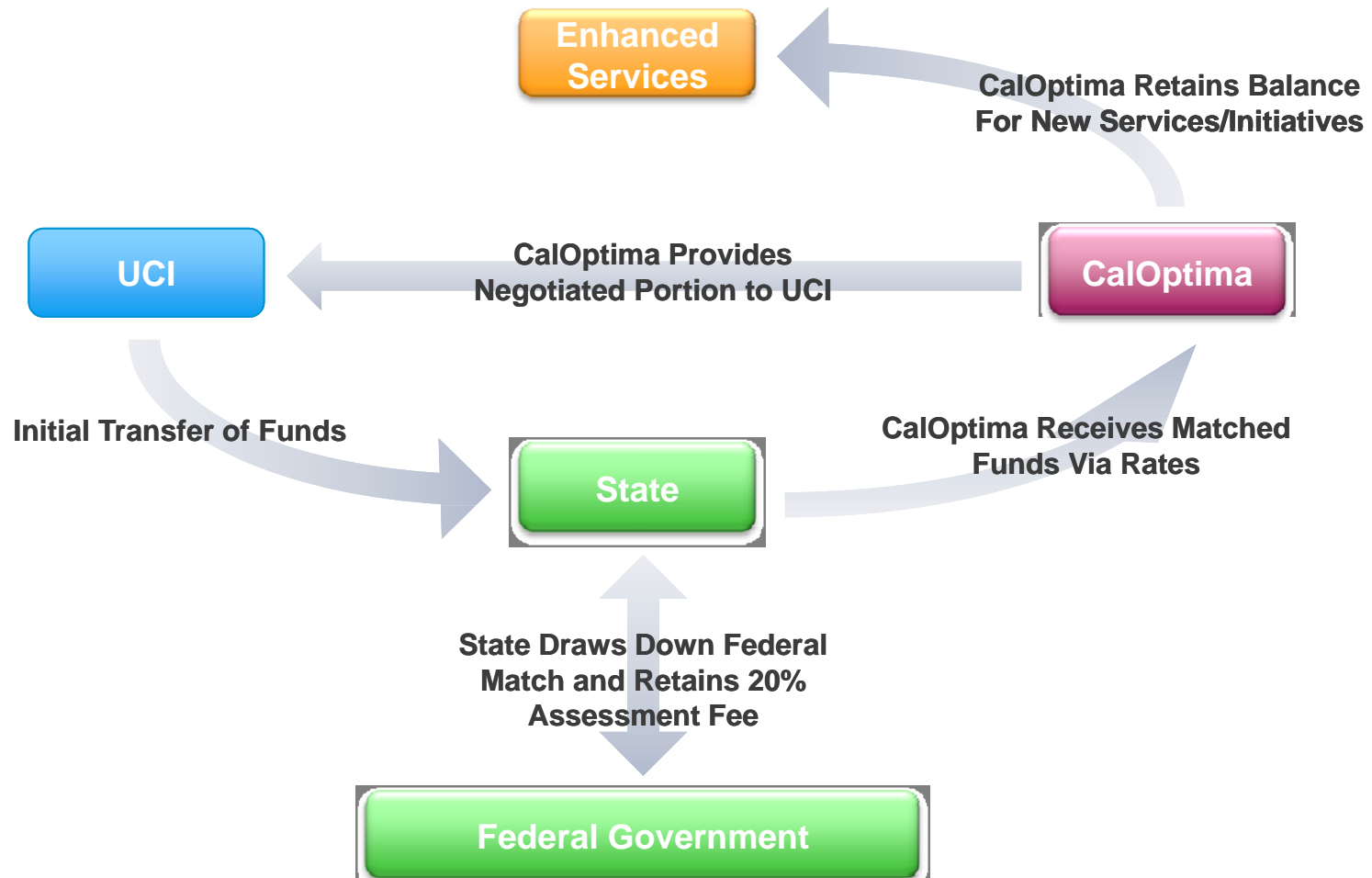
# Background

# About IGTs

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- Intergovernmental Transfers (IGTs) are transfers of public funds between governmental entities
- Extensive precedent of IGTs among managed care plans in California
- California managed care plans have historically saved state/federal governments millions in health care costs
  - Federal Medical Assistance Percentage (FMAP): Amount of federal match for states' expenditures on social, medical services
    - California: 50%
    - Mississippi: 73%
- IGTs are a means of leveling the field and ensuring continued investment in our healthcare systems

# IGT Transaction Overview



# Use of Funds

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- Revenue must be used to finance improvements in services for Medi-Cal beneficiaries
- No guarantee of future IGT agreements -- thus funds are best suited for one-time investments or as seed capital for new services or initiatives
- Budgeted uses for current IGTs are consistent with system improvements that will support successful response to OneCare audit
- Agreements are silent on deadline for use of funds

# IGTs Received to Date

Funding Source	Claim Year	Year Received	CalOptima Amount	UCI Amount	State Amount	Total
IGT 1	FY 10-11	2012	\$12.4 M	\$8.4 M*	\$3.1 M	\$23.9 M
IGT 2	FY 11-12	2013	\$7.4 M	\$4.8 M	\$5.4 M	\$17.6 M
Total Funds			\$19.8 M	\$13.2 M	\$8.5 M	\$41.5 M

- IGT 1 included a one-year community vetting process; proposed uses for IGTs 2 and 3 are consistent with results of this earlier process
- Status of IGT Year 1 expenditures: \$2 M contract award for new case management system; agreements with health networks for approximately \$2 M in funding for personal care coordinators pending

\* UCI's net revenue was \$3.4 Million due to exclusion from approximately \$5.0 million in state disproportionate share (DSH) payments



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# Proposal

# IGT 1 Expenditure Plan

Proposed Uses	Year 1	Year 2	Impacted Programs	Timing	Description
Complex Case Management I	\$5.1 M	\$4.2 M	—	—	
Personal Care Coordinators	\$1.85 M	\$1.95 M	CMC	CY 14	Additional PMPM line item payment to networks
Case Management System	\$2.0 M	\$0	All	CY 14	Replace existing case management system
Strategies to Reduce Readmission	\$1.0 M	\$2.0 M	MC, CMC OneCare	CY 14	Post-discharge follow up; transitions of care
Program for High-Risk Children	\$250 K	\$250 K	MC	FY 14/15	Services for children affected by both obesity and asthma
<b>Complex Case Management II</b>	<b>\$1.8 M</b>	<b>\$200,000</b>	<b>N/A</b>	<b>N/A</b>	<b>Merge this category with CCM 1</b>
Access Strategies	\$450,000	\$650,000	—	—	
e-Referral/ Telemedicine	TBD	TBD	All	CY 14	Dermatology project in development
Total Funds	\$7.35 M	\$5.05 M			

# Proposed IGT 2 Expenditure Plan

CMS and CalOptima Board Approved Categories	Proposed Allocation	
<b>Enhanced Core Systems</b> <ul style="list-style-type: none"> <li>• Facets system upgrade and reconfiguration</li> <li>• Provider network management solution</li> <li>• Security audit remediation</li> <li>• Funding to continue COREC services for two years</li> </ul>	<b>\$3.0 M</b>	
<b>Continued / Expanded IGT 1 Services</b> <ul style="list-style-type: none"> <li>• Personal care coordinators</li> <li>• Strategies to reduce hospital readmissions</li> </ul>	<b>\$3.0 M</b>	
<b>Wraparound Services &amp; Optional Benefits</b> <ul style="list-style-type: none"> <li>• To be developed further.</li> <li>• May include: school-based vision and dental services for children; recuperative care for homeless members discharged from hospital; and/or backfilling Medi-Cal cuts to payments and/or benefits.</li> </ul>	<b>\$1.4 M</b>	] 60% for direct services
<b>Total Funds</b>	<b>\$7.4 M</b>	

# Next Steps

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- Execute approved expenditure plan for IGT 1
- Begin implementation of IGT 2 funded activities
- Initiate process to explore feasibility of securing third IGT
- Periodic Board updates on progress

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken March 6, 2014** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

VI. C. Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

#### **Contact**

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

#### **Recommended Actions**

1. Approve final expenditure plan for \$12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds;
2. Approve expenditure plan for \$7.4 Million in FY 2011-12 IGT funds;
3. Authorize the CEO to initiate the required process for FY 2012-13 IGT and execute the required application documents consistent with Board approved terms.

#### **Background**

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date. The two transactions are summarized below:

- IGT 1 was authorized by the CalOptima Board on March 3, 2011, and covers the claiming period of Fiscal Year (FY) 2010-11. CalOptima retained \$12.4 Million, UCI retained \$8.4 Million, and the state disbursed the funds in August 2012.
- IGT 2 was authorized by the CalOptima Board on March 7, 2013 for the FY 2011-12 claiming period. CalOptima retained \$7.4 million, UCI retained \$4.8 Million, and the state disbursed the funds in June 2013.

IGTs are transfers of public funds between governmental entities. The revenue generated through the CalOptima /UCI IGTs must be used to finance improvements in services for Medi-Cal beneficiaries. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives for Medi-Cal beneficiaries.

The present item seeks: 1) authorization to adjust the expenditure plan for IGT 1 to reflect the final funding distribution needed to fully implement the approved uses; 2) approval of the proposed expenditure plan for IGT 2; and 3) authorization to initiate the process to secure a third IGT.

#### **Discussion**

##### *Final Expenditure Plan for IGT 1*

On March 7, 2013, the CalOptima Board approved the following expenditure plan for IGT 1:

<b>Table 1. Approved Expenditure Plan for IGT 1</b>	<b>Budget</b>
Complex Case Management – Part 1 <ul style="list-style-type: none"> <li>Case management for high-risk members across various care settings</li> </ul>	Year 1: \$5.1M Year 2: \$4.2M
Complex Case Management – Part 2 <ul style="list-style-type: none"> <li>Improved health network documentation of clinical needs</li> </ul>	Year 1: \$1.8M Year 2: \$200K
Expanded Access Pilots <ul style="list-style-type: none"> <li>Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points</li> </ul>	Year 1: \$450K Year 2: \$650K
<b>Total Budget</b>	<b>\$12.4 M</b>

As reported at the February 2014 CalOptima Board meeting, recent data analyses indicate that the need for improved health network documentation of clinical needs (i.e., Complex Case Management – Part 2 in the above table) is not consistent among the networks, and thus will not require the entire budgeted amount. At the same time, full implementation of the uses proposed under Complex Case Management – Part 1, including reimbursement of health networks for enhanced care coordination, requires more funding than originally budgeted. To allow for greater efficiency and ensure that funds are used most effectively, staff recommends merging the two Complex Case Management budget categories, as reflected in Table 2 below.

<b>Table 2. Final Expenditure Plan for IGT 1</b>	<b>Budget</b>
Complex Case Management <ul style="list-style-type: none"> <li>Case management for high-risk members across various care settings, including improved documentation of clinical risk</li> </ul>	Year 1: \$6.9M Year 2: \$4.4M
Expanded Access Pilots <ul style="list-style-type: none"> <li>Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points</li> </ul>	Year 1: \$450K Year 2: \$650K
<b>Total Budget</b>	<b>\$12.4 M</b>

*Proposed Expenditure Plan for IGT 2*

As previously stated, CalOptima retained \$7.4 million from the second IGT. Per the state's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must be used for any of three Board-approved general purposes:

1. Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care;
2. Continue and/or expand on services and initiatives developed with FY 2010-11 IGT funds; and/or
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health, preventive dental services and supplies, and incentives to encourage members to participate in preventive health programs.

Based on an analysis of current and emerging priorities, staff proposes the budget allocation plan presented in the attached presentation and summarized below:

<b>Table 3. Proposed Expenditure Plan for IGT 2</b>	<b>Budget</b>
Enhancement of Core Data Systems	\$3.0 M
Continuation/Expansion of IGT 1 Initiatives	\$3.0 M
Wraparound Services/Optional Benefits to Address Critical Gaps	\$1.4 M
<b>Total Budget</b>	<b>\$7.4 M</b>

#### *Proposed FY 2012-13 IGT*

UCI has notified CalOptima of its interest to secure a third IGT for FY 2012-13. The Department of Health Care Services (DHCS) is in the process of calculating the amount of funds that would be available for this transaction. Authorization is requested to begin working with UCI to determine feasibility of securing a third IGT under the same general terms as the prior two IGTs, and to initiate the process. If IGT 3 is secured, funds will be applied to uses consistent with the categories outlined in Table 3 above.

#### **Fiscal Impact**

The recommended action is to be funded from DHCS capitation receipts which are currently reserved. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. It should be noted that the proposed expenditures under IGTs 1 and 2 are aligned with many of the system improvements required in response to the recent CMS audit.

#### **Rationale for Recommendation**

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

CalOptima Board Action Agenda Referral  
Approve Final Expenditure Plan for Use of FY 2010-11 IGT  
Funds; Approve Expenditure Plan for Use of FY 2011-12 IGT  
Funds; Authorize the CEO to Initiate Required Process for  
FY 2012-13 IGT Funds and Execute the Standard Required  
Application Documents  
Page 4

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

2/28/2014  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken September 4, 2014** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

VII. B. Authorize and Direct the Chairman of the Board of Directors to Enter into the Necessary Agreements with the University of California at Irvine (UCI) and the California Department of Health Care Services (DHCS) to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2012-13, Including Approval of Proposed Funding Categories; Recommend Board of Directors Approval of an Updated Expenditure Plan for FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of \$900,000 of IGT 2 Funds and Authorize Procurement Process for School-Based Vision and Dental Wraparound Services

#### **Contact**

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

#### **Recommended Actions**

1. Authorize the Chairman of the Board of Directors to execute an amendment to the primary agreements among DHCS, UCI, and CalOptima for the upcoming FY 2012-13 IGT (IGT 3), including approval of proposed general use categories;
2. Approve final IGT 2 budget of \$8.7 million and allocate the additional \$1.3 Million to children's health and/or safety net services; and
3. Consider proposal for school-based vision and dental wraparound services for children enrolled in Medi-Cal, in amounts not to exceed \$500,000 for vision services and \$400,000 for dental services.

#### **Background**

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date, with a third IGT pending for FY 2012-13.

Presently staff recommends two actions related to the pending IGT 3 transaction, and two pertaining to FY IGT 2 revenue. Approval of these recommendations is requested in order to implement programmatic priorities.

#### **Discussion**

##### *IGT 3 Application*

On June 20, 2014, CalOptima and UCI submitted a proposal to DHCS for a third IGT. If approved, the proposed IGT will result in revenue of approximately \$4.8 million each to UCI and CalOptima. Our understanding is that DHCS anticipates disbursement of an IGT payment to CalOptima in September 2014. At this time, staff requests authorization to amend the primary agreement between the DHCS and CalOptima for purposes of accepting an increased rate that includes IGT 3 funding. Additionally, consistent with the proposal to DHCS submitted in June 2014, staff requests approval of four general categories of uses for IGT 3 revenue as follows:

1. Services related to care coordination and case management for CalOptima members;
2. Expansion of optional benefits for CalOptima members potentially including but not limited to vision, dental, and prevention and treatment of chronic disease;

CalOptima Board Action Agenda Referral  
Authorize and Direct the Chairman of the Board of Directors to  
Enter into the Necessary Agreements with UCI and the DHCS to  
Secure Additional Medi-Cal Funds Through an IGT for FY 2012-13,  
Including Approval of Proposed Funding Categories; Recommend  
Board of Directors Approval of an Updated Expenditure Plan for  
FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of \$900,000 of  
IGT 2 Funds and Authorize Procurement Process for School-Based  
Vision and Dental Wraparound Services  
Page 2

3. Innovation and enhancement of the health care delivery model;
4. Continuing improvements to information services infrastructure and applications to enhance services to CalOptima members.

A budget allocation for the proposed categories will be presented at a future Board meeting after the transaction has received federal approval and funds have been received from the state.

#### *Additional IGT 2 Revenue*

The current Board approved budget for IGT 2 is based on an original revenue estimate of \$7.4 million, while actual revenue received was \$8.7 million. Based upon discussion and direction provided at the August 27, 2014, Quality Assurance Committee, staff recommends allocating the additional \$1.3 million for children's health and/or support of the safety net. For children's health services, priority could be given to addressing pediatric obesity and expanding access to children's health services. Safety net support could include, but not limited to, assisting safety net provider in their sustainability efforts.

Staff will present a proposed plan and recommendations for the additional funding allocation for Board consideration at a future meeting.

#### *Plan for Wraparound Services*

As discussed above, the Board-approved IGT 2 budget includes an allocation of \$1.4 million for wraparound services and optional benefits for CalOptima members. The intent of these funds is to help address recognized gaps in services, as well as barriers to accessing preventive care and treatment.

The Board previously identified children's dental and vision services as priorities for this category of IGT funding, given the historically low utilization of these services. For example, only 54% of the nearly 190,000 Orange County children enrolled in Denti-Cal, which is administered directly by the state on a fee for service basis, had a dental visit in the previous year.<sup>1</sup> Similarly, only 52% of CalOptima's population under 19 years of age received a vision screening through a CalOptima provider in 2011. Lack of transportation; language barriers; inconvenient office hours; difficulty locating a provider that accepts Denti-Cal or Medi-Cal/Vision Services Plan (VSP); and parental beliefs regarding the timing of the first dental visit or vision screening are some reasons for the low utilization rates.

To help inform a funding plan to begin addressing these gaps, staff consulted with Kids Vision for Life, a non-profit dedicated to prevention of vision problems in children; Dr. Marc Lerner, Medical Officer, Center for Healthy Kids and Schools, Orange County Department of Education; and the

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<sup>1</sup> "Why kids in Denti-Cal are feeling the pain," Children Now, 2013.

CalOptima Board Action Agenda Referral  
Authorize and Direct the Chairman of the Board of Directors to  
Enter into the Necessary Agreements with UCI and the DHCS to  
Secure Additional Medi-Cal Funds Through an IGT for FY 2012-13,  
Including Approval of Proposed Funding Categories; Recommend  
Board of Directors Approval of an Updated Expenditure Plan for  
FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of \$900,000 of  
IGT 2 Funds and Authorize Procurement Process for School-Based  
Vision and Dental Wraparound Services  
Page 3

Children and Families Commission of Orange County, all of which have extensive expertise in these subjects, as well as deep knowledge regarding service gaps and access barriers affecting Orange County children.

At this time, staff recommends the Board consider expenditure of \$900,000 for school-based children's dental and vision services, in amounts not to exceed \$500,000 for vision services and \$400,000 for dental. If approved, the recommended action will be accomplished in accordance with approved CalOptima Procurement Policy. Conditions for selection will include previous experience providing services at Orange County schools in high-need areas, as well as willingness to partner and coordinate with other providers for co-deployment of vision and dental services.

#### Children's Vision Services – \$500,000

- Conduct school-based vision screening and assessment and supply eyeglasses to children with vision problems as medically recommended, with priority given to schools with the highest concentration of Medi-Cal eligible pupils;
- Provide referrals to local vision care providers and conduct follow-up to encourage families to connect with these providers for their children's ongoing vision care.

#### Children's Dental Services – \$400,000

- Conduct school-based dental screening, education and preventive care, with priority given to schools with the highest concentration of Medi-Cal eligible pupils;
- Provide referrals to local dentists and conduct follow-up to encourage families to connect with these providers for their children's ongoing dental care.

If approved, staff anticipates selection of service providers, and inception of services, during the current (2014-15) school year. Moreover, staff will work with the selected vision and dental health partners to monitor and evaluate outcomes, and evaluation reports will be submitted to the Board's Quality Assurance Committee (QAC) for review. Upon completion of both programs, proof of concept data will be submitted to the Department of Health Care Services for its consideration of future reimbursement to providers of school-based vision and dental care.

As a separate but complementary effort, staff is also exploring opportunities to pilot incentives for pediatric primary care providers to provide basic oral health education and make timely referrals for dental care.

Another wraparound service being explored is pediatric obesity prevention and treatment. FY 2010-11 (IGT 1) funds were set aside for this purpose by prior Board action. However, given the complexity of this health issue and the dearth of effective models, staff brought this topic to the August meeting of the Board's QAC for discussion and direction. Dr. Candice Taylor Lucas, a noted expert on pediatric

CalOptima Board Action Agenda Referral  
Authorize and Direct the Chairman of the Board of Directors to  
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Vision and Dental Wraparound Services  
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obesity, provided guidelines and recommendations to the QAC. Based on input from this group, staff anticipates presenting funding recommendations for the Board's consideration in October.

#### *Quality Assurance Committee Action*

At its August meeting, the Board's Quality Assurance Committee approved the recommended Board of Directors approval of requested actions, but did not take action on proposed school-based services due to lack of consensus regarding whether schools are the most effective platform for children's vision and dental services, and whether IGT funds should be expended on these services.

#### **Fiscal Impact**

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

#### **Rationale for Recommendations**

The final budget for IGT 2 incorporates additional funds received in a manner consistent with prior Board actions. Funding for vision and dental wraparound service was approved by prior Board action and will provide enhanced services to current CalOptima members not available through current covered benefits, a key requirement for the use of IGT funds. Proposed funding categories for IGT 3 allow for continued support of key organizational priorities and programs.

#### **Concurrence**

Gary Crockett, Chief Counsel

#### **Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

8/29/2014  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken October 2, 2014** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

VII. E. Approve Grant Awards to Designated Organizations in Support of New and Prospective Federally Qualified Health Centers (FQHCs)

#### **Contact**

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

#### **Recommended Actions**

Approve grant awards in the aggregate amount of up to \$200,000 to designated community health centers to support new and prospective Federally Qualified Health Centers (FQHCs) in Orange County, to be funded with Intergovernmental Transfer (IGT) 2 funds.

#### **Background**

Through recent discussions with representatives of Orange County's community health centers, CalOptima learned that several health centers have an urgent need for specialized technical assistance to ensure successful attainment of, and transition to, Federally Qualified Health Center (FQHC) designation. FQHCs are vital to Orange County's safety net because they provide comprehensive healthcare for low-income residents, including a significant number of current and future CalOptima Medi-Cal members. There are currently 10 FQHCs in the county, and collectively they operate 26 sites.

To qualify for FQHC designation, clinics must be located in or serve a community that has been designated a Medically Underserved Area or Population by the federal government; be governed by a community board; provide comprehensive primary health care; and provide services to all, with fees adjusted based on ability to pay. Prospective FQHCs often begin by applying to become a Non-grant-supported Health Center, more commonly known as an FQHC "look-alike." This interim designation confers many of the same benefits as full FQHC status, with the exception of the annual \$650,000 grant that full FQHCs receive from the Health Resources and Services Administration (HRSA) to offset the cost of uncompensated care. Additional benefits of FQHC status are listed in the attachment to this item.

According to the Coalition of Orange County Community Health Centers, there are currently two look-alikes in the county; both are preparing to submit an application for full designation by the October 7<sup>th</sup> federal deadline. Existing FQHCs are also required to submit an application in order to expand to new sites; three Orange County FQHCs plan to apply for a New Access Points grant in October, with new sites planned for Tustin, Santa Ana and Lake Forest.

Prospective FQHCs, and those that wish to expand, must submit a successful application to HRSA's Bureau of Primary Health Care. There is typically no more than one application cycle per year. During the rigorous federal application process, prospective FQHCs often need specialized technical assistance to prepare the required application, and to conduct thorough financial analysis and planning to avoid adverse fiscal impact during the implementation period. In addition, newly-designated FQHCs derive long-term benefit from technical assistance with state and federal rate setting negotiations,

which help ensure a sustainable business model. Centers also need infrastructure support, such as information technology consultation and capital support, to meet more stringent federal guidelines.

### **Discussion**

Five (5) Orange County health centers are preparing to submit applications by the next federal deadline of October 7, 2014. Clinics will be notified of the application outcome no later than June 30, 2015, and most likely in the Spring. A total of eight (8) grant recipients are proposed. Of those, six (6) are prospective FQHCs, applicants for new access points, or “look-alikes” upgrading to full FQHC status, as follows:

1. VNCOC Southland Health Center: FQHC “look-alike” applying for full designation;
2. North Orange County Regional Health Foundation: “look-alike” applying for full designation;
3. Camino Health Center: Full FQHC applying for a new access point in Lake Forest;
4. Friends of Family Health Center: Full FQHC applying for a new access point in Tustin;
5. Share Our Selves (SOS): Full FQHC applying for a new access point in Santa Ana; and
6. La Amistad / Puente a la Salud: New applicant.

In addition, two other clinics that received FQHC designation in 2013, Nhan Hoa Comprehensive Health Care Clinic and Serve the People, are scheduled for HRSA site visits in late 2014, which they must pass in order to successfully complete the federal designation process.

At this time, staff recommends a grant to up to eight (8) community health centers for an individual allocation not to exceed \$30,000 per organization and a total aggregate amount not to exceed \$200,000. In approving the staff recommendation, the Board would be making a finding that the proposed expenditures are in the public good and consistent with CalOptima’s statutory purpose. The proposed grants are to be used to assist new and prospective FQHCs with consulting costs, such as for rate negotiations and HRSA site visit preparation, but shall not be used for centers’ administrative costs or staff time. The proposed grants are expected to lead to enhancements to the safety net and its ability to serve the Orange County Medi-Cal population. In addition, terms of the funding agreements will require a detailed scope of services and prior approval of all contracts and subcontractors utilized for the specialized technical assistance.

CalOptima is committed to working with community health centers to explore additional opportunities to support the safety net during this period of rapid change and increased demand in the healthcare sector, and will return to the Board with recommendations at a future meeting.

### **Fiscal Impact**

The recommended action is consistent with the Board’s previously approved IGT 2 allocation of \$1.3 million for children’s health or support of the safety net. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

### **Rationale for Recommendation**

FQHCs are vital to Orange County’s safety net; the proposed support for new and prospective FQHCs has the potential to enhance access to comprehensive health services for current CalOptima Medi-Cal members.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

Benefits of FQHC Status

/s/ Michael Schrader  
**Authorized Signature**

9/26/2014  
**Date**

## **Benefits of Federally Qualified Health Center (FQHC) Designation**

- Section 330 grant funds to offset the costs of uncompensated care and other key enabling services (Health Center Program grantees receive these grant funds. Look-alikes are eligible to compete for them.)
- Access to medical malpractice coverage under Federal Tort Claims Act (FTCA) (Look-alikes are not eligible for this benefit.)
- Prospective Payment System reimbursement for services to Medicaid patients
- Cost-based reimbursement for services to Medicare patients
- PHS Drug Pricing Discounts for pharmaceutical products under the 340B Program  
Federal loan guarantees for capital improvements (Look-alikes are not eligible for this benefit.)
- Access to on-site eligibility workers to provide Medicaid and Child Health Insurance Program (CHIP) enrollment services
- Reimbursement by Medicare for “first dollar” of services because deductible is waived if FQHC is providing services
- Access to Vaccines for Children Program for uninsured children
- The National Health Service Corps (NHSC) can help health centers, look-alikes, and free clinics recruit and retain qualified providers who care about communities in need and choose to work where they are needed most.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration. *Primary Care: The Health Center Program: Program Benefits*. Downloaded from <http://bphc.hrsa.gov/about/benefits/>.

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken December 4, 2014** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

VII. C. Authorize Grant Awards in Support of Prospective Federally Qualified Health Centers (FQHCs) and Funding for Expert Consultation to Manage and Ensure Satisfactory Progress on Clinic Grants

#### **Contact**

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

#### **Recommended Actions**

1. Authorize grant awards in the aggregate amount of up to \$200,000 to eligible community health centers for Phase 2 of the Safety Net Program to support prospective Federally Qualified Health Centers (FQHCs) in Orange County, to be funded with Intergovernmental Transfer (IGT) 2 funds; and
2. Approve \$25,000 for an expert consultant to monitor grant recipients' performance and assess progress toward FQHC designation, to be funded with Intergovernmental Transfer (IGT) 2 funds.

#### **Background**

In October 2014, the CalOptima Board of Directors approved grant awards for specified new and prospective community health centers to address clinics' need for specialized technical assistance to attain, or transition to, Federally Qualified Health Center (FQHC) designation. A total of \$200,000 in FY 2012-13 Intergovernmental Transfer (IGT 2) funds was approved for eight (8) centers for Phase I of this initiative.

For Phase 2 of CalOptima's safety net support initiative, staff proposes grant awards for clinics that are interested in applying for FQHC designation, but were not ready for the 2014 cycle and would benefit from funding support to assist with costs related to feasibility analysis; FQHC application development; and/or capital improvements to meet more stringent federal requirements (such as implementation of an electronic health record system or improvements to clinics' waiting rooms).

FQHCs are vital to Orange County's safety net because they provide comprehensive healthcare for low-income residents, including a significant number of current and future CalOptima members. There are currently 10 FQHCs in the county, and collectively they operate 26 sites. To qualify for FQHC designation, clinics must be located in or serve a community that has been designated a Medically Underserved Area or Population by the federal government; be governed by a community board; provide comprehensive primary health care; and provide services to all, with fees adjusted based on ability to pay.

Prospective FQHCs must submit a successful application to HRSA's Bureau of Primary Health Care. There is typically no more than one application cycle per year. During the rigorous federal application process, prospective FQHCs often need specialized technical assistance to prepare the required application, and to conduct thorough financial analysis and planning to avoid adverse fiscal

impact during the implementation period. Centers also need infrastructure support, such as information technology consultation and capital support, to meet more stringent federal guidelines.

### **Discussion**

Based on discussions with the Coalition of Orange County Community Health Centers, it is understood that at least three (3) Orange County health centers are interested in pursuing FQHC designation. Hence, for Phase 2 of CalOptima's safety net support initiative, staff recommends grant awards for up to four (4) community health centers for an individual allocation not to exceed \$50,000 per organization, and a total aggregate amount not to exceed \$200,000.

At this time, Sierra Health Center, Korean Community Services and Laguna Beach Clinic would be eligible for Phase 2 support. The final selection of health centers would be based upon a staff assessment of readiness and a commitment by the health center to undertake the necessary process for the grant award. However, community health centers currently included in Phase 1 would not be eligible for Phase 2 support.

The proposed grants are to be used to assist prospective FQHCs with consulting costs, such as for feasibility assessment and financial analysis, work plan development, and formulation of HRSA application, or for infrastructure or capital improvements that may be needed for readiness to submit a HRSA application. Funds shall not be used for general operating support. A key early deliverable for these grants will be a clinic self-assessment and written plan for moving toward FQHC designation. The proposed grants are expected to lead to enhancements to the safety net and its ability to serve the Orange County Medi-Cal population.

Staff also recommends that an additional \$25,000 of IGT 2 funds be set aside for a consultant with expertise in FQHCs to assist CalOptima in monitoring grant recipients' performance toward grant objectives; assessing grantees' progress toward attainment of FQHC designation; and making recommendations for any needed future support to prospective FQHCs. Qualified consultants are currently conducting the work required for Phase I of the Safety Net FQHC support and staff would procure needed services from one or more of the current vendors consistent with CalOptima procurement policy.

In approving the staff recommendations, the Board would be making a finding that the proposed expenditures are in the public interest and consistent with CalOptima's statutory purpose.

### **Fiscal Impact**

The recommended action is consistent with the Board's previously approved IGT 2 allocation of \$1.3 million for children's health or support of the safety net. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations or expenditures.

**Rationale for Recommendation**

FQHCs are vital to Orange County's safety net; the proposed support for prospective FQHCs has the potential to enhance access to comprehensive health services for current CalOptima Medi-Cal members.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
Authorized Signature

11/26/2014  
Date

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken December 4, 2014** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

#### **Contact**

Javier Sanchez, Chief Network Officer, (714) 246-8400

#### **Recommended Actions**

1. Authorize expenditures of up to \$500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised  
12/4/14

#### **Background**

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

#### **Discussion**

Staff requests authority by the Board of Directors to allocate up to \$500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the \$500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

#### **Fiscal Impact**

A total of up to \$500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of \$150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

#### **Rationale for Recommendation**

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

#### **Concurrence**

Gary Crockett, Chief Counsel

CalOptima Board Action Agenda Referral  
Authorize Expenditure of IGT Funds for Post Acute  
Inpatient Hospital Recuperative Care for Members Enrolled in  
CalOptima Medi-Cal; Authorize Amendments to CalOptima  
Medi-Cal Hospital Contracts as Required for Implementation  
Page 3

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

11/26/2014  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2015** **Regular Meeting of the CalOptima Board of Directors**

#### **Consent Calendar**

VII. G. Authorize Reallocation of OneCare Personal Care Coordinator (PCC) Funding to Cover the Cost of the Program

#### **Contact**

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

#### **Recommended Action**

Authorize the reallocation of OneCare PCC funds from Year 2 to Year 1 in order to compensate delegated OneCare Physician Medical Groups (PMGs) for the month of March 2015.

#### **Background**

At its March 6, 2014, meeting, the CalOptima Board of Directors (Board) approved the final expenditure plan for \$12.4 million in Fiscal Year (FY) 2010-11 Intergovernmental Transfer (IGT) funds. The expenditure plan included an initiative, Complex Case Management – Part 1, to provide case management for high-risk members across various care setting. As part of this initiative CalOptima and PMGs would hire PCCs for up to two (2) years. Within the PMG, PCCs would serve as a single point of contact for OneCare members and assist members in navigating the healthcare delivery system, facilitating access to care and services.

On April 3, 2014, the Board authorized the CEO, with the assistance of legal counsel, to execute OneCare PMG contract amendments to provide funding to PMGs to hire and retain PCCs. The Board authorized the expenditure of FY 2010-11 IGT funds over a two-year period, with a total of up to \$1.85 million expended in Year 1, and up to \$1.95 million expended in Year 2 as authorized by the Board in March 2014.

#### **Discussion**

The Board authorized \$1.85 million to fund PCCs in Year 1. However, due to a higher than expected retention of membership in OneCare, the funding allocation was depleted when the February 2015 PCC capitation payment was made to contracted OneCare PMGs.

Management requests that the Board approve a budget reallocation of approximately \$200,000 from the \$1.95 million budget allocation in Year 2 to make the March 2015 PCC capitation payment. Staff estimates that the remaining funding for the PCC program in Year 2, which was authorized through March 31, 2016, will be sufficient since OneCare members will transition to OneCare Connect in December 2015.

#### **Fiscal Impact**

The recommended action will reallocate \$200,000 in FY 2010-11 IGT funds from Year 2 to Year 1, and is consistent with the expenditure plan previously approved by the Board on March 6, 2014. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

**Rationale for Recommendation**

CalOptima staff recommends this action in support the OneCare PCC program, which is an integral component of the enhanced Model of Care that has been developed for the OneCare Program and expands our ability to apply best practices in care coordination for CalOptima's Medicare members.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

3/27/2015  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2015** **Regular Meeting of the CalOptima Board of Directors**

#### **Consent Calendar**

VII. H. Approve the Allocation of Intergovernmental Transfer (IGT) Funds for Personal Care Coordinators (PCC) for the OneCare Connect (OCC) Program Including for OCC Members in the CalOptima Community Network

#### **Contact**

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

#### **Recommended Actions**

1. Approve \$3.6 million in Fiscal Year (FY) 2010-11 IGT funds for Complex Case Management for PCCs in the OneCare Connect Program, including for OCC members in the CalOptima Community Network:
  - a. Allocate \$1.15 million from ‘PCC supplemental’;
  - b. Allocate \$500,000 from ‘General Contingency’; and
  - c. Reallocate \$1.95 million from “Strategies to Reduce Readmissions.”
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to execute OneCare Connect Health Network contracts that include funding to hire, train and retain PCCs for the period of July 1, 2015, through June 30, 2016.
3. Authorize CalOptima staff to hire, train and retain PCCs to support OneCare Connect members in the CalOptima Community Network during the July 1, 2015 through June 30, 2016 period.

#### **Background**

In actions taken at the January 3, 2013, February 7, 2013, and December 5, 2013, meetings, the CalOptima Board of Directors (Board) authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, also now known in the state as the Cal MediConnect Program and branded by CalOptima as OneCare Connect.

At its March 6, 2014, meeting, the Board authorized the expenditure of IGT funds to support the hiring of PCCs by both CalOptima and Physician Medical Groups (PMGs) for up to two (2) years to provide services to OneCare members. Within the PMG, PCCs would serve as a single point of contact for OneCare members and help members navigate the healthcare delivery system, facilitating access to care and services.

Subsequently, at the April 3, 2014, meeting, the Board authorized the CEO, with the assistance of legal counsel, to execute amendments to OneCare PMG contracts to include funding for hiring, training, and retention of PCCs. The Board approved funding for the PCCs at a rate of \$14.53 per member per month (PMPM). PCC payments rates are further adjusted according to performance metrics established by CalOptima and described in a CalOptima PCC Policy and Procedure.

### **Discussion**

The Board has authorized the use of up to \$3.8 million in FY 2010-11 IGT funds over a two-year period to hire PCCs to support the execution of the OneCare Model of Care by delegated PMGs. The creation of the position proved to be an integral part of the remediation of the OneCare audit findings. CMS found CalOptima's PCC Program to be a best practice among Medicare Advantage plans. The PCC program launch has exceeded expectations, and is an integral feature of the approved Model of Care for OneCare Connect, and is no longer an optional component.

Management recommends the Board to approve this action to effectuate the implementation of the successful PCC program for the Cal MediConnect Program, which CalOptima has branded as OneCare Connect. CalOptima would require OneCare Connect contracted Health Networks to hire and retain PCCs. The OneCare Connect contracts will stipulate the conditions for the funding of the PCC positions and will provide the parameters and expectations of the PCC program. Management is requesting \$3.6 million in total FY 2010-11 IGT funds for PCCs for OneCare Connect Program from the following:

- Allocate \$1.15 million from 'PCC supplemental';
- Allocate \$500,000 from 'General Contingency'; and
- Reallocate \$1.95 million from "Strategies to Reduce Readmissions."

Management requests funding the program with IGT funds for FY 2015-16, with additional funding subject to future Board approval and IGT fund availability. Funds will be used for the creation of the PCC position by the delegated health networks and the CalOptima Community Network in order to execute the OneCare Model of Care for OneCare Connect and provide ongoing funding of the PCC positions for the next year of the OneCare Connect program. After this time, CalOptima will evaluate if these positions will be self-funding following the first year based upon improved clinical outcomes and lower utilization costs. In addition, the PCCs will support preventive and chronic disease services that results in improvement in HEDIS scores and an anticipated improvement in OneCare Connect's quality rating. Finally, PCCs will improve data capture that support appropriate Hierarchical Condition Category (HCC) scores for OneCare Connect.

The PCC positions hired by CalOptima to serve OneCare Connect members in the CalOptima Community Network will be funded in the same manner as CalOptima's delegated Health Networks.

### **Fiscal Impact**

The recommended action will result in the expenditure of IGT funds in FY 2015-16 of \$3.6 million in FY 2010-11 IGT funds. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations.

### **Rationale for Recommendation**

CalOptima staff recommends this action in support of the expenditure of IGT funds as approved at the March 2014 Board Meeting. In addition, the PCCs are an integral component of the enhanced Model of Care that has been a successful program in OneCare and will an important component of the OneCare Connect Program that will expand CalOptima's ability to apply best practices in care coordination for CalOptima's members eligible for Medi-Cal and Medicare.

CalOptima Board Action Agenda Referral  
Approve the Allocation of IGT Funds for PCC for the  
OCC Program Including for OCC Members in the  
CalOptima Community Network  
Page 3

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

3/27/2015  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken May 7, 2015**

### **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

- VIII. B. Authorize Agreements Necessary to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2013-14 (IGT 4); Consider Approval of a Modification of Eligible Use for IGT 2 Funds Allocated to Support Federally Qualified Health Centers (FQHCs)

#### **Contact**

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

#### **Recommended Actions**

1. Authorize and direct the Board Chair to execute an amendment to the primary agreements among the California Department of Health Care Services (DHCS), the Regents of the University of California on behalf of the University of California, Irvine, and CalOptima for the purpose of securing an IGT for the upcoming Rate Year 2013-14 IGT (IGT 4); and
2. Approve modification in eligible uses for IGT 2 funds designated to support Federally Qualified Health Centers in Orange County.

#### **Background**

CalOptima began participating in the rate range IGT program for its rate year that began July 1, 2010. This IGT arrangement involves an approved government entity (“funding entity”) providing non-federal funds to serve as a match to allow the State to draw down the difference between the highest and lowest actuarially approved Medi-Cal reimbursement rate from the Center for Medicare and Medicaid Services (CMS). Management’s understanding is that rate range IGTs are currently in place in all managed care counties in California. Eligible funding entities include but are not limited to county governments, district hospitals, and UC hospitals. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives, which enhance care to Medi-Cal members.

CalOptima has partnered with the Regents of the University of California on behalf of UCI to secure three IGTs to date, and staff has started the process for a fourth proposed IGT for Rate Year 2013-14. This IGT arrangement involves UCI providing the non-federal funds for the rate increase to CalOptima and the administrative fee charged by DHCS. A high-level progress update for each of these IGTs is attached.

The CalOptima Board approves all proposed uses and authorizes the plan to participate in each available IGT. Per the State’s agreement with the Centers for Medicare and Medi-Cal (CMS), funds must finance improvements in services for Medi-Cal members. The approved uses are intended to generate a positive impact on members, CalOptima and its delegated networks, while also providing a sustainable return on investment for the future.

Presently, staff recommends one action related to the proposed IGT 4 transaction and one modification to a program funded by IGT 2 revenue. Approval of these recommendations is requested in order to implement programmatic priorities.

IGT	Rate Year	IGT Funds Received by CalOptima (\$)
IGT 1	2010-2011	12.4M
IGT 2	2011-2012	8.7M
IGT 3	2012-2013	4.8M
IGT 4	2013-2014	5.5M (projected)

## **Discussion**

### **IGT 4 Application**

On April 24, 2015, CalOptima and UCI submitted a proposal to DHCS for a fourth IGT. If approved, the proposed IGT will result in revenue of approximately \$5.5 million each to UCI and CalOptima. Our understanding is that DHCS anticipates disbursement of an IGT payment to CalOptima in or about September 2015. At this time, staff requests authorization to amend the primary agreement between the DHCS and CalOptima for purposes of accepting an increased rate that includes IGT 4 funding. Additionally, consistent with the proposal to DHCS submitted in April 2015, staff recommends two general categories of use for IGT 4 revenue as follows:

1. Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health, consistent with the Board's March 2015 approval of these five priority areas;
2. Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver initiatives. This would be one-time funding allocation for planning and to implement pilot programs as required.

Staff will develop a budget allocation for the proposed categories to be presented at a future Board meeting after the transaction has received federal approval and funds have been received from the State. Staff will continue to gather information on whether there may be additional acceptable funding entities in Orange County with the capacity to partner to participate in future rate range transfer processes. The intent is to allow CalOptima to draw down maximum available rate range eligible funding to support Medi-Cal enrollees. For example, in the most recently proposed IGT 4, the State indicated that funding entities in Orange County could provide up to \$28M as the non-federal source; UCI Health was able to provide \$13.7M tied to uncompensated care rendered by UCI Physicians to CalOptima members. After factoring in the available federal match and required state fees, it is possible that CalOptima could have accessed an additional \$11M in net revenue to support Medi-Cal members for this rate year.

### ***Potential IGT 4 Funding Needs/Priorities***

#### ***Health Homes***

The Medicaid Health Home State Plan Option, under the Affordable Care Act (Section 2703), enables states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries

with chronic conditions, including homelessness and/or mental illness. California's Health Homes Program is intended to serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. On April 20<sup>th</sup>, 2015, the DHCS indicated its intent to require participation from all counties effective 2016, with the benefit implemented through the managed care organizations who will then contract with community organizations. Staff is monitoring the development of final program regulations and will provide details on specific projects in the future as additional information becomes available.

#### *1115 Waiver*

California's existing Bridge to Reform 1115 Waiver expires on October 31, 2015. DHCS will seek approval of the new Waiver by November 2015 from CMS. At this time, the State's Waiver application proposes key delivery system transformations, including but not limited to changes for counties with public hospitals, regional incentives among managed care organizations, providers and counties behavioral health systems, workforce development initiatives, access to housing and supportive services, and whole person care pilots to improve and integrate physical and behavioral health. Staff will continue to monitor the development of final program regulations and will keep the Board apprised as new information becomes available.

As additional details become available, staff will return to the Board as appropriate with recommendations on the possible use of one-time IGT funded to launch potential early implementation projects to prepare for these critical programmatic changes.

#### **Approve modification of IGT 2 funds designated to support Federally Qualified Health Centers (FQHC)**

The Board approved \$200,000 in funding in the *Strengthening the Safety Net* priority area at its October 2014 meeting. Specifically, the funding was designated to support engagements with qualified consultants/vendors to partner with up to eight named Orange County community clinics to support their conversion to FQHC status from FQHC "look-alike" status. To date, staff have received formal submissions from seven eligible clinics, with an additional application in progress. The ultimate goal was to contribute to a robust and sustainable system of care for vulnerable CalOptima members who access care at community clinics. Receipt of FQHC status will allow clinics to receive critical and stabilizing federal funds. A second cycle of funding (FQHC Phase 2) was designated for clinics in earlier stages of readiness to apply. The status of IGT-funded Safety Net projects is listed in the attachment.

At this time, staff recommends broadening eligible expenses to include permitting funding for one-time costs associated with merging with an existing FQHC or consulting costs associated with adding a critical new service that will facilitate greater access to care and a more robust reimbursement rate.

No funds will be used to support staff costs or recurring expenses. Currently, funds are designated for consulting services only. Specifically, staff has learned that one area clinic has elected to merge with an existing FQHC to achieve its sustainability goals. Effective May 2015, L'Amistad Health Center will be part of St. Jude Neighborhood Centers, which was not named as one of the eight clinics in the original Board approval. What is being proposed is a modification to enable St. Jude's to receive

support in lieu of L'Amistad. This funding will address the project management expense associated with bringing L'Amistad on to St. Jude Neighborhood Center existing electronic health record at a cost of \$12,000, an expense within the maximum amount allowable for each clinic under the grant program. This modification is recommended as the expense is consistent with the Board's intent of accelerating sustainability and access. Likewise, a modification is recommended to enable clinics to allocate eligible consulting hours to prepare for a scope of service request in conjunction with preparation for new access point submission. This proposed change will provide an avenue for greater access to critical services such as dental or behavioral health in underserved communities.

### **Fiscal Impact**

Fiscal Year (FY) 2013-14 IGT (IGT 4)

The recommended action to execute the FY 2013-14 IGT will provide approximately \$5.5 million in one-time IGT revenue. Management will present an expenditure plan for Board approval at an upcoming meeting.

FY 2011-12 IGT (IGT 2)

The recommended action to permit St. Jude's to act as an eligible recipient under the Phase 1 FQHC program is budget neutral, as St. Jude's Neighborhood Clinic will replace L'Amistad as one of the eight eligible grantees. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

### **Rationale for Recommendations**

Proposed funding categories for IGT 4 would allow for continued support of key organizational priorities and programs. Modification to IGT 2 is proposed to ensure broad participation from area community clinics in the FQHC grant cycle.

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachments**

Presentation: IGT Progress Report

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**Authorized Signature**

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**Date**



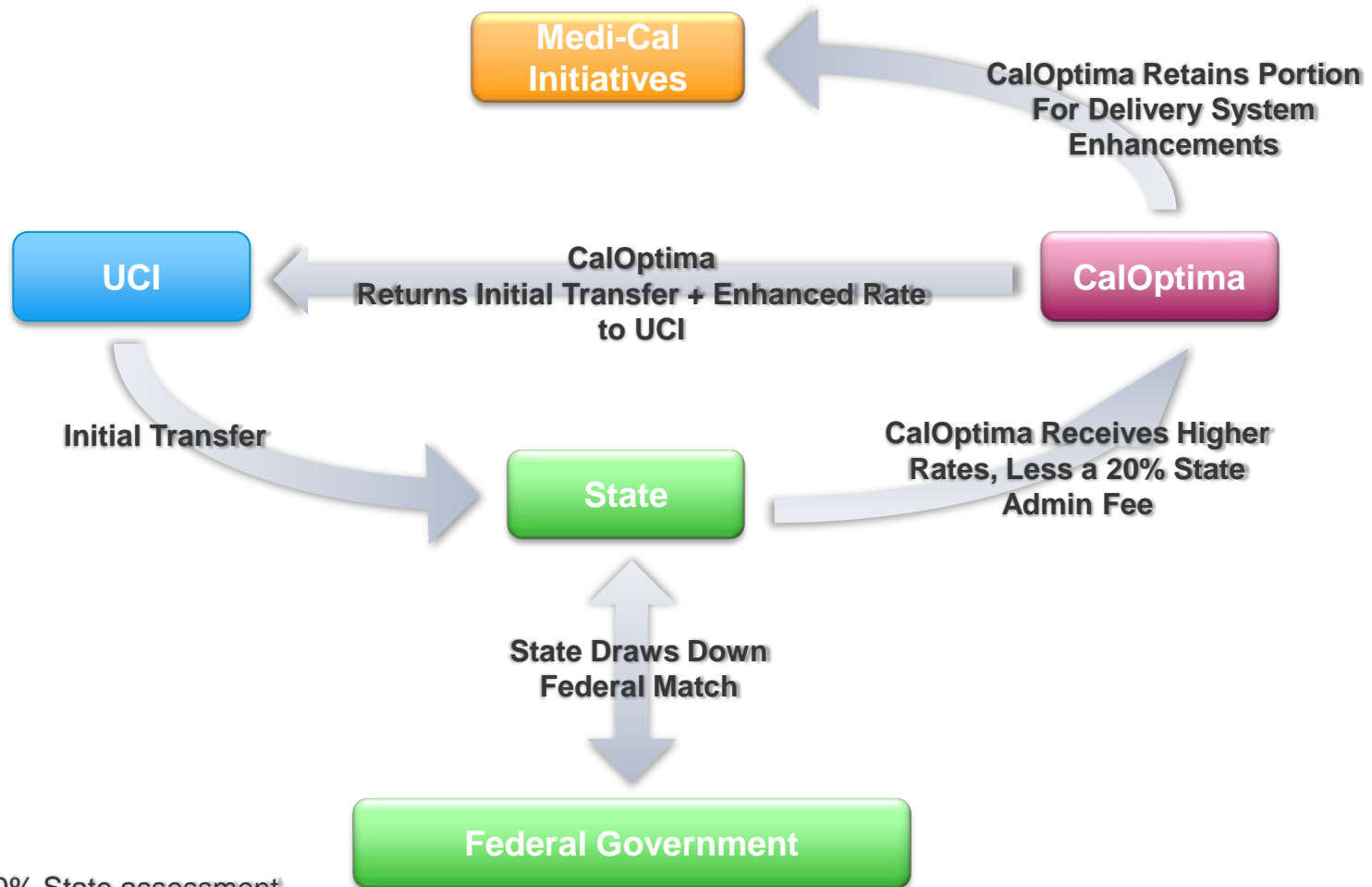
**CalOptima**  
Better. Together.

# **Intergovernmental Transfers (IGT): Progress**

**Board of Directors Meeting  
May 7, 2015**

**Lindsey Angelats  
Director, Strategic Development**

# Overview of CalOptima/UC Irvine IGT



\* Includes 20% State assessment fee

# IGTs Purpose and Restrictions

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- Revenue generated through IGTs must be used to finance enhancements in services for Medi-Cal members
  - Support enhanced Medi-Cal program
  - Enable CalOptima to pay providers designated by the funding entity (UCI is currently the only funding entity used)
- Funds are potentially non-recurring, since there is no guarantee of future IGT agreements; funds are suited for one-time investments or as seed capital for new initiatives for members
- CalOptima is only plan allowed to retain funds. This process is consistent with state and federal rules and was approved by DHCS and CMS.

# IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount
IGT 1	12-13	\$12.4 M
IGT 2	13-14	\$8.7 M
IGT 3	14-15	\$4.8 M
IGT 4	15-16*	(Est. \$5.5 M)*
Total Funds Received		\$25.9 M

\* Transaction has received state and federal approval but funds have not been received yet.

# IGT Presentation Timeline

	May	June	July	Aug	Sept	Oct
Board		IGT 3 Budgeting; IGT 1-2 Progress Report				IGT 3 Budgeting; IGT 1-3 Progress Report
QAC	IGT 3 Budgeting				IGT 4 Budgeting	
FAC	IGT 3 Budgeting				IGT 4 Budgeting	

## CALOPTIMA BOARD ACTION AGENDA REFERRAL

### Action To Be Taken October 1, 2015 Regular Meeting of the CalOptima Board of Directors

#### Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

#### Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

#### Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of \$3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of \$4,880,000 in IGT 3 funds to support this purpose.

#### Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing \$26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional \$5.5 million in project funds. Collectively, the four IGTs represent \$31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	\$12.4 million
IGT 2	\$8.7 million
IGT 3	\$4.9 million
IGT 4	\$5.5 million*
Total	\$31.5 million

\*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

#### IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of \$3,875,000 in IGT 2 funds to support the following projects:

- \$2,400,000 previously approved for the ‘Expansion of IGT 1 Initiatives’ will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16 fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.
- \$100,000 previously approved for the ‘Expansion of IGT 1 Initiatives’ will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.
- \$875,000 previously approved for ‘Children’s Health/Safety Net Services’ will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.
- \$500,000 previously approved for ‘Wraparound Services’ will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.
- Staff also request a modification to the Board’s December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from \$50,000 up to \$100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from \$50,000 to \$100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics’ FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

### IGT 3 Expenditure Plan

For the \$4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- \$4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima’s Model of Care.

\$500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board’s previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

These recuperative care services would be made available subject to required regulator approval(s), if any.

- \$165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

### **Fiscal Impact**

The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of \$4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

### **Rationale for Recommendation**

Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachments**

1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

/s/ Michael Schrader  
**Authorized Signature**

9/25/2015  
**Date**



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# **IGT Progress Report and Proposal**

**Board of Directors Meeting  
October 1, 2015**

**Lindsey Angelats  
Dir, Strategic Development**

# IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	\$12.4 M	100%
IGT 2	13-14	\$8.7 M	55%
IGT 3	14-15	\$4.8 M	0%
IGT 4	15-16*	(Est. \$5.5 M)*	NA
Total Funds Received or Anticipated		\$31.4 M	

\* Transaction has received state and federal approval but funds have not yet been received

# Considerations for IGT Outstanding Funds

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- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers
- **Value in supporting providers serving more vulnerable members with greater needs: *(examples)***
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

# IGT Investment Parameters and Requirements

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Time  
Limited/  
Sustainable

Evidence-  
Informed

Measureable  
Impact (e.g.  
Access,  
Quality,  
Cost)

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries
- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

# Recommended Use of IGT 2 Funds (\$3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
<b>Continuation of IGT 1 Initiatives</b>	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	\$2.4M	<b>Coordinated Care Initiative</b>	Providers and members receive timely support
<b>Children's Health/Safety Net Services</b>	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	\$875K	<b>Alternative Payment Pilot</b>	FQHCs launch critical services that can be sustained through higher PPS rates
<b>Wraparound Services</b>	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	\$500K	<b>Autism Benefits in Managed Care</b>	Earlier identification and treatment for the 1 in 68 children with autism
<b>Continuation of IGT 1 Initiatives</b>	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents 23% admin costs)	\$100K	<b>Intergovernmental Transfers</b>	Faster launch of IGT funded projects to support members and physicians

# Recommended Use of IGT 3 Funds (\$4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	Adult Mental Health	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	\$500K	Support for improved and integrated care for vulnerable members
Integrated Care	Support Primary Care Access	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	\$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	\$165K	Faster launch of IGT funded projects to support members and physicians

# Recommended Next Steps

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- **Timing**

- November: Development of project plans and launch

- **Accountability**

- Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016

- **Engagement**

- Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression

- **Maximization/Leverage**

- In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

## Board of Directors Meeting October 1, 2015

### Intergovernmental Transfer (IGT) Funds Progress Report

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#### Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
<b>New Case Management System</b>	To enhance management and coordination of care for vulnerable members	\$2M	03/06/14	2 years	75%
<b>Personal Care Coordinators for OneCare members</b>	To help OneCare members navigate healthcare services and to facilitate timely access to care	\$3.8M	04/03/14	3 years	50%
<b>OneCare Connect Personal Care Coordinators</b>	To help OneCare Connect members navigate health services and to facilitate timely access to care	\$3.6M	04/02/15	1 year	25%
<b>Strategies to Reduce Readmission</b>	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	\$1.05 M	03/06/14	2 years	25%
<b>Complex Case Management Consulting</b>	Staffing and data support for case management system	\$350K	03/06/14	2 years	50%
<b>Telemedicine</b>	Expand access to specialty care	\$1.1M	03/07/13	2 years	25%
<b>Program for High Risk Children</b>	CalOptima pediatric obesity and pediatric asthma planning and evaluation	\$500K	03/06/14	3 years	25%

IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
<b>Facets System Upgrade &amp; Reconfiguration</b>	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	\$1.25M	03/06/14	2 years	75%
<b>Continuation of the CalOptima Regional Extension Center</b>	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	\$1M	04/03/14	3 years	25%
<b>Enhancing the Safety Net</b>	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	\$200K	10/02/14	2 years	50%
<b>Enhancing the Safety Net</b>	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	\$225K	12/04/14	2 years	25%
<b>Recuperative Care</b>	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	\$500K	12/04/14	1 year	25%
<b>Facets System Upgrade &amp; Reconfiguration</b>	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	\$1.25M	03/06/14	2 years	75%
<b>School-Based Vision</b>	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	\$500K	09/04/14	2 years	25%
<b>School-Based Dental</b>	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	\$400K	09/04/14	2 years	25%
<b>Provider Network Management Solution</b>	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	\$500K	03/06/14	1 year	25%
<b>Security Audit Remediation</b>	To increase protection of CalOptima member data	\$200K	03/06/14	1 year	85%

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken March 3, 2016** **Regular Meeting of the CalOptima Board of Directors**

#### **Consent Calendar**

3. Authorize Extension of Expenditures of Fiscal Year 2010-11 Intergovernmental Transfer Funds for OneCare Personal Care Coordinators (PCC) through December 31, 2016; and Authorize the Reallocation of OneCare Connect PCC Funding to Cover the Cost of the OneCare PCC Program through Calendar Year 2016

#### **Contact**

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

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

#### **Recommended Actions**

1. Extend the authorization of expenditures of Fiscal Year (FY) 2010-11 Intergovernmental Transfer (IGT) Funds (IGT 1) for OneCare Personal Care Coordinators (PCC) from April 1, 2016 through December 31, 2016; and
2. Authorize the reallocation of \$50,000 in OneCare Connect PCC funds from IGT 1 to OneCare PCC in order to compensate delegated OneCare health networks for the period of April 1, 2016, through December 31, 2016.

#### **Background**

At the March 6, 2014, meeting, CalOptima's Board of Directors approved the final expenditure plan for \$12.4 million for IGT 1. The expenditure plan included an initiative, Complex Case Management – Part 1, to provide case management for high-risk members across various care settings. As part of this initiative, CalOptima and health networks would hire PCCs for up to two years. At the health network level, the PCC serves as a single point of contact for OneCare members and assist members in navigating the healthcare delivery system, facilitating access to care and services.

On April 3, 2014, the Board authorized the CEO, with the assistance of legal counsel, to execute OneCare health network PMG contract amendments to provide funding to health networks to hire and retain PCCs. The Board authorized the expenditure of IGT 1 funds over a two-year period, with a total of up to \$1.85 million expended in Year 1, and up to \$1.95 million expended in Year 2 as authorized by the Board in March 2014. The end date of the two-year authorization is March 31, 2016.

At the April 2, 2015, meeting, the Board authorized reallocation of \$200,000 from the \$1.95 million budget allocation in Year 2 to make the March 2015 OneCare PCC capitation payment.

### **Discussion**

On January 1, 2016, the majority of OneCare members were passively enrolled into the OneCare Connect program. However, not all OneCare members were eligible for this transition, and these members still remain in OneCare. As of January 2016, there were approximately 1,238 active OneCare members. In order to maintain similar practices for OneCare and OneCare Connect, so that OneCare members receive the same quality of care as OneCare Connect members, staff proposes to continue the PCC program for the remaining OneCare members through December 31, 2016.

Staff estimates the monthly expenditures for OneCare PCCs is approximately \$20,000. As of January 31, 2016, \$175,401 remains in IGT 1 funds for the OneCare PCC program. Assuming the same level of funding through the rest of the calendar year, the projected shortfall for the OneCare PCC capitation payments by December 31, 2016, will be approximately \$44,599. To cover this shortfall, Management recommends that the Board approve a budget reallocation of \$50,000 from OneCare Connect PCC funds from IGT 1 to OneCare PCC in order to compensate delegated OneCare health networks for the period of April 1, 2016 through December 31, 2016.

### **Fiscal Impact**

The recommended actions to extend authorization of expenditures for the OneCare PCC program through December 31, 2016 and to reallocate \$50,000 from the OneCare Connect PCC program to the OneCare PCC program is expected to have a neutral fiscal impact to CalOptima. Expenditure of IGT funds is limited to providing enhanced benefits to CalOptima Medi-Cal beneficiaries, and has been restricted to one-time purposes, and does not commit CalOptima to future funding or budget allocations.

### **Rationale for Recommendation**

CalOptima staff recommends this action in support of the OneCare PCC program, which is an integral component of the enhanced Model of Care that has been developed for the OneCare program and expands our ability to apply best practices in care coordination for CalOptima's Medicare members.

### **Concurrence**

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

### **Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

02/26/2016  
**Date**

[Date]

[Provider First name, Last Name] [Title][Address 1] [Address 2]  
[City], CA [Zip]

**Re: IGT 4 Project - Depression Screening for Members 12 Years of Age**

Dear Providers:

CalOptima is launching a project on Screening for Clinical Depression in Adolescents and we would like to collaborate with you. This project is designed to increase the rate of depression screening during annual visit of **12-year-old members**, the beginning stage of adolescence. Pediatricians will receive an incentive pay of **\$50.00** upon completion of the screening and submission of a separate claim to CalOptima.

You are receiving this packet because we have identified that you have members who are turning 12 years old this year. We expect that a good portion of these members may be contacting you for school required vaccinations (Senate Bill 277) when they schedule their physical exams this year.

Attached are the materials you will need to incorporate the depression screening tool into office visits:

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Administering and Scoring the PHQ-A Screening Questionnaire
- Instructions on coding & interpreting the score
- Information on making a referral to CalOptima Behavioral Health provider

If you have questions regarding the program, utilization of the assessment tools, claims or need additional materials, please contact CalOptima's Behavioral Health Integration department at 657-900-1097 or send us an email at [behavioralhealth@caloptima.org](mailto:behavioralhealth@caloptima.org).

Sincerely,



Donald Sharps, M.D.  
Medical Director, Behavioral Health Integration  
Enclosures

## Administering and Scoring the PHQ-A Screening Questionnaire

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### Administering

- Patient checks in at the Reception desk.
- Reception will present the PHQ-A (PHQ-9 modified for Adolescents) Questionnaire using the script below:

“We are screening for symptoms of depressed mood at all 12-year-old physical exams. Please have your child fill out this questionnaire if he/she wants to, or we can administer the form for him/her. Dr. \_\_\_\_\_ (or state the name of the provider or NP if the provider is an NP) will discuss the results with all of you together during the appointment.”
- The PHQ-A (PHQ-9 modified for Adolescents) takes less than five minutes to complete and score.
- If patient decides to complete the PHQ-A by himself/herself, he/she should be left alone to complete the PHQ-A in a private area, such as an exam room or a private area of the waiting room.
- The PHQ-A can also be administered and scored by a nurse, medical technician, physician assistant, physician or other office staff.
- Patients should be informed of their confidentiality rights before the PHQ-A is administered.
- It is recommended that parents are informed that a mental health checkup will be administered as part of the exam.
- Office staff will give the completed PHQ-A to the provider as it may have comments on it, and unclear marks made by the patient can be reviewed.

### Scoring

- Each item on the PHQ-A is scored as follows:

Not at all = 0   Several Days = 1   More than half the days = 2   Nearly every day = 3
- To calculate the score, add all of the item scores together:

Item	Number of Items	Weight	Weighted Score
Not at all		X 0	
Several Days		X 1	
More than half the days		X 2	
Nearly every day		X 3	
TOTAL			

## Instructions on coding and interpreting the scores

### Coding

- HCPCS outcome codes used to bill for administering the PHQ-A Screening Questionnaire:

PHQ-A Scored <b>POSITIVE</b> for Depressive Symptoms $\geq 5$	PHQ-A scored <b>NEGATIVE</b> for Depressive Symptoms $\leq 0-4$
<b>G8431</b> Follow-up plan by PCP or referral to BH provider	<b>G8510</b> A follow-up plan is not required

### Interpreting the scores:

	Total score	Recommended Next Steps
None or Minimal depressive symptoms	0-4	<ul style="list-style-type: none"><li>PCP reviews with patient</li><li>Confirms negatives</li><li>Option to discuss additional issues</li><li>Considers other diagnosis (ADHD, etc) and treats accordingly, if applicable</li></ul>
Mild to Moderate depressive symptoms	5-14	<ul style="list-style-type: none"><li>Watchful waiting</li><li>Supportive counseling</li><li>Educate member to call if symptoms deteriorate</li><li>Repeat PHQ-A at PCP follow-up</li><li>Consider referral if PHQ-A scores fall in high risk areas</li></ul>
Moderate to severe depressive symptoms	15-19	<ul style="list-style-type: none"><li>Consider anti-depressant medication management through PCP (w/ consultation if needed)</li><li>Consider referral/linkage to community-based organizations, school-based counseling, etc</li><li>Consider referral to psychiatrist for medication and/or to therapist for therapy services</li></ul>
Severe depressive symptoms	20-27	<ul style="list-style-type: none"><li>Immediate referral to <b>CalOptima Behavioral Health Line at 1-855-877-3885</b></li></ul>

- Patients that score positive on their PHQ-A should be evaluated by the primary care provider (PCP) to determine if the symptoms endorsed on the questionnaire are significant, causing impairment and warrant a referral to a mental health specialist or follow-up or treatment by the PCP.
- For patients who score negative on the PHQ-A, it is recommended that the PCP briefly review the symptoms marked as “sometimes” and “often” with the patient.

Please complete the CMS 1500 Health Insurance Claim form and mail it to:

**CalOptima Claims Department**  
**PO Box 11037**  
**Orange, CA 92856**

### Engaging and Informing Parents

- Inform parents of the screening results (positive or negative), and recommendations for referral, treatment or follow-up.
- Provide parents with information about the next steps and offer support and assistance with finding or making an appointment with a behavioral health specialist.
- Give information to parents about why the referral is being made, how the services you are referring can help, and details about where you are sending them.
- Compile a list of appropriate referral resources in the community and share that list with families of patients that receive a referral.

# PHQ-A (Adolescent)

Name: \_\_\_\_\_ Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the **past month** when you have had serious thought about ending your life?

☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐ Yes ☐ No

Office use only:

Severity score:

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# Outpatient Mental Health Services



Outpatient mental health services are a benefit covered by CalOptima. These services are for the treatment of mild to moderate mental health conditions, which include:

- Individual and group mental health treatment (psychotherapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services that include lab work, drugs and supplies
- Outpatient services to monitor drug therapy
- Psychiatric consultation

You can still get specialty mental health services from the Orange County Mental Health Plan.

Members can access benefits by calling CalOptima Behavioral Health toll-free at

**1-855-877-3885**

This number is available 24 hours a day, 7 days a week.  
TDD/TTY users can call toll-free at **1-800-735-2929**.

*The people in the photographs that appear in this document are models and used for illustrative purposes only.*



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### IGT Project Status Report - Depression Screenings

IGT Year	Budget	Status Date	Project Lead(s)	Start Date	End Date	Category
IGT 4 (2014)	\$1,000,000	Q1 2017	Dr. Sharps; Edwin Poon	1/1/2017	3/31/2019	Children's Mental Health
Project Description			Milestones	Start Date	End Date	% Complete
<p>Short but clear definition of the project including purpose and benefit to the organization</p> <p>Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members aged 12. Subject to regulator approval, as applicable, incentive payments per screening will be \$50 and made directly to primary care providers upon submission of a HCPCS code that indicates the screening was performed and was negative or a HCPCS code that indicates the screening was performed and was positive. Beginning with Year 2 of the project, it is preferred that a sufficient process/infrastructure be in place to collect more detailed depression screening scores in addition to the positive/negative scoring HCPCS claims from providers in order for incentive payment to be made.</p>			Educate pediatricians on depression screening	1/1/2017	3/31/2017	25%
			Identify additional resources needed	1/1/2017	3/31/2017	75%
			Evaluate impact of pilot to inform continuation	10/1/2017	1/31/2019	0%
			Submit final report	2/1/2019	3/31/2019	0%
						0%
						0%
						0%

#### Quarterly Summary

Executive briefing of the quarter's successes and any major challenges

On 1/1/2017, BHI team started planning, developing, and creating materials that will be disseminated to pediatricians as outlined in the project description. Initial research was done with regard to the number of enrollees who belong in the 11-12 year old range and their respective pediatricians. Data was then used to develop a comprehensive list of targeted members sorted by their providers. During this reporting period, depression screening tool and supporting materials were designed and developed. This informational packet and support will be provided to pediatricians to optimize the implementation of the project. Direct mailing will be used as a method of dissemination. Additionally, BHI team interfaced with various departments affected by the project which includes Claims, IS and Provider Network. The goal is to launch the project on May 1, 2017.

The main challenge that we have encountered is the various codes reported in the system. BHI team had to investigate what codes are being used and billed for by providers for Medi-Cal line of business. The complexity of these codes has resulted in an increased time and effort in establishing the codes that will be used for the project. However, BHI team has overcome this challenge by enabling cross-department collaboration.

#### Current Quarter Accomplishments

- Designed, developed and evaluation of informational packet for providers
- Coordinated with other departments and verified current internal processes and procedures of providers when submitting claims
- Assessment of Medi-Cal members who are turning 12 years old and assigned pediatricians by running data to capture the information required for the project
- Developed a mailing list of providers

#### Next Quarter's Planned Activities

- Dissemination of Depression Screening tool (PHQ-A) and its accompanying materials to identified providers
- May 1, 2017 - Implementation of the project with the supporting packet
- Training of Top 50 high volume providers by health managers to ensure successful utilization of screening tool
- BHI team will work closely with Health Network Provider Relations to ensure that project's objectives are met

Risk/Issues	Mitigation/Resolution Steps		Owner	Target Date
New process for providers	Meet with providers and provide training for proper utilization of the screening tool		Dr. Sharps; Edwin Poon	June 1, 2017-onwards

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### IGT Project Status Report - Depression Screenings

IGT Year	Budget	Status Date	Project Lead(s)	Start Date	End Date	Category
IGT 4 (2014)	\$1,000,000	Q2 2017	Dr. Sharps; Edwin Poon	1/1/2017	3/31/2019	Children's Mental Health
Project Description			Milestones	Start Date	End Date	% Complete
<p><i>Short but clear definition of the project including purpose and benefit to the organization</i></p> <p><i>Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members aged 12. Subject to regulator approval, as applicable, incentive payments per screening will be \$50 and made directly to primary care providers upon submission of a HCPCS code that indicates the screening was performed and was negative or a HCPCS code that indicates the screening was performed and was positive. Beginning with Year 2 of the project, it is preferred that a sufficient process/infrastructure be in place to collect more detailed depression screening scores in addition to the positive/negative scoring HCPCS claims from providers in order for incentive payment to be made.</i></p>			Identify additional resources needed	1/1/2017	5/31/2017	100%
			Dissemination of informational packets to providers	5/1/2017	5/19/2017	100%
			Translation of the Depression Screening tool in Spanish and Vietnamese languages	6/1/2017	6/28/2017	100%
			Developed a list of providers by health network for provider outreach	6/1/2017	6/28/2017	100%
			Educate pediatricians on depression screening	1/1/2017	8/31/2017	50%
			Evaluate impact of pilot to inform continuation	10/1/2017	1/31/2019	25%
			Submit final report	2/1/2019	3/31/2019	0%
						0%

#### Quarterly Summary

*Executive briefing of the quarter's successes and any major challenges:*

*This reporting quarter included the dissemination of informational packets regarding the Depression Screening Initiative. A total of 641 provider packets were mailed to providers who are seeing an estimate of 16,760 members who will be turning 12 years old in 2017. Mailing has to be done in two batches due to a large volume of recipients. All identified providers received an informational packet and guidelines for future reference. Providers have expressed their support and indicated that finally something is being done to raise awareness about depression screening in adolescents. Behavioral Health Integration department provided additional resources by creating a Frequently Asked Question (FAQ) document to help providers get answers to frequently asked questions, and help initiate an effective response in a timely manner. This was shared to the providers via newsletters and e-mail campaigns. Effective coordination with Health Network Relations has led the providers to a better understanding of the initiative. BHI team has also extended campaign on the provider initiative by doing presentations at CalOptima advisory committee meetings such as PAC, MAC, and QIC. Additionally, BHI team created a list of providers that will be disseminated to the health networks to support their provider outreach efforts. During this quarter, the depression screening tool was translated in two (2) most common languages, Spanish and Vietnamese. This was aimed at reaching CalOptima members that speak the other threshold languages.*

#### Current Quarter Accomplishments

- Distributed a total of 641 informational packets to identified providers
- Created an FAQ (Frequently Asked Questions) document that will help providers address common questions about the initiative
- Translated the depression assessment tool (PHQ-A) into Spanish and Vietnamese for members who speak these threshold languages
- Developed a list of providers to support health networks with their provider outreach

#### Next Quarter's Planned Activities

- Ongoing monitoring to ensure project's objectives are met
- BHI team will actively collaborate with Health Network Relations by providing resources as needed
- Work with Provider Relations team to train the top 40 providers by scheduling in-person meetings by end of July

Risk/Issues	Mitigation/Resolution Steps		Owner	Target Date
New process for providers	Meet with providers and provide training for proper utilization of the screening tool		Dr. Sharps; Edwin Poon	June 1, 2017-onwards

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## IGT Project Status Report - Depression Screenings

IGT Year	Budget	Status Date	Project Lead(s)	Start Date	End Date	Category
IGT 4 (2014)	\$1,000,000	Q3 2017	Dr. Sharps; Edwin Poon	1/1/2017	3/31/2019	Children's Mental Health
Project Description			Milestones	Start Date	End Date	% Complete
<p>Short but clear definition of the project including purpose and benefit to the organization</p> <p>Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members aged 12. Subject to regulator approval, as applicable, incentive payments per screening will be \$50 and made directly to primary care providers upon submission of a HCPCS code that indicates the screening was performed and was negative or a HCPCS code that indicates the screening was performed and was positive. Beginning with Year 2 of the project, it is preferred that a sufficient process/infrastructure be in place to collect more detailed depression screening scores in addition to the positive/negative scoring HCPCS claims from providers in order for incentive payment to be made.</p>			Educate pediatricians on depression screening	1/1/2017	8/31/2017	100%
			Evaluate impact of pilot to inform continuation	10/1/2017	1/31/2019	50%
			Submit final report	2/1/2019	3/31/2019	0%
			Tracking of depression outcomes	8/1/2017	3/31/2017	25%
			Follow up analysis on positive screenings by reviewing subsequent BH claims	8/1/2017	3/31/2017	25%

### Quarterly Summary

Executive briefing of the quarter's successes and any major challenges:

The third quarter of 2017 saw a steady increase in depression screening utilization. To date, 1,324 screenings have been performed by 88 providers since project's inception five months ago. Of which 1,088 claims were paid for a total of \$54,400 claims payment. IS developed a CORE utilization report that outlines submitted claims (denied vs. paid) and screenings (positive and negative). This report also includes information on claims which will help BHI identify factors that led to claims denial and spot some of the more common billing errors from providers. IS reprocessed and paid the initial 123 claims that were denied due to other services that were billed. A number of providers are still unaware of the requirements and claims submission process. Several efforts were made to address the issue. Information about claims submission was sent through provider newsletters and e-mail campaigns on a regular basis. In August, Provider Relations conducted in-person outreach/training to all 20 physicians with the highest eligible members. Feedback has been overwhelmingly positive. BHI will continue to assist providers who have questions about the incentive program and provide additional packets if requested. Tracking of depression outcomes is scheduled for the 4th quarter of 2017. This includes follow up analysis on positive screenings and monitor BH claims for members who had follow-up services.

### Current Quarter Accomplishments

- IS developed a CORE report that outlines the depression screenings utilization
- Reprocessed and paid denied claims that were submitted with other services
- Constant communication to providers through provider newsletters and email campaigns
- In-person training to all 20 physician offices with the highest eligible members

### Next Quarter's Planned Activities

- Tracking of depression screening outcomes using the PHQ-A questionnaire
- Follow-up analysis on positive screenings by reviewing subsequent BH claims
- BHI will continue to promote the initiative through provider newsletters, e-mail campaigns, and community presentations
- Schedule another round of in-person trainings to pediatricians if needed

Risk/Issues	Mitigation/Resolution Steps	Owner	Target Date
New process for providers	Meet with providers and provide training for proper utilization of the screening tool	Dr. Sharps; Edwin Poon	June 1, 2017-onwards
	<a href="#">Back to Agenda</a>		

## IGT Project Status Report - Depression Screenings

IGT Year	Budget	Status Date	Project Lead(s)	Start Date	End Date	Category
IGT 4 (2014)	\$1,000,000	Q4 2017	Dr. Sharps; Edwin Poon	1/1/2017	3/31/2019	Children's Mental Health
<b>Project Description</b>			<b>Milestones</b>	<b>Start Date</b>	<b>End Date</b>	<b>% Complete</b>
Short but clear definition of the project including purpose and benefit to the organization			Educate pediatricians on depression screening	1/1/2017	8/31/2017	100%
Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members aged 12. Subject to regulator approval, as applicable, incentive payments per screening will be \$50 and made directly to primary care providers upon submission of a HCPCS code that indicates the screening was performed and was negative or a HCPCS code that indicates the screening was performed and was positive. Beginning with Year 2 of the project, it is preferred that a sufficient process/infrastructure be in place to collect more detailed depression screening scores in addition to the positive/negative scoring HCPCS claims from providers in order for incentive payment to be made.			Evaluate impact of pilot to inform continuation	10/1/2017	3/31/2019	50%
			Submit final report	2/1/2019	3/31/2019	0%
			Tracking of depression outcomes	8/1/2017	3/31/2019	25%
			Follow up analysis on positive screenings by reviewing subsequent BH claims	8/1/2017	3/31/2019	50%

## Quarterly Summary

## Executive briefing of the quarter's successes and any major challenges:

Progress was made during this reporting period. As of 12/31/17, there were 2,044 total number of members screened for depression, for a total of 1,948 paid claims. There were 20 members with positive results who had follow up services. The use of the PHQ-A depression assessment tool facilitated the screening process. BHI maintained its support to providers by providing information and resource materials about depression. To date, 16% of members screened received positive results (317/2,044).

Challenge still remains with a few providers who continue to send claims that are billed with other services. Providers are still unfamiliar with the billing process as they continue to submit incorrect service information or bill for members outside the set age range that result in denials. Through ongoing data collection and analysis, we are pleased to report that we are already seeing a huge success with the project and we anticipate an increase in the number of members that will be screened for depression this year. Even though this initiative is for members 12 years of age, we will continue to encourage providers to screen their patients (other than 12) for depression on a routine basis. This will help identify those at risk for depression and refer them for support and possible engagement in behavioral health treatment.

Current Quarter Accomplishments	Next Quarter's Planned Activities
<ul style="list-style-type: none"> <li>Reviewed processed claims to evaluate payment discrepancies</li> <li>Tracked the utilization report on an ongoing basis</li> <li>Constant communication to providers through provider newsletters and email campaigns</li> <li>PR provided in-person meetings at provider offices to provide guidance on how to bill</li> </ul>	<ul style="list-style-type: none"> <li>In-person follow-up visits from PR staff to expalin billing/payment procedures</li> <li>Work with PR staff to conduct another round of training to pediatricians</li> <li>Review the claims and payment procedure and reclassify the spent funds to the appropriate IGT account</li> <li>Follow-up analysis on positive screeningsby reviewing subsequent BH claims</li> </ul>

Risk/Issues	Mitigation/Resolution Steps	Owner	Target Date

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## CALOPTIMA BOARD ACTION AGENDA REFERRAL

### Action To Be Taken February 20, 2018 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

#### **Report Item**

9. Consider Recommending Board of Directors' Approval of Policy GG.1656, Quality Improvement and Utilization Management Conflict of Interest

Rev.  
2/20/2018

#### **Contact**

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

#### **Recommended Action**

Authorize the Chief Executive Officer (CEO) to approve new Policy GG.1656, Quality Improvement and Utilization Management Conflict of Interest.

Rev.  
2/20/2018

#### **Background**

This policy describes CalOptima's requirement that all individuals serving in an appointed, volunteer or employed position in the Quality Improvement (QI) or Utilization Management (UM) departments or otherwise carrying out quality improvement or utilization management oversight activities, including but not limited to serving on QI or UM committees or subcommittees or who otherwise make decisions regarding quality or utilization management oversight or activities, fully disclose any actual, perceived, or potential Conflicts of Interest (s) that arise in the course and scope of serving in such a capacity. The purpose of this policy is to provide guidance regarding the identification, disclosure, and evaluation of conflicts of interest in order to resolve and/or avoid them in a manner consistent with legal and ethical standards, statutes and regulations.

On an annual basis each participant involved in CalOptima QI or UM decisions shall sign a Conflict of Interest Attestation and complete a Conflict of Interest Disclosure Form identifying any activities, interests, relationships, or financial holdings that create or have a potential to create a Conflict of Interest for the participant.

#### **Discussion**

This new Conflict of Interest policy was developed in response to a DHCS/CMS contract requirement which states that the CalOptima Quality Improvement Committee is responsible for maintaining a process to ensure rules of confidentiality in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members. CalOptima has a policy to ensure rules of confidentiality are met (GG.1620), and CalOptima has an existing Human Resource policy (GA.8012) that ensures that all designated CalOptima employees in positions listed in the CalOptima Conflict of Interest Code shall complete Form 700 Statement of Economic Interest and the Supplement to Form 700. Designated employees include employees who make decisions which foreseeably may have a substantial economic impact. This policy however is applicable only to CalOptima designated employees and members of the Board of Directors. Therefore, a new policy was created to ensure that the Quality Improvement Committee and its subcommittees, who oversight quality and utilization activities, fully disclose any actual or perceived conflicts of interest. The Quality Improvement

Committee and subcommittee members will annually sign a Conflict of Interest attestation as well as a CalOptima Conflict of Interest Disclosure Form.

**Fiscal Impact**

There is no fiscal impact for the recommended action to approve the Conflict of Interest Policy.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

GG.1656: Quality Improvement and Utilization Management Conflict of Interest policy with three attachments:

Rev.  
2/20/2018

1. Conflict of Interest Attestation (Quality Improvement Committee/Subcommittee(s))
2. Conflict of Interest and Non-Discrimination Attestation (Credentialing and Peer Review Committee)
3. CalOptima Conflict of Interest Disclosure Form

/s/ Michael Schrader  
**Authorized Signature**

2/12/2018  
**Date**

Policy #: GG.1656  
 Title: **Quality Improvement and Utilization Management Conflicts of Interest**  
 Department: Medical Affairs  
 Section: Quality Improvement

CEO Approval: Michael Schrader \_\_\_\_\_

Effective Date: TBD  
 Last Review Date: Not Applicable  
 Last Revised Date: Not Applicable

Applicable to: ☒ Medi-Cal  
☒ OneCare  
☒ OneCare Connect  
☒ PACE

## I. PURPOSE

This policy describes CalOptima's requirement that all individuals serving in an appointed, volunteer, or employed position in the Quality Improvement (QI) or Utilization Management (UM) Departments or otherwise carrying out quality improvement or utilization management oversight activities, including, but not limited to serving on QI or UM committees or subcommittees or who otherwise make decisions regarding quality or utilization management oversight or activities fully disclose any actual, perceived, or potential Conflicts of Interest(s) that arise in the course and scope of serving in such a capacity. The purpose of this policy is to provide guidance regarding the identification, disclosure, and evaluation of conflicts of interest in order to resolve and/or avoid them in a manner consistent with legal and ethical standards, statutes, and regulations.

## II. POLICY

- A. It is the policy of CalOptima to promote the best interests of its Members. All decisions concerning the safe care, quality of treatment, and services provided to CalOptima's Members must be made solely with the intent to meet the needs of those Members and without any actual, perceived, or potential conflicts of interest. Under no circumstances may a Participant place his/her own financial interests above the welfare of CalOptima's Members.
- B. Participants shall conduct their affairs so as to avoid or minimize Conflicts of Interest, and must appropriately disclose when Conflicts of Interest arise.
- C. Participants have a continuing obligation to disclose the existence and nature of any actual, perceived, or potential Conflicts of Interest to CalOptima in accordance with this Policy.
- D. The Chief Medical Officer and/or committee chairperson shall evaluate all Conflicts of Interest and determine whether a Conflict of Interest exists, with the assistance of legal counsel, as necessary. The Chief Medical Officer and/or committee chairperson will resolve all conflicts and impose safeguards, as necessary, to appropriately manage Conflicts of Interest.
- E. Delegated Health Networks shall have policies and procedures consistent with this policy in order to identify, avoid and/or manage Conflicts of Interest, as appropriate.

### III. PROCEDURE

#### A. Conflict of Interest

1. A Conflict of Interest depends on the situation and not on the character of the individual. Conflicts of Interest may arise where a Participant and/or a Related Party or an entity directly controlled by them:
  - a. Receives material compensation (e.g., gifts, grants, stipends, amenities) from any individual (and/or his employer) or entity that is the subject of a CalOptima QI or UM review;
  - b. Has an ownership interest in any entity that is the subject of a CalOptima QI or UM review;
  - c. Has a past or present personal relationship with the subject of a CalOptima QI or UM review; and/or
  - d. Has a financial interest in any consultant that is engaged and/or contracted by CalOptima to assist it with a QI or UM review and/or investigation.
2. The following are examples of Conflicts of Interest:
  - a. A Participant considers or makes decisions with respect to a credentialing or peer review matter where the provider who is the subject of the peer review matter is a direct competitor of the Participant or an individual with whom the Participant previously had a personal, employment, or financial relationship.
  - b. A Participant has an ownership or financial interest in the consulting firm engaged by CalOptima to review medical records in connection with a peer review matter.
  - c. A Participant receives monetary or non-monetary compensation from a Pharmaceutical manufacturer whose drug is reviewed for listing on the CalOptima Formulary.
  - d. A Participant holds a fiscal or management position or role at CalOptima and participates in utilization management decisions (e.g., approving, modifying, deferring, or denying requested services, establishing drug formularies, conducting drug utilization reviews).
  - e. A Participant considers and makes decisions regarding the CalOptima credentialing application of a physician where the Participant was a member of a judicial review committee that ruled on a prior hospital peer review matter involving the same physician.

#### B. Conflict of Interest Disclosure Process

1. On an annual basis, each Participant who is involved in CalOptima QI or UM decisions shall sign a Conflict of Interest Attestation and complete a Conflict of Interest Disclosure Form identifying any activities, interests, relationships, or financial holdings that create or have the potential to create a Conflict of Interest for the Participant.
2. Upon appointment and prior to serving on any QI or UM committee or subcommittee, each Participant shall sign a Conflict of Interest Attestation and complete a Conflict of Interest

1 Disclosure Form, identifying any activities, interests, relationships, or financial holdings that  
2 create or have the potential to create a Conflict of Interest for the Participant.

- 3 3. If a Participant believes that he/she may have a potential, perceived, or actual Conflict of  
4 Interest prior to a committee, or subcommittee, meeting, he/she will provide written notice to  
5 the committee, or subcommittee, chairperson disclosing the potential, perceived, or actual  
6 Conflict of Interest.

- 7  
8 4. Whenever a Participant believes that he/she may have a potential, perceived, or actual Conflict  
9 of Interest during a committee, or subcommittee, meeting, he/she will immediately alert the  
10 committee, or subcommittee, chairperson that he/she may have a potential, perceived, or actual  
11 Conflict of Interest. Before leaving the meeting, the Participant may be asked, and may  
12 answer, any questions concerning the Conflict of Interest.

- 13  
14 5. In all other situations, whenever a Participant realizes that he/she may have a potential or  
15 actual Conflict of Interest, he/she will provide written notice to the Chief Medical Officer  
16 disclosing the potential, perceived, or actual Conflict of Interest.

- 17  
18 6. To the extent the QI Department and/or UM Department engages an external reviewer or  
19 expert consultant for peer review or other QI or UM purposes, that individual shall be required  
20 to sign a Conflict of Interest Statement and complete a Conflict of Interest Disclosure Form  
21 prior to performing any services for CalOptima.

22  
23 **B. Management and Resolution of the Conflicts of Interest**

- 24  
25 1. The Chief Medical Officer or the committee chairperson will review and evaluate all written  
26 disclosures thoroughly for conflicts. For any decision involving a CalOptima employee, the  
27 Chief Medical Officer shall involve Legal Counsel before taking any action.

- 28  
29 2. The applicable committee or subcommittee chairperson shall resolve any issue over the  
30 existence of a Conflict of Interest involving a Participant who is a committee or subcommittee  
31 member. All other Conflict of Interest issues shall be resolved by the Chief Medical Director.  
32 CalOptima shall verify that no unresolved Conflicts of Interest exist prior to retaining the  
33 external reviewer or expert consultant.

- 34  
35 3. If it is determined that there is no conflict, then the Participant can continue to be involved in  
36 the matter, subject to any limitations imposed by the Chief Medical Officer or committee or  
37 subcommittee chairperson.

- 38  
39 4. If it is determined that there is a Conflict of Interest, the Participant may be excluded from  
40 participation in the matter that gave rise to the Conflict of Interest.

- 41  
42 5. The committee chairperson and/or Chief Medical Officer may resolve the conflict, if and when  
43 appropriate, by imposing limitations in where there is a determination that a Conflict of  
44 Interest does not prohibit the Participant's continued involvement in the matter. These  
45 limitations may include, but are not limited to, requiring that the Participant abstain from  
46 voting with regard to the matter, or prohibiting the Participant from participating in any  
47 investigation of the matter.

6. If a Participant disagrees with a committee chairperson's decision regarding a Conflict of Interest, he/she can request that the Chief Medical Officer review the Conflict of Interest.

**D. Record Retention**

1. The Quality Improvement and Utilization Management Departments, as applicable, shall keep copies of all Conflict of Interest Disclosure Forms and any written information disclosing a Conflict of Interest in accordance with applicable regulatory record retention requirements.
2. Credentialing and Peer Review Committee (CPRC) minutes shall reflect the disclosure of Conflicts of Interest and any abstentions from voting on actions.

**E. Non-Compliance with Conflicts of Interest Policy**

1. Suspected violations of this Policy should be reported to the Chief Medical Officer . Such reports may be made confidentially.
2. The failure of a Participant to disclose a Conflict of Interest when it is known or reasonably should be known to the Participant may result in actions against the Participant, including, but not limited to disciplinary action, sanctions, removal, dismissal, and/or termination from a committee or subcommittee. The matter may also be referred to the CalOptima Office of Compliance and/or Human Resources Department for further action as appropriate.

**IV. ATTACHMENTS**

- A. Conflict of Interest Attestation
- B. Conflict of Interest and Non-Discrimination Attestation (CPRC)
- C. Conflict of Interest Disclosure Form

**V. REFERENCES**

- A. Cal MediConnect Quality Improvement TAG QI-001
- B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
- C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- D. CalOptima PACE Program Agreement
- E. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and DHCS for Cal MediConnect
- F. Health and Safety Code §1367(g)
- G. Title 42, Code of Federal Regulations (C.F.R.), §422.205
- H. Title 28, California Code of Regulations, §1300.67.3

**VI. REGULATORY AGENCY APPROVALS**

None to Date

**VII. BOARD ACTIONS**

TBD

Policy #: GG.1656  
Title: Quality Improvement and Utilization Management  
Conflicts of Interest

Effective Date: TBD

**VIII. REVIEW/REVISION HISTORY**

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	TBD	GG.1656	Quality Improvement and Utilization Management Conflicts of Interest	Medi-Cal OneCare OneCare Connect PACE

**IX. GLOSSARY**

<b>Term</b>	<b>Definition</b>
Conflict of Interest	A conflict of interest may occur whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision. A conflict of interest may arise when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise.
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Pharmacy & Therapeutics (P&T) Committee for prescribing to Members without the need for Prior Authorization.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Participant	Any individual serving in an appointed, volunteer, or employed position in CalOptima QI and/or UM Departments and/or on any QI or UM committees or subcommittees. This includes, but is not limited to, those individuals making decisions in connection with member quality of care complaints and grievances, provider credentialing and re-credentialing, and/or peer review activities.
Related Party	The Participant's spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in-law, or the spouse of a grandparent.

## Conflict of Interest Attestation

[Quality Improvement Committee/Sub-Committee(s)]

I, \_\_\_\_\_, agree and attest as follows:

1. I am a member of the following CalOptima [Quality Improvement Committee/Sub-Committee(s)]: \_\_\_\_\_.
2. I understand CalOptima requires that all individuals who serve on [Quality Improvement Committee/Sub-Committee(s)] or who otherwise make decisions on quality oversight and activities (“Participant”), timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.
3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:
  - a. when there is a divergence between the Participant’s private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant’s professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;
  - b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant’s immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in-law, or the spouse of a grandparent), or the Participant’s employers, partners, or other business associates; and
  - c. when medical decisions are unduly influenced by fiscal and administrative management.

4. I understand all decisions concerning the safe care, quality of treatment, and services provided to CalOptima's patients must be made solely with the intent to meet the needs of those patients and without any actual, perceived, or potential conflicts of interest.
5. That, under no circumstances, may I place my own financial interests above the welfare of CalOptima's patients.
6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CalOptima's policies and procedures.
7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.
8. I will comply with all CalOptima decisions regarding the resolution of conflicts and/or CalOptima's imposition of safeguards (e.g., abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.

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Signature

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Printed Name

---

Date

## Conflict of Interest and Non-Discrimination Attestation

### Credentialing and Peer Review Committee

I, \_\_\_\_\_, agree and attest as follows:

1. I am a member of the CalOptima Credentialing and Peer Review Committee (CPRC).
2. I understand CalOptima requires that all individuals who serve on the CPRC (“Participant”), timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.
3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:
  - a. when there is a divergence between the Participant’s private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant’s professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;
  - b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant’s immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in-law, or the spouse of a grandparent), or the Participant’s employers, partners, or other business associates; and
  - c. when medical decisions are unduly influenced by fiscal and administrative management.
4. I understand all decisions concerning the safe care, quality of treatment, and services provided to CalOptima’s members must be made solely with the intent to meet the needs of those members and without any actual, perceived, or potential conflicts of interest.
5. That, under no circumstances, may I place my own financial interests above the welfare of CalOptima members.

6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CalOptima's policies and procedures.
7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.
8. I will comply with all CalOptima decisions regarding the resolution of conflicts and/or CalOptima's imposition of safeguards (e.g., abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.
9. I acknowledge that Federal law prohibits CalOptima from discriminating, in terms of participation, against any health care professional who acts within the scope of his or her license or certification under State law, solely on the basis of the license or certification category but that this prohibition does not preclude actions designed to maintain quality of care.
10. I acknowledge and understand that I may not base credentialing or re-credentialing recommendations or decisions and/or peer review recommendations or decisions on a provider's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) and I agree that I will not discriminate against any CalOptima provider in making such recommendations or decisions.

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Signature

---

Printed Name

---

Date

## CALOPTIMA CONFLICT OF INTEREST DISCLOSURE FORM

*Quality Improvement and Utilization Management Departments, Committees and Subcommittees*

Name: \_\_\_\_\_

Department: \_\_\_\_\_

Committee/Subcommittee: \_\_\_\_\_

**Please complete the information below. The terms “Conflict of Interest” and “Related Party” as used in this Conflict of Interest Disclosure Form are defined below.**

### **Definitions:**

A. **Conflict of Interest:** A conflict of interest may occur whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision. A conflict of interest may arise when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise.

B. **Related Party:** The Participant's spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in-law, or the spouse of a grandparent.

### **Conflict of Interest Disclosures:**

Please answer all questions below to the best of your knowledge. Indicate by marking YES or NO if any of the questions apply to you or to any Related Party. Please attach supplementary pages if you have additional disclosures that will not fit in the space below.

1. Do you and/or any Related Party currently have, or within the last five (5) years had, ownership, employment, contractual and/or other interest or affiliation in any clinic, medical group, Independent Practice Association (IPA) and/or Health Maintenance Organization?

☐ Yes ☐ No

If yes, please complete the information below.

<u>Entity</u>	<u>Role</u>	<u>Remuneration Type</u>

2. Do you and/or any Related Party currently have, or within the last five (5) years had, any ownership, employment, contractual and/or other interest or affiliation in any company, vendor or organization that conducts provider peer review, credentialing/re-credentialing, quality assurance, utilization review medical record review, hearing officer/judicial review committee services, expert witness services and/or similar activities or services?

☐ Yes ☐ No

If yes, please complete the information below.

<u>Entity</u>	<u>Your Role</u>	<u>Nature of Services</u>

3. Do you or any Related Party currently have, or within the last five (5) years had, any ownership interest in or receive any payment(s) or other remuneration from a pharmaceutical, medical device or supply, biotechnology, or medical consulting, manufacturing or distributing company (including, but not limited to, any salary, commission, advance, interest, rent, gift, loan, loan forgiveness, payment of indebtedness, rebate, payment or reimbursement of expenses, fees for consulting, speaker's bureaus, advisory boards or other committees)?

☐ Yes ☐ No

If yes, please complete the information below.

<u>Entity</u>	<u>Role</u>	<u>Remuneration Type</u>

4. Do you and/or any Related Party currently have, or within the last five (5) years had, any ownership interest in or receive any equity, including stock, stock options, or venture capital funds from a pharmaceutical, medical device, biotechnology, or medical consulting, manufacturing or distributing company? (Mutual funds and publicly traded stock are excluded).

☐ Yes ☐ No

If yes, please complete the information below.

<u>Entity</u>	<u>Role</u>	<u>Remuneration Type</u>

5. Do you and/or any Related Party currently have, or within the last five (5) years had, rights to medical intellectual property, including patent rights or royalty income?

☐ Yes ☐ No

If yes, please complete the information below.

<u>Entity</u>	<u>Nature and Amount of Interest</u>	<u>Medical Company</u>

6. Do you and/or any Related Party receive any payment(s) or other remuneration for research, including any grants within the last five (5) years?

☐ Yes ☐ No

If yes, please complete the information below.

<u>Entity</u>	<u>Role</u>	<u>Remuneration Type</u>

7. Do you and/or any Related Party currently hold, or within the last five (5) years held, any position as an officer, director, partner, or manager in a hospital, ambulatory surgery center, pharmaceutical, medical device, or biotechnology manufacturing, distributing, or consulting company?

☐ Yes ☐ No

If yes, please complete the information below.

<u>Entity</u>	<u>Role</u>	<u>Remuneration Type</u>	<u>Annual Dollar Value</u>

8. Do you have any other potential or actual Conflict(s) of Interest?

☐ Yes ☐ No

If yes, please describe below.

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I acknowledge and agree that I have received, reviewed, understand and will comply with, CalOptima's Conflicts of Interest Policy No. [REDACTED]. I further acknowledge and agree that I have disclosed all known Conflicts of Interest below.

By my signature below, I understand and acknowledge that I have an ongoing obligation to disclose any known Conflicts of Interest that arise while participating in any capacity in the Quality Improvement and/or Utilization Management Departments and/or during my participation on any CalOptima Quality Improvement and/or Utilization Management committee or subcommittee and that I will promptly disclose the existence and nature of any potential or actual Conflicts of Interest.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Board of Director's Quality Assurance Committee Meeting February 20, 2018**

### **PACE Member Advisory Committee (PMAC) Update**

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#### **PMAC Meeting December 11, 2017**

- Updates from the Director
  - Staff no longer with the program include the Center Manager, Case Manager, Medication Nurse, and Nurse Practitioner.
  - Staffing changes due to promotion include the Level of Care Nurse promoted to Quality Improvement Manager and Marketing Specialist promoted to Manager of Marketing and Enrollment.
  - New staff welcomed to the PACE team include a new Physician, Personal Care Coordinator, Social Worker, Center Manager, and three Clinic Nurses.
- New Items Discussed
  - Social Work Supervisor Rebekah Bitterman provided an update to committee members on PACE's Split IDT that started on 12/1/17. There are now two interdisciplinary teams, Team 1 and Team 2. Participants were informed to request a list from their social worker if interested in knowing who is assigned to them.
  - Participants were reminded to save the date for holiday activities at the PACE center, including a sing-along and visit from Santa Claus.
- The following suggestions and comments were provided by PACE Participants:
  - Request was made for make-up sessions with Santa Claus.
  - Participants requested advance notification in the future when staff members leave.
  - Transportation concerns were shared regarding late departures.
  - Request for more activities outside, like the 'Sunshine Club'.
  - Request for a cell phone help class to learn more about how to operate a smart phone.
  - Discussion of what the acronyms represent on staff name badges.

## **Executive Summary**

### **Quality Improvement Committee (QIC) 4th Quarter 2017**

Quarterly reports provided by all key areas:

- **Credentialing and Peer Review Committee (CPRC)**
  - Reported on initial and re-credentialing of the provider network and related facility site review, medical record review and physical accessibility review results
  - Reported on Potential Quality of Care (PQI) cases – Case loads continue to increase due to the volume of complaints being referred to QI from Customer Service and Grievance and Appeals (GARS)
- **Long-Term Services and Supports QI subcommittee update (LTSS-QISC)**
  - Case turnaround time standards were met
  - Admissions: Met goals for Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Long-Term Care (LTC) and Multipurpose Senior Services Program (MSSP)
  - Readmissions: Met goals for LTC and MSSP ; CBAS and IHSS did not meet goals
  - Emergency Room (ER) Visits: Met goals for CBAS, IHSS, LTC and MSSP
  - LTSS Utilization: Met goals for LTSS and LTC
- **PACE Quality Improvement Committee update**
  - Membership growth
  - Utilization trends
  - Physician Orders for Life-Sustaining Treatment (POLST) improvement
  - Annual diabetic eye exams
  - Areas to be addressed in Q4

- Clinical Operations/Medical Affairs Update
  - Improve processes to monitor over and under utilization
  - Improve notification of authorization approvals to Medi-Cal CalOptima Community Network (CCN) and CalOptima Direct (COD) members
  - Improve communication and continuity of care during transitions
  - Improved percentage of Health Risk Assessment (HRA) collection
  - Tracking ER High Utilizers as part of Case Management program
  - Continue to track and update 2017 Model of Care dashboard to align with Centers for Medicare and Medicaid Services (CMS) requirements
- Quality Analytics update
  - Reviewed progress on the 2017 Quality Initiatives
  - Member incentive program extended for several programs including: Postpartum, Breast Cancer Screening, PCP Office Staff, and Extended Office Hours,
  - Women's Health Campaign completed
- Pay 4 Value (P4V) update
  - Final payments for HN P4V program based on Measurement Year (MY 2016) were calculated and distributed
  - 2018 P4V Program for HN including CCN fully approved by CalOptima's Board of Directors
  - OneCare Connect Cal MediConnect Plan (Medicare and Medicaid Plan) (OCC) Quality Withhold payments for year 1 were disbursed November 2017
- Member Experience (MEMX) Subcommittee update
  - Medi-Cal Customer Service met goal for First Call Resolution, however did not meet goal for Average Speed of Answer and Notification to Member of PCP termination.
  - OneCare (OC) and OCC Customer Service met goals for all three key performance indicators (KPI)
  - Distributed Medi-Cal health network specific Consumer Assessment of Healthcare Providers and Systems (CAHPS) results.
  - Provider Coaching Request for Proposal (RFP) resulted in vendor selection and contract initiation

- Network Adequacy continues to be monitored and shared with Health networks. QI Plans were issued in December to HN that did not meet standards
- Grievance and Appeal Resolution Services (GARS) Committee update
  - CCN appeals increased by 24%, due to high volume of requests for Tertiary Level of Care and inpatient retro authorization that don't meet medical necessity
  - COD appeals increase slightly due to non-emergency medical transportation (NEMT) and Durable Medical Equipment (DME) requests
  - Member billing grievances increased by 67%. Going forward billing issues not resolved by the next business day are categorized as standard grievances and will follow grievance process.
  - Increases in member billing are driving up rates/1000 members for HN

Reported 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 Q3 — Attachment 1a
- 2017 HEDIS Dashboard Q3 — Attachment 1b
- 2017 Case Management Dashboard Q3 — Attachment 1c

Accepted Q3 minutes from the following committees:

- Medical Affairs: 07/31/17, 08/28/17, 09/11/17 and 09/18/17
- Long Term Services and Supports: 09/18/17
- PACE Quality Improvement Committee: 07/25/17 and 08/08/17
- Members Experience: 10/03/17, 10/17/17, 11/01/17, 11/14/17, 11/28/17 and 12/08/17
- GARS: 08/29/17; Member & Provider Trend Report Q3
- Utilization Management Committee: 8/24/17 accepted in previous report to QAC
- Behavioral Health Integration QI Committee: 8/1/17 accepted in previous report to QAC



**CalOptima**  
Better. Together.

# **Quality Improvement Committee Fourth Quarter 2017 Update**

**Board of Directors' Quality Assurance Committee Meeting  
February 20, 2018**

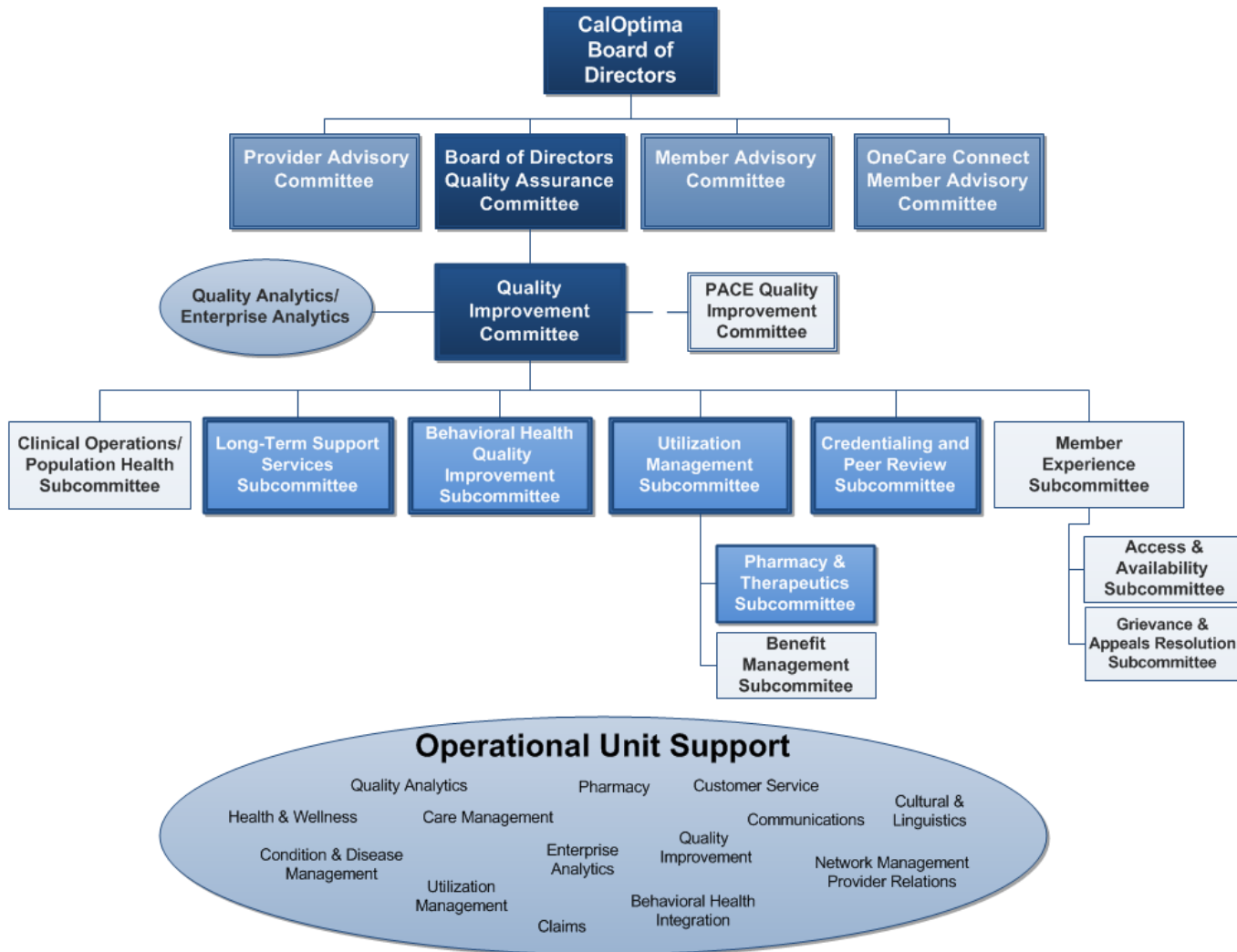
**Richard Bock, MD, MBA  
Deputy Chief Medical Officer**

# Quality Improvement Committee (QIC) Reporting

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- The following departments report to the QIC quarterly through various subcommittees:
  - Case Management and Complex Case Management
  - Behavioral Health Integration (BHI)
  - Customer Service
  - Grievance & Appeals (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)

# 2017 QI Reporting Structure



# 4<sup>th</sup> Quarter QIC Highlights

## (Based on 3rd Quarter Data and Activities)

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- Quarterly reports provided by all key areas
  - Credentialing Peer Review Report
    - Reported on initial and re-credentialing of the provider network and related facility site review/medical record review/physical accessibility review results
    - Reported on Potential Quality of Care (PQI) cases – Case loads continue to increase due to the volume of complaints being referred to QI from Customer Service and Grievance and Appeals (GARS)
  - Long-Term Support Services Report
    - Case turn-around-time standards were met
    - Admissions – CBAS, IHSS, LTC and MSSP met the goal
    - Readmissions – LTC and MSSP met the goal, CBAS and IHSS did not meet goal
    - Emergency Room Visits – CBAS, IHSS, LTC and MSSP met the goal
    - Long Term Services and Supports Utilization – LTSS and LTC met the goal

# 4th Quarter QIC Highlights (cont.)

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## ➤ PACE Report

- Membership growth
- Utilization trends
- POLST improvement
- Annual diabetic eye exams
- Areas to be addressed in Q4

## ➤ Clinical Operations/Medical Affairs Report

- Improve processes to monitor over and under utilization
- Improve notification of authorization approvals to Medi-Cal CCN/COD members
- Improve communication and continuity of care during transitions
- Improved percentage of Health Risk Assessment (HRA) collection
- Tracking ER High Utilizers as part of Case Management program
- Continue to track and update 2017 Model of Care dashboard to align with CMS requirements

# 4th Quarter QIC Highlights (cont.)

---

## ➤ Quality Analytics Report

- Reviewed progress on the 2017 Quality Initiatives
- Member incentive program extended for several programs including: Postpartum, Breast Cancer Screening, PCP Office Staff, and Extended Office Hours,
- Women's Health Campaign completed

## ➤ Pay 4 Value Report

- Final payments for HN P4V program based on MY 2016 were calculated and distributed
- 2018 P4V Program for HN including CCN fully approved by BOD
- OCC Quality Withhold payments for year 1 to be disbursed November 2017

# 4th Quarter QIC Highlights (cont.)

---

## ➤ Member Experience Report

- Medi-Cal Customer Service met goal for First Call Resolution, however did not meet goal for Average Speed of Answer and Notification to Member of PCP termination.
- OC/OCC Customer Service met goals for all three KPI
- Distributed MC health network specific CAHPS results.
- Provider Coaching RFP resulted in vendor selection and contract initiation
- Network Adequacy continues to be monitored and shared with Health networks. Quality Improvement Plans were issued in December to plans that did not meet standards

## ➤ Grievance and Appeal Resolution Services (GARS) Report – see Member and Provider Trend Report

## ➤ Utilization Management Committee and BHQIC Reports 4<sup>th</sup> Quarter updates will be included in the next QIC report.

# Committee Updates

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- Accepted Q3 minutes from the following committees:
  - Medical Affairs: 07/31/17, 08/28/17, 09/11/17, 09/18/17
  - Long Term Services and Supports: 09/18/17
  - PACE Quality Improvement Committee: 07/25/17, 08/08/17
  - Members Experience: 10/03/17, 10/17/17, 11/01/17, 11/14/17, 11/28/17, 12/08/17
  - GARS: 08/29/17, Member & Provider Trend Report Q3
  - Utilization Management Committee: 8/24/17 accepted in previous report to QAC
  - Behavioral Health Integration QI Committee: 8/1/17 accepted in previous report to QAC

# CPRC Summary – Q3 Highlights

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- CPRC met 7/20/17, 08/17/17, 09/21/17 & 09/28/17 (adHoc)
- New board approved credentialing policies have been posted on the Infonet, and are effective 7/1/2017.
- Recognize the need to improve reporting of 805s and terminations by Health Networks to CPRC
- In an effort to reduce the TAT for PQI's and based on CAP from DMHC, nurses are now reviewing all PQI's within 3-5 business days to see if the member has any urgent medical (BH or dental) issues that require immediate assistance from the nurse.
- Our PQI team is working closely with Customer Service to help staff better identify Quality of Care issues. Training of CS staff setup in October.

# Credentialing and Peer Review Subcommittee (CPRC) Q3 Highlights: Credentialing

Credentialing Activity	3 <sup>rd</sup> Quarter	YTD
Total number of initial files completed	73	140
Total number of re-credentialed files completed	117	326
Total Number of Initial and Recred files (Clean list and CPRC Approved)	180	466
Number of files with issues – presented to CPRC and NOT approved	0	0
Timeliness for Initials – Goal Met (Within 180 days from attestation date)	100%	100%
Timeliness for Recreds – Goal Not Met (Within 36 Months)	100%	100%

# FSR/MRR/PARS\* – Q3 and YTD, 2017

Site Reviews Activity	3 <sup>rd</sup> Quarter, 2017	YTD 2017
Total number of Full Scope FSR/MRR Completed (PCP)	65	206
% of FSR/MRR Completed Score >80%	100%	100%
Total number of PARS Completed (PCP & HVS)	146	411
% of PARS with BASIC Access	58%	58%
Number Critical Element CAPS Issued	11 issued	34 issued
Number of FSR CAPs Issued	31 issued	91 issued
Number of MRR CAPS Issued	18 issued	65 issued
Number of Member Panels Closed	1	6

\*Facility Site Review/Medical Record Review/Physical Accessibility Review Survey

# CPRC Q3 Highlights — PQI

Severity Code	Definition	Number of Cases
0	No quality of care issue	208
1	Clinical judgment issue without adverse outcome	9
2	Clinical judgment issue with a mild to moderate adverse outcome	2
3	Severe clinical judgment issue with or without severe adverse outcome	1
HDS	Healthcare delivery system issue with or without adverse outcome	5
H1	Potential clinical care issue with or without adverse outcome in hospital	2
S0	Service-related issue, unable to verify	69
S1	Service-related issue, verified	106
Close PQI and open new PQI with another Provider		2

# LTSS — QI Sub-Committee Report Highlights

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- LTSS QISC 9/18/17
- LTSS Metrics Reporting
  - Case turn-around-time standards were met
  - Admissions – CBAS, IHSS, LTC and MSSP met the goal
  - Readmissions – LTC and MSSP met the goal, CBAS and IHSS did not meet goal
  - Emergency Room Visits – CBAS, IHSS, LTC and MSSP met the goal
  - Long Term Services and Supports Utilization – LTSS and LTC met the goal

# LTSS Program Utilization Trends by Age and Year

Category	2014	2015	Trend	2016	Trend	2017	Trend
<b>Population 41-64</b>	123,161	169,144		178,868		176,773	
%	19%	22%	↑	22%	↔	22%	↔
<b>Population 65+</b>	84,809	91,213		88,110		91,707	
%	13%	12%	↓	11%	↓	11%	↔
<b>LTSS 41-64</b>	4,354	4,335		3,788		3,590	
%	3.54%	2.56%	↓	2.12%	↓	2.03%	↓
<b>LTSS 65+</b>	16,498	16,904		14,860		14,983	
%	19.45%	18.53%	↓	16.87%	↓	16.34%	↓
<b>LTC 41-64</b>	1,283	1,333		1,319		1,278	
%	1.04%	0.79%	↓	0.74%	↓	0.72%	↓
<b>LTC 65+</b>	3,671	3,908		3,775		3,694	
%	1.51%	4.28%	↑	4.28%	↔	4.03%	↓

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# LTSS QISC (cont.)

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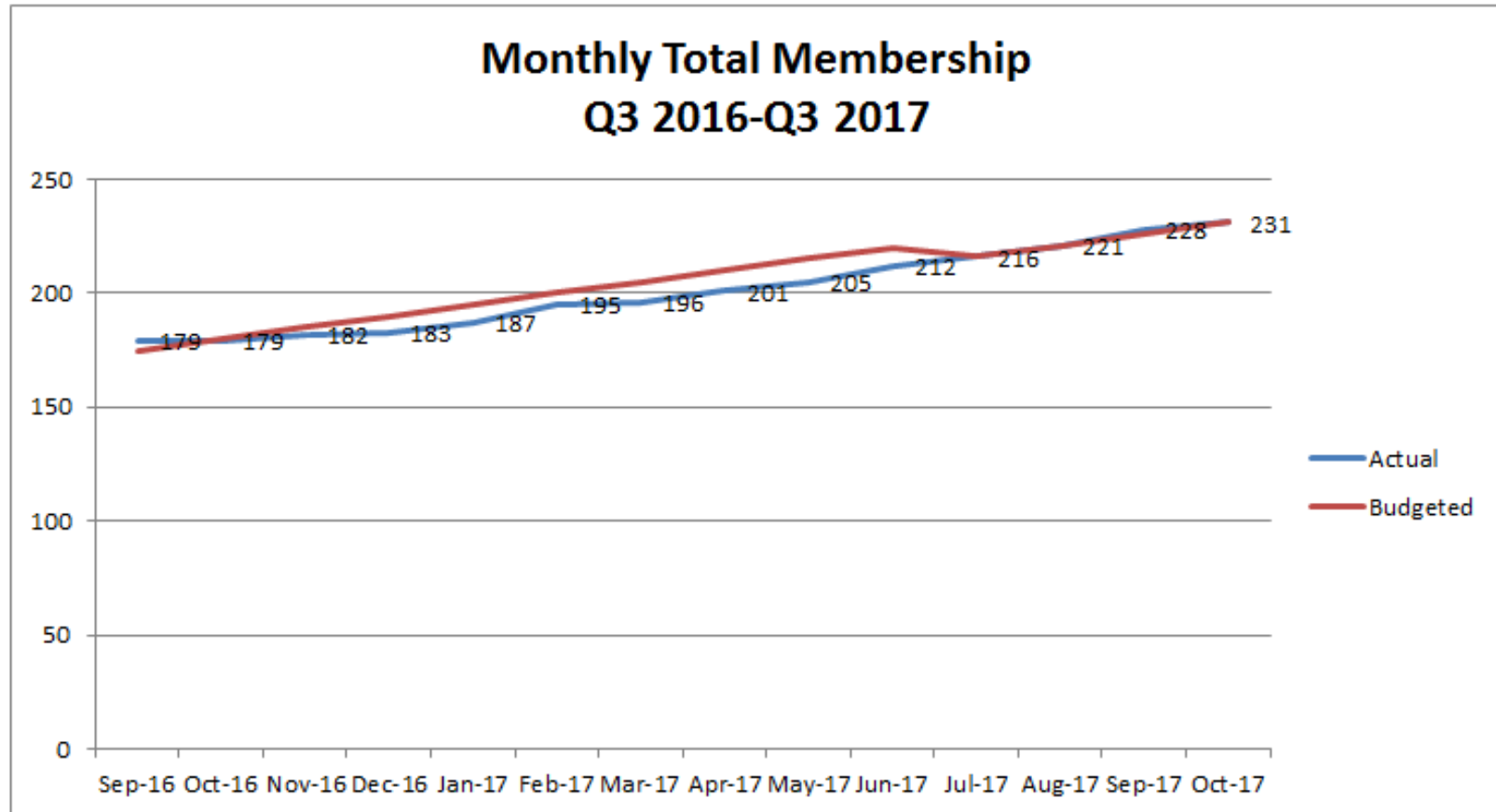
- Planned interventions to reduce admissions/readmissions include:
- LTC:
  - LTC on-site RNs complete member assessment reviews to ensure members needs are being met and provide referrals to the appropriate resources when appropriate.
  - LTC on-site RNs attend member Interdisciplinary Care Team (ICT) meetings.
  - Increased focus on Treatment in Place (TIP).
- CBAS:
  - Workgroup with CBAS center staff to address barriers to preventing readmissions.

# PACE Report Highlights

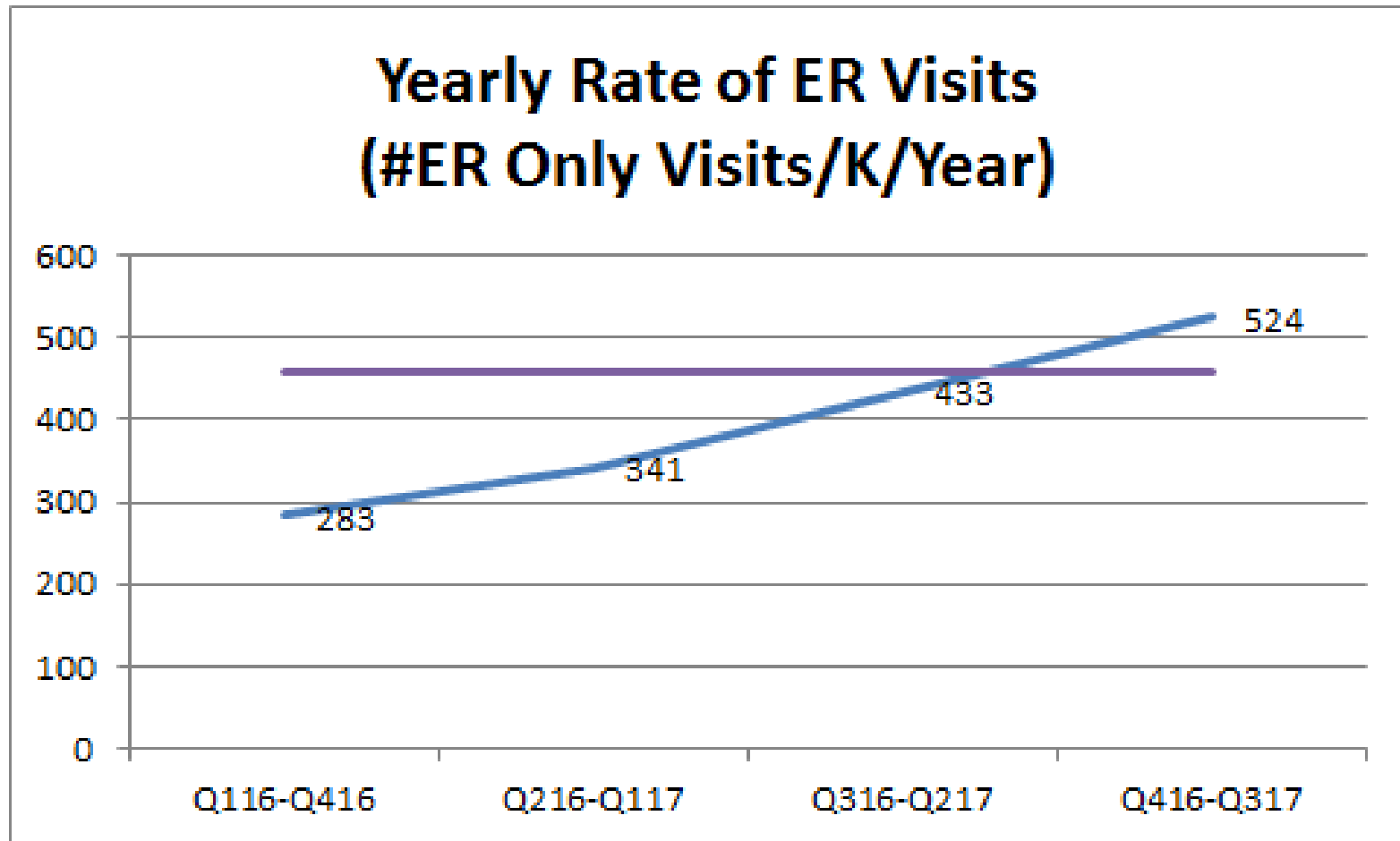
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- PACE QIC 7/25/17 & 8/8/17
- Membership growth
- Utilization trends
- POLST improvement
- Annual diabetic eye exams
- Areas to be addressed in Q4

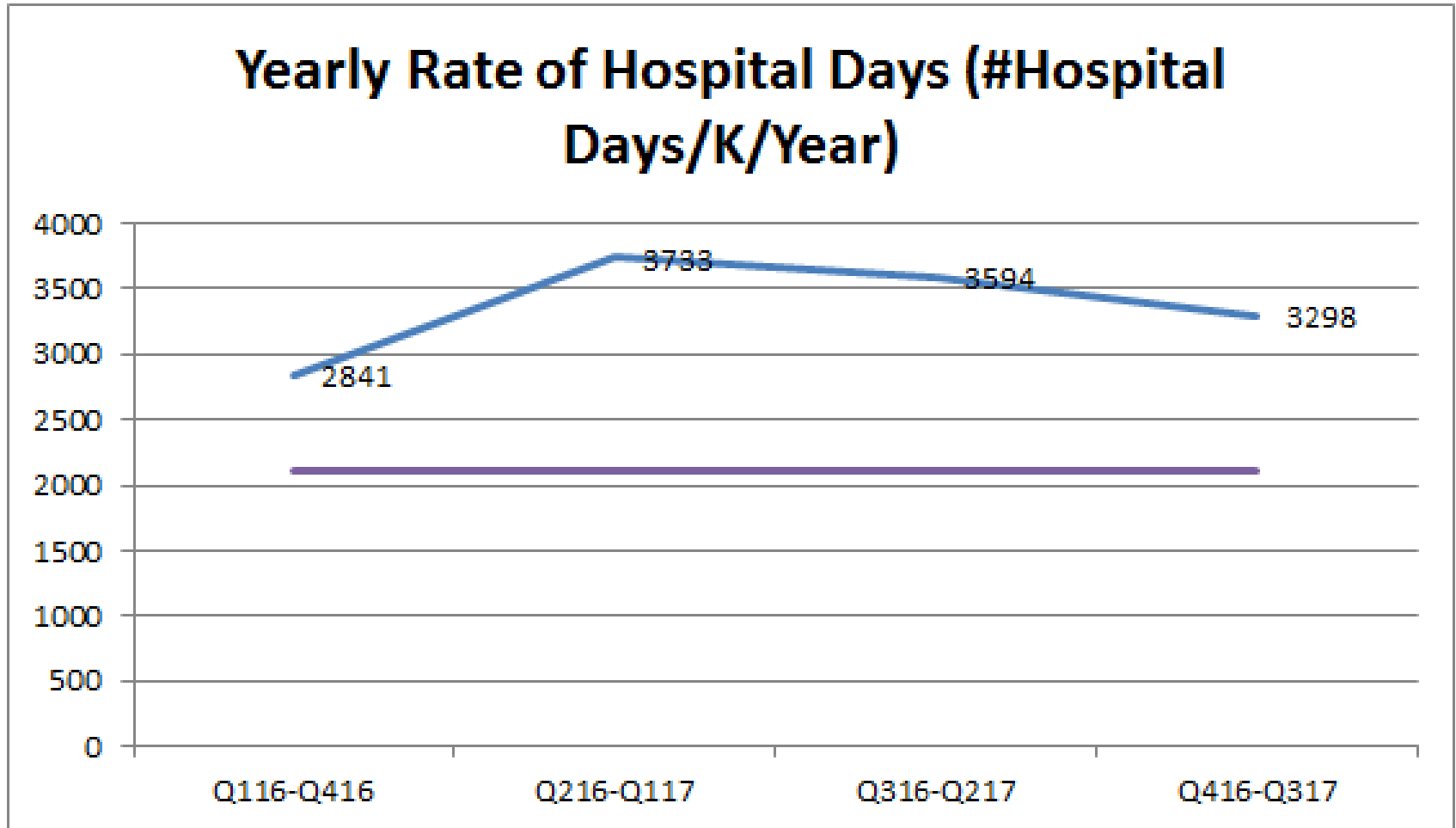
# Total Membership



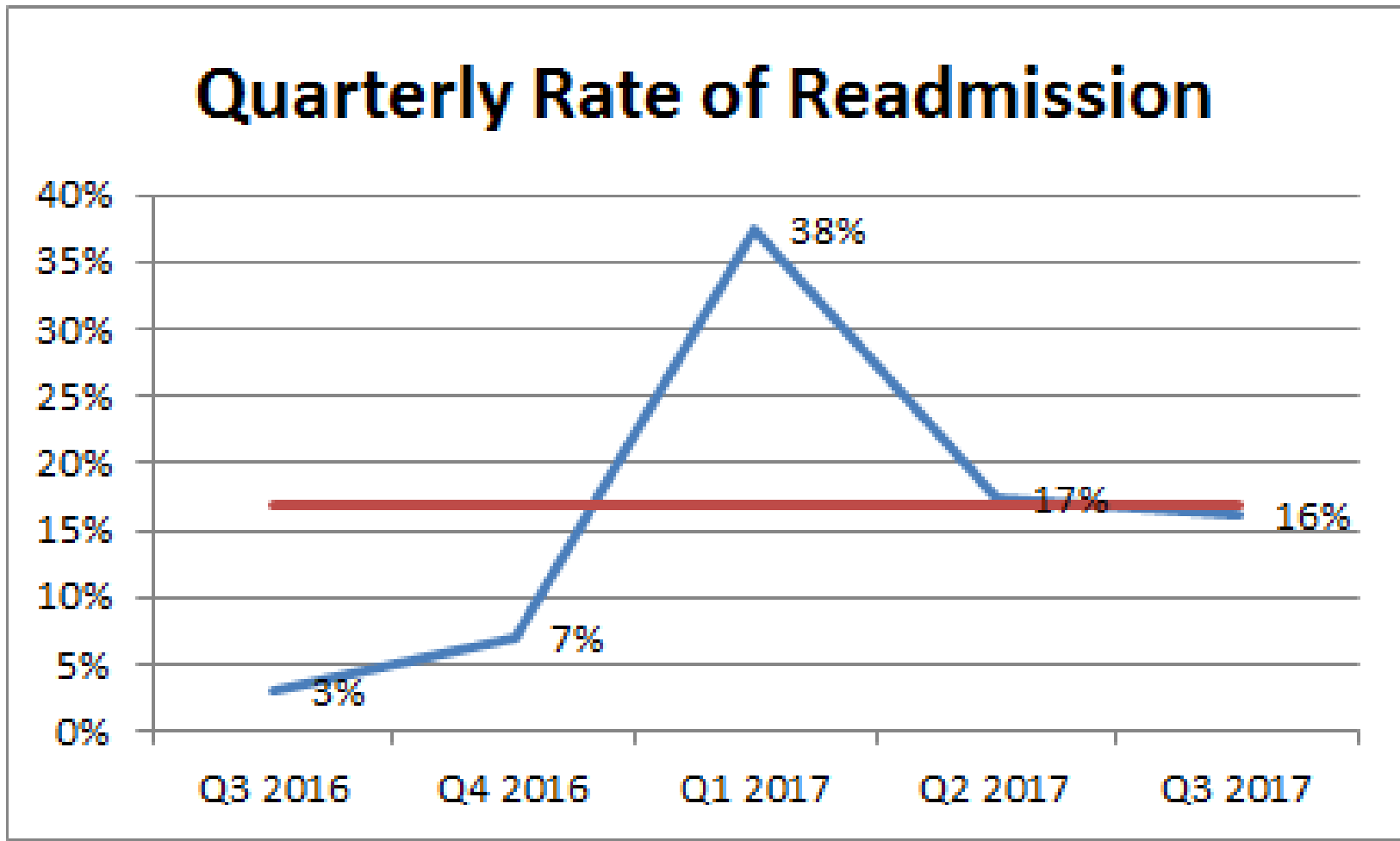
# ER Visits (Goal: 458 Visits/K/Y)



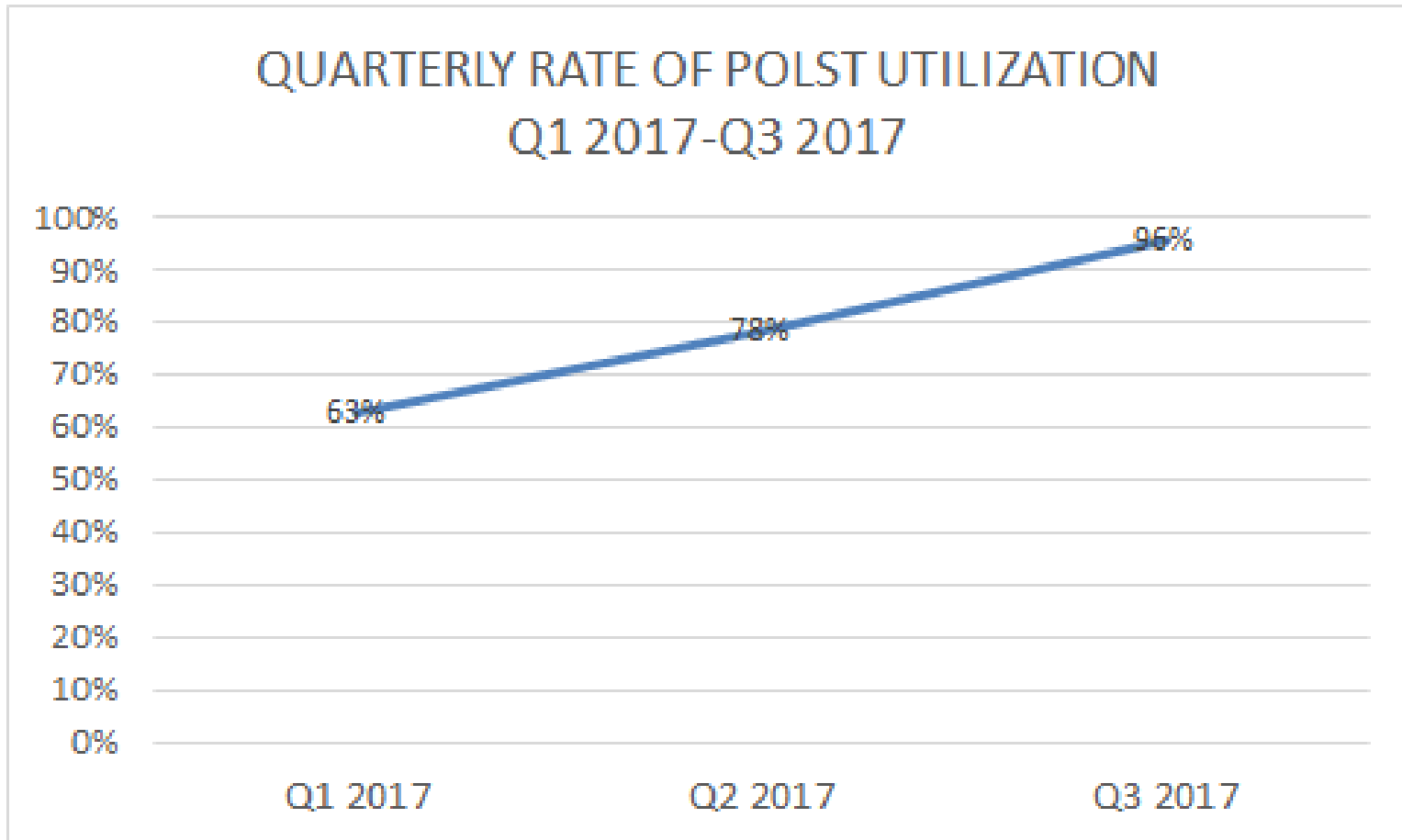
# Hospital Days (Goal: 2104 Days/K/Year)



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

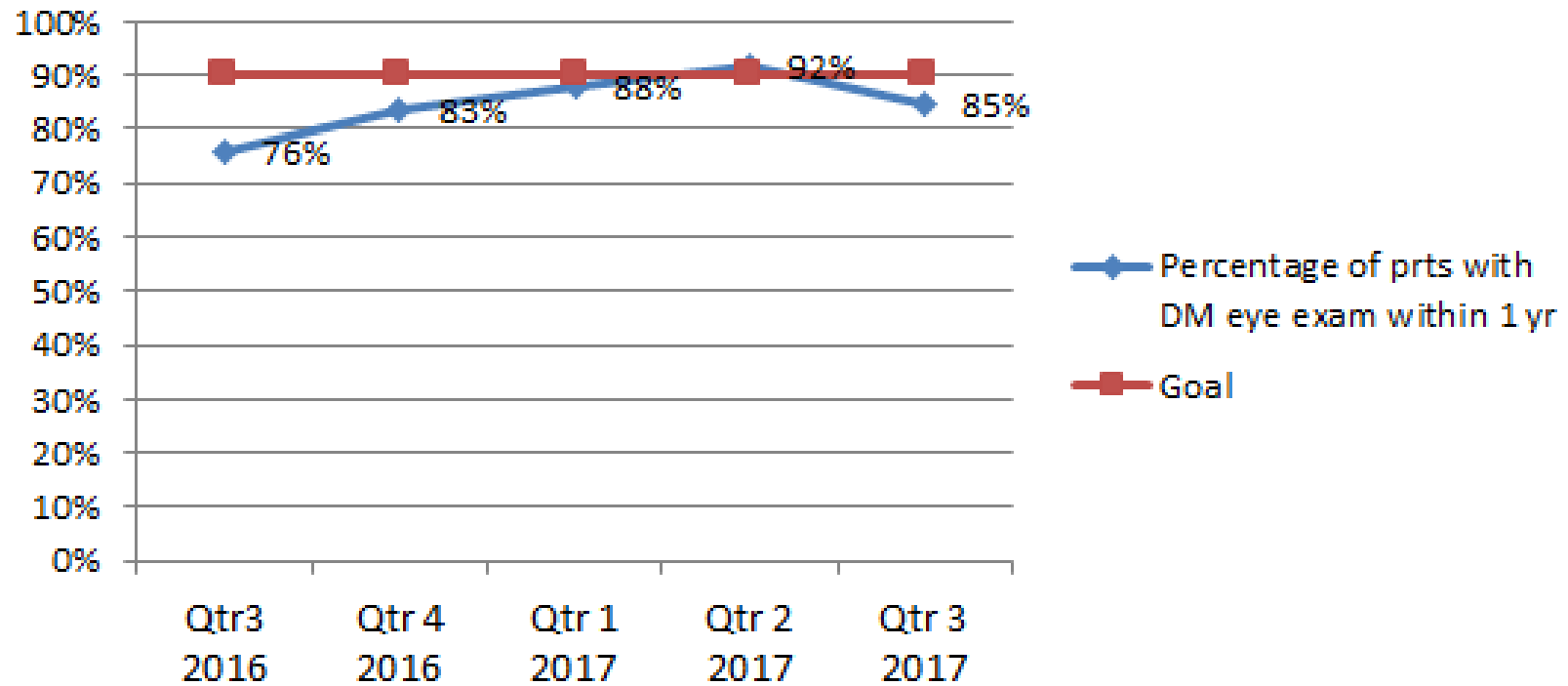


# Physician Orders for Life-Sustaining Treatment (POLST) Goal: 75%



# Annual Diabetic Eye Exams

## Diabetic Eye Exams 2017 Goal: >90%



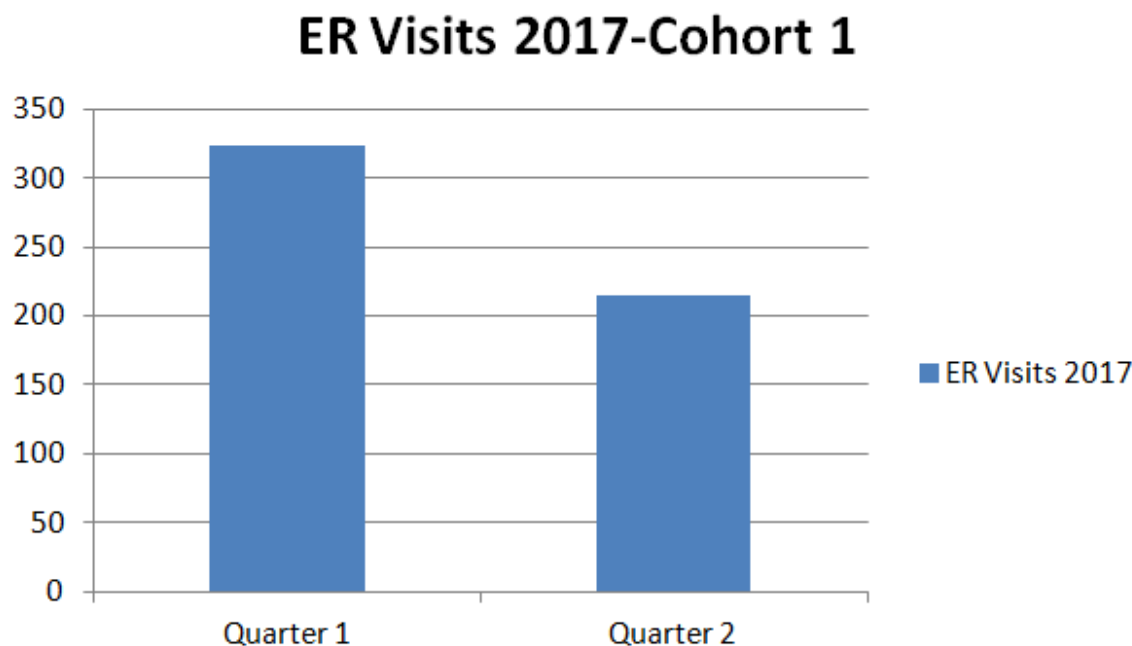
# PACE Summary, Priorities and Resource Allocation

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- Access and Availability
  - Split-shifts implemented
  - Community Physician Waiver
- Utilization Management
  - Implemented Concurrent Review Workflow
  - Specialty Authorization Workflow Development
  - Specialty Medication Review Program Development
- QI
  - Preventative Influenza clinics
  - Ongoing monitoring of our Transportation Vendor
  - Analysis of Drug/Disease Interactions in the Elderly (DAE)
  - Analyze Care for Older Adults HEDIS Metrics

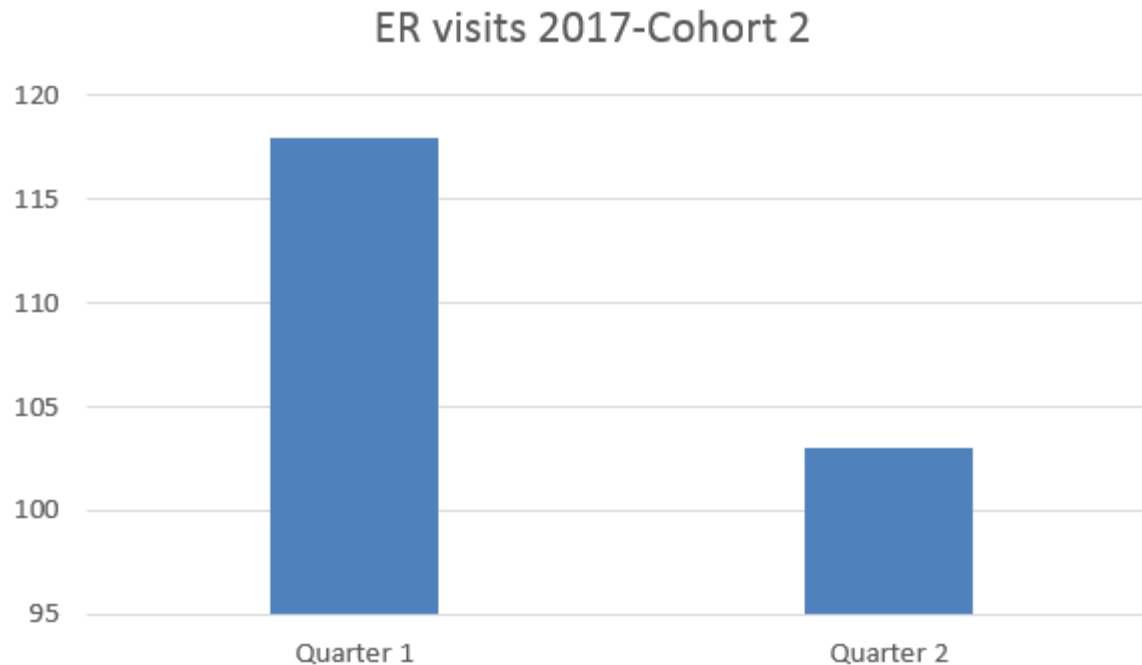
# Clinical Operations/Medical Affairs Report

- Tracking ER High Utilizers as part of Case Management program



# Clinical Operations/Medical Affairs Report

- ER Visits Q1 vs Q2 Cohort 2



# Clinical Operations/Medical Affairs Report

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- ER High Utilizers Next Steps
  - Further analysis underway
    - BH
    - Substance use
    - Homelessness
    - Eligibility issues
    - Out of area
    - PCP Engagement
  - Development of new strategies for outreach and engagement
  - Addition of new cohorts

# 2017 Model of Care (MOC) Updates

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- Continued enhancements to MOC dashboards:
  - Align with CMS' requirements PPME: SNP, QIPE: OCC
  - Preparation for mock audit: completed in September
  - Results of mock audit pending
- Effective September 11, 2017, The Medicare-Medicaid Coordination Office made changes to MOC requirements:
  - MMPs no longer required to submit their Model of Care for approval
  - No change to training requirements for staff/delegates/providers
  - CalOptima will continue to maintain the MOC document to ensure a coordinated approach to care

# Quality Analytics Report

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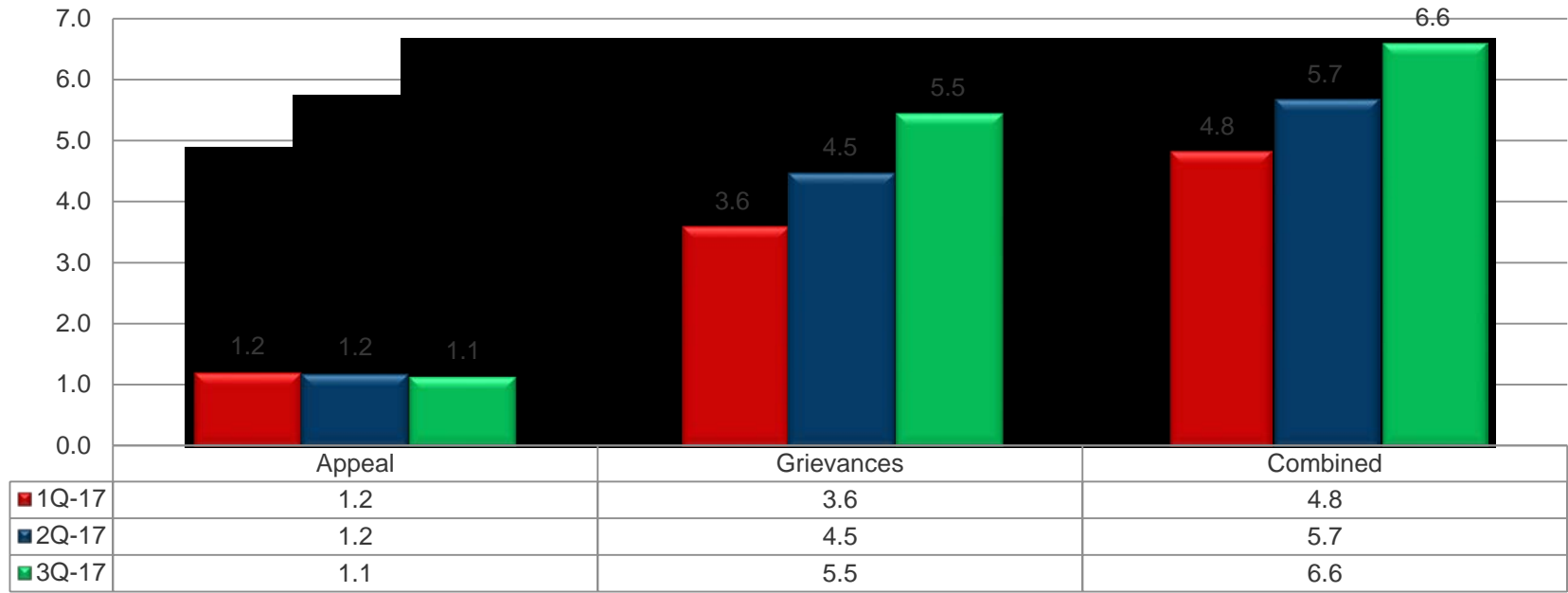
- Quality Analytics Report
  - Reviewed progress on the 2017 Quality Initiatives
  - Member incentive program extended for several programs including: Postpartum, Breast Cancer Screening, PCP Office Staff, and Extended Office Hours,
  - Women's Health Campaign completed
- Pay 4 Value Report
  - Final payments for HN P4V program based on MY 2016 were calculated and distributed
  - 2018 P4V Program for HN including CCN fully approved by BOD
  - OCC Quality Withhold payments for year 1 to be disbursed November 2017

# Member Experience Report Highlights

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- 2017 CAHPS results distributed to Health Networks
- Provider Coaching RFP resulted in vendor selection and contract initiation
- Customer service key performance indicators (KPI)
  - First call resolution — KPI met for all programs
  - Speed of answer — KPI Met OC/OCC, Not met for Medi-Cal
  - Notification of Termination – KPI Not Met for Medi-Cal
- Network Adequacy continues to be monitored and shared with Health Networks. Quality Improvement Plans issued in December to plans that did not meet standards
- GARS report directly to both QIC and Member Experience

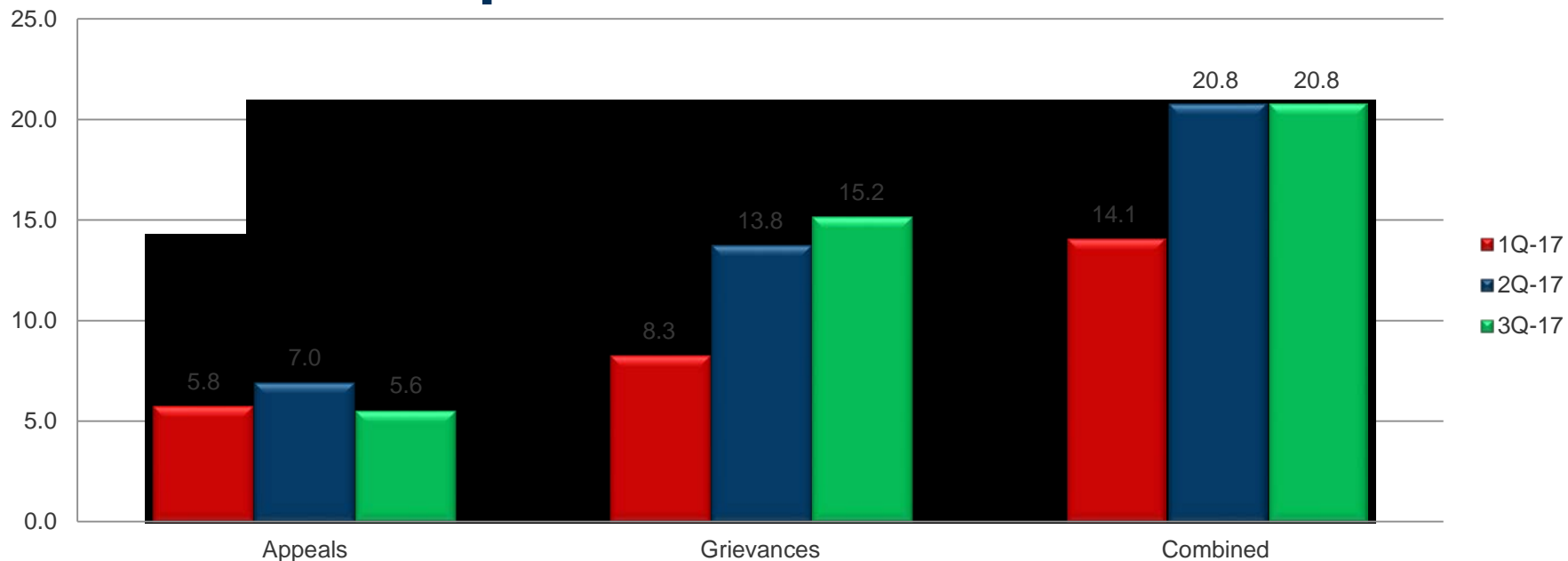
# Member Experience: Medi-Cal Member Complaints



	Total Complaints	Appeals	Grievances	Membership
1Q-2017	921	233	688	774,750
2Q-2017	1094	232	862	772,074
3Q-2017	1288	224	1064	773,314

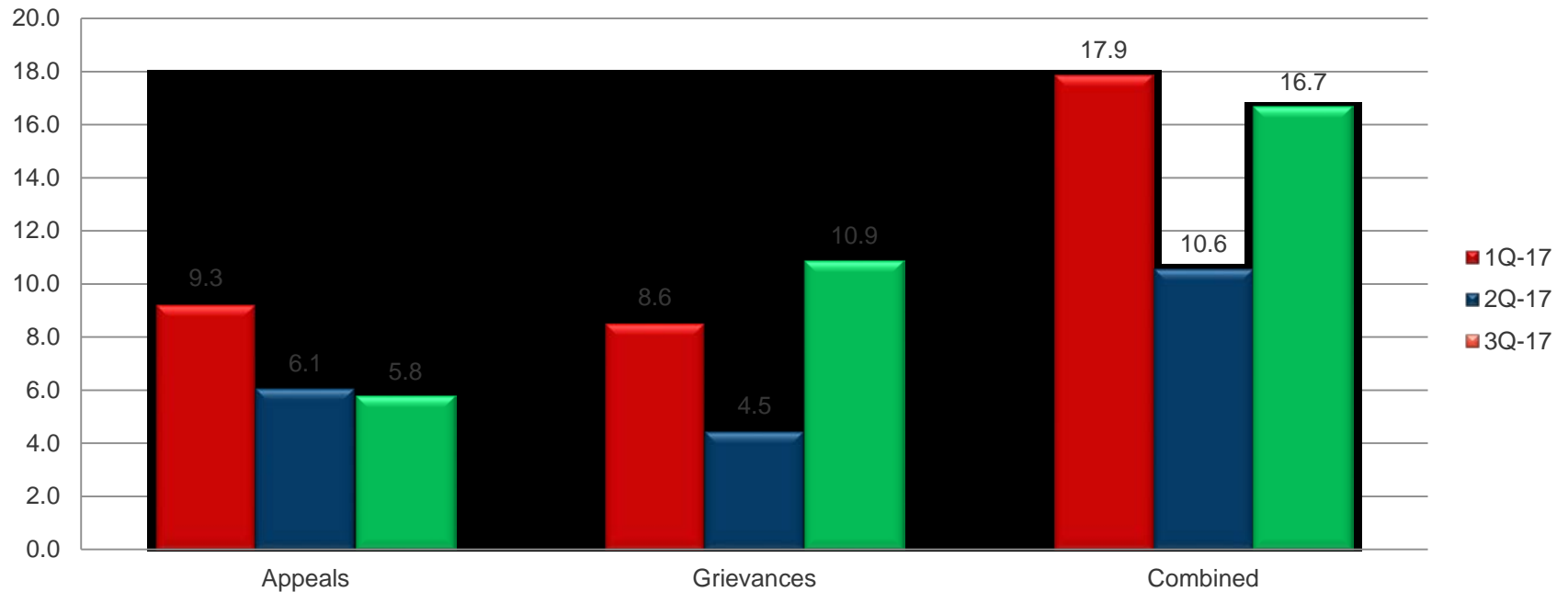
# Member Experience: OneCare Connect

## Member Complaints



	Total Complaints	Appeals	Grievances	Membership
1Q-2017	38	95	135	16,297
2Q-2017	18	110	218	15,810
3Q-2017	22	86	234	15,348

# Member Experience: OneCare Member Complaints



	Total Complaints	Appeals	Grievances	Membership
1Q-2017	23	12	11	1,285
2Q-2017	14	8	6	1,320
3Q-2017	23	8	15	1,373

2017 QI Work Plan	Owner	Goal	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Q3 Dashboard Red - Goal at Risk Yellow – Concerned with Meeting Goal Green – On Target
<b>Program Oversight</b>						
I. A. Program Scope-2017 QI Annual oversight of programs and work plans	Caryn Ireland	Annual Adoption	Adopted and approved.		3/22/2017	
I. B. Program Scope-2016 QI Program Annual Evaluation	Caryn Ireland	Annual Evaluation	Adopted and approved.		5/22/2017	
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 Effectiveness 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 Effectiveness approved at QIC		5/1/2017	
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	Achieved Commendable status for NCQA. Annual Health Plan Rating		8/31/2017	
<b>Case Management</b>						
II. A. Quality of Clinical Care- Review of health risk assessments to OCC, OC, SPD members	Sloane Petrillo	56%	OCC initials met collection goal for high risk at 80%	Increased visibility of feedback to PCCs. Will continue to monitor and provide feedback to PCCs.	Q4	Initials OCC
	Sloane Petrillo	43%	OCC initials met collection goal for low risk with collection still in progress for low risk at 69%	Increased visibility of feedback to PCCs. Will continue to monitor and provide feedback to PCCs.	Q4	Initials OCC
	Sloane Petrillo	78%	OC initials did not meet goal, at 66%, additional calls in progress for the low risk September eligibles.	Increased visibility of feedback to PCCs. Will continue to monitor and provide feedback to PCCs.	Q4	Initials OC
	Sloane Petrillo	63%	SPD met goal, at 65% for initials high risk	Increased visibility of feedback to PCCs. Will continue to monitor and provide feedback to PCCs.	Q4	Initials SPD
	Sloane Petrillo	63%	SPD slightly below goal, at 62% for initials low risk	Increased visibility of feedback to PCCs. Will continue to monitor and provide feedback to PCCs.	Q4	Initials SPD
	Sloane Petrillo	OCC Goal: 50% OC Goal: 34% SPD: Mailed Timely	OCC annuals are nearly at goal at 48%. Collection still in progress. OC annuals exceeded the goal for collection at 55%. SPD annual mailing completed timely	Increased visibility of feedback to PCCs. Revised annual outreach methodology for OCC. Will continue to monitor and provide feedback to PCCs.	Q4	Annual SPD
	Sloane Petrillo	ICT Participation 100% for BHI	BHI participation for ICT remains at 100%.		Q1 2018	BHI Intergration
	Sloane Petrillo	ICT Participation 85% MBHO	Individual provider participation does not meet goal, however providers were represented at ICT and provided feedback via MBHO.	BHI invites County Mental Health individually for each case. BHI will continue current invitation process for providers with Magellan. Transition to directly contracted Behavioral Health providers in 2018 for Medi Cal.	Q1 2018	BHI Intergration

II. B. Quality of Clinical Care- Continuity & Coordination of Medical/BH	Sloane Petrillo	ICT Participation 10% Individual Providers	Individual provider participation does not meet goal, however providers were represented at ICT and provided feedback via MBHO.	BHI invites County Mental Health individually for each case. BHI will continue current invitation process for providers with Magellan. Transition to directly contracted Behavioral Health providers in 2018 for Medi Cal.	Q1 2018	BHI Intergration
	Sloane Petrillo	ICT Participation 20% County Mental Health	The rates for county participation are rising, with 55% participation by county in Q3.	BHI invites County Mental Health individually for each case. BHI will continue current invitation process for providers with Magellan. Transition to directly contracted Behavioral Health providers in 2018 for Medi Cal.	Q1 2018	BHI Intergration
II. C. Patient Safety, Quality of Care Case Management-High ER utilization	Sloane Petrillo	5% reduction in ER visits among intervention cohort Process Measure: Enroll 10 High ED utilizers quarterly .	Work group established in Q1. Baseline data collected on cohort of 10 high utilizers and meeting convened. Met goal of 5% reduction in ER visits.	Meetings will be updated to include medical director in 2018. Baseline data gathering and problem solving and analysis continues.	Q1 2018	
II. D. Quality of Clinical Care-Review of member satisfaction with CM programs	Sloane Petrillo	Satisfaction with Case Management - 88%	Annual survey exceeded goal of 88% for the year.	Alteration of methodology to increase sample size.	Q4	
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	Reporting on partial quarter due to timing of reporting: UCMG, Prospect, and Altamed did not meet the overall goal. CAP was submitted and completed for Altamed. Will watch UCMG for improvement in Q2.	Outreach to Prospect to determine barriers and offer additional training.	Q4	
<b>Behavioral Health</b>						
III. A. Quality of Clinical Care: HEDIS Measure for M/C & OCC	Dr. Donald Sharps	At or above the 50th Percentile	Difficulty finding trends that allow for one fell swoop attempt at improving rates. Each measure has its own challenges. Many times, first provider to see member is not the same member follows up with which creates the challenge for effective follow through.	Continue to monitor and look at ways to improve various measurements. Take items of concern to additional BHQI monthly work group and perform more focused drill down and interventions to address lower performance metrics.	ongoing	
III. B. Quality of Clinical Care: Interdisciplinary Care Treatment Team Participation	Dr. Donald Sharps	10% Improvement over 2016	Progress is seen and improvement from last year is slowly gaining speed. Challenges with the existing system and transmission of invitations has been key challenge. Without a shared member system, scheduling and participation in meetings is biggest challenge. Completing forms necessary for information sharing is largest barrier to success.	Encourage MBHO and County partners to participate and extend invitations when possible.	ongoing	
III. C. Quality of Clinical Care: Behavioral Health Practice Guidelines	Dr. Donald Sharps	100%	These have been completed as of Quarter 2.	Completed Q2.	Completed	
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 uniform process for accessing BH in LTC	Survey results tabulated. Trends show majority of facilities have access to a BH provider who can perform consultation when necessary, although better access is preferred. Availability was key challenge mentioned and seeking clarity on this will help guide ability to improve access. Will follow up with those commenting on access to gain better understanding.	Present Results summary to BHQI (11/14/17). Committee to review/provide feedback on identifying any opportunities for improvement based on results.	Q4	
<b>LTSS</b>						

IV. A. Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program: <b>Hospital Admissions</b>	Tracy Hitzeman	<p>Hospital Admissions</p> <p>CBAS - 254/PTMPY</p> <p>IHSS - 263/PTMPY</p> <p>LTC - 768/PTMPY</p> <p>MSSP - 310/PTMPY</p>	<p>CBAS, IHSS, LTC and MSSP met the goal.</p> <ul style="list-style-type: none"> <li>CBAS: While still meeting goal, there was a slight increase in admissions from 221/1000 to 248/1000 compared to quarter two. However, there was a decrease in average length of stay and cost per day compared to Q2.</li> <li>IHSS: Admissions, ALOS, cost per day and total bed days are down compared to Q2.</li> <li>LTC: While still meeting goal, there was a slight increase in admissions, ALOS, cost per day, and total bed days compared to quarter two.</li> <li>MSSP: While still meeting goal, there was a slight increase in admissions from 276/1000 to 319/1000 compared to quarter two. However, there was a decrease in ALOS and cost per day compared to Q2.</li> </ul>	<p>Organize a hospital admissions workgroup to decrease admissions for LTC members. The workgroup will include LTC facility administrators and CalOptima LTSS staff.</p> <p>Q1 2018</p>	
IV. B. Safety of Clinical Care and Quality of Clinical Care-Review and assess emergency department visits for LTSS members participating with each organization/program	Tracy Hitzeman	<p>Emergency Department Visits</p> <p>CBAS - 491/PTMPY</p> <p>IHSS - 625/PTMPY</p> <p>LTC - 521/PTMPY</p> <p>MSSP - 867/PTMPY</p>	<p>CBAS, IHSS, LTC and MSSP met the goal.</p> <ul style="list-style-type: none"> <li>CBAS: Significant decrease in ED visits compared to Q2, 461/1000 to 227/1000.</li> <li>IHSS: Significant decrease in ED visits compared to Q2, 530/1000 to 341/1000.</li> <li>LTC: While still meeting goal, there was an increase in ED visits compared to Q2, 338/1000 to 385/1000. However, the cost per visit was significantly reduced in Q3, \$533 to \$439.</li> <li>MSSP: Significant decrease in ED visits compared to Q2, 701/1000 to 254/1000.</li> </ul>	<p>Continue working with Data Analytics to identify specific members who are high utilizers of hospital services.</p> <p>Continue evaluating high cost diagnosis among CBAS and LTC members.</p> <p>Ongoing</p>	
IV. C. Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program: <b>Hospital Readmissions</b>	Tracy Hitzeman	<p>Hospital Readmissions</p> <p>CBAS - 15%</p> <p>IHSS - 16%</p> <p>LTC - 24%</p> <p>MSSP - 10%</p>	<p>CBAS, LTC and MSSP met the goal. IHSS: The goal of 16% was not met; the readmission rate was 17%.</p> <ul style="list-style-type: none"> <li>CBAS: Significant decrease in readmissions compared to Q2 from 24% to 11%.</li> <li>IHSS: While over goal, there was a decrease in readmissions compared to Q2 from 18% to 17%.</li> <li>LTC: Remains the same as Q2 with 14% readmissions.</li> <li>MSSP: While meeting goal, there was an increase in readmissions compared to Q2 from 0% to 8%. However, the increase is not significant as only one MSSP member was readmitted during the reporting period.</li> </ul>	<p>CBAS Readmissions Workgroup will continue to meet to develop a plan to reduce hospital readmissions. Initial ideas include addressing symptomology of high cost diagnosis in the CBAS centers.</p> <p>Ongoing</p>	
IV. D. Safety of Clinical Care and Quality of Clinical Care-Review and Assess Long Term Services and Supports Utilization: Long Term Care and Home and Community Based Services	Tracy Hitzeman	<p>LTC - 3.9%</p> <p>HCBS - 17%</p>	<p>HCBS met the goal. LTC: the goal of 3.9% was not met; the LTC utilization rate is 4.22%.</p> <ul style="list-style-type: none"> <li>While the LTC goal was not met, there is a decrease in LTC utilization compared to Q2, from 4.32% to 4.22%.</li> <li>There is a slight increase in HCBS utilization compared to Q2, from 16.95% to 17.01%.</li> <li>The goal of HCBS is to maintain members living in the community. Therefore, it is appropriate to see an increase in HCBS utilization with the ultimate goal of reducing LTC utilization.</li> </ul>	<p>Continue educating CalOptima Care Managers and community resources regarding CBAS, including the benefits of maintaining members at a community level.</p> <p>Ongoing</p>	
IV. E. Quality of Clinical Care-Review of health risk assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members	Tracy Hitzeman	<p>Goal is measured as part of CM, need to make sure it is captured in CM</p>			
IV. F. CBAS Member Satisfaction	Laura Guest	<p>Achieve an overall satisfaction rating of 90%.</p>	<p>In progress. Surveys are in the process of being distributed and collected. The implementation was delayed due to the envelope design and ordering.</p>	<p>12/31/2017</p>	
IV. G. SNF Member Satisfaction	Laura Guest	<p>Achieve an overall satisfaction rating of 90%.</p>	<p>In progress. Surveys are in the process of being distributed and collected. The implementation was delayed due to the envelope design and ordering.</p>	<p>12/31/2017</p>	
<b>Health Education &amp; Disease Management</b>					

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%	Received final validation for Initial Health Assessment PIP. Implemented IVR calls tied to HIF/MET reminder in 3rd Q, 2017.  2016 IHA Completion Rate: 42.05% 2017 IHA Completion Rate: 44.77% 2.72% increase from 2016  Completion Rate - Fully Met & Partially Met	Work with IS to add health plan effective date on the monthly eligibility extract sent to the health networks.	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 (MPM) Ace Inhibitors or ARBs - Increase to 50th percentile for HbA1c Testing - Medicare; 50th percentile for Controlling High Blood Pressure (CBP); 85% satisfaction with DM Programs	Medi-Cal Prospective Rates:  AMR 5-11: 75.61% 50th percentile  MMA 5-64: 25th Percentile  HbA1c Testing: < 25th Percentile  HbA1c Poor Control: 25th Percentile  Eye Exam: 25th Percentile  Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBs: >25th percentile  Medicare Prospective Rates:  HbA1c Testing: < 25th Percentile  Controlling High Blood Pressure: >25th Percentile	Member incentive for Eye Exam and HbA1c Testing (using QI Reserves) drops 10/2017.  Second phase of Asthma ED campaign to drop 11/2017	Q4	
V. C. Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business	Pshyra Jones	100%	Activity Completed. CPG's Approved	CPGs Approved at QIC	7/18/2017	
V.D. Quality of Clinical Care-Review of Cardiovascular Disease	Pshyra Jones	As determined by CMS	Chronic Care Improvement Programs OC Blood Pressure CCIP - Discontinued in September due to unique characteristics of population and updated guidance from CMS for SNPs beginning in 2018.  OCC Heart Failure CCIP- Unable to leverage TOC process to prevent unplanned readmissions within 30 days. Changes to program methodology are pending.	OC CCIP- Update methodology using new guidance from CMS.  OCC CCIP- Leverage new CORE reports to identify population for intervention.	12/31/2017	
V. E. Implementation of Population Health & Wellness Programs	Pshyra Jones	Implement revised program design-2017; Evaluate progress semi-annually	SYL Childhood Obesity Program - Received two response for RFP - Dr. Riba's Fit Club and Latino Health Access.  Perinatal Support Services RFI- Received two responses for RFI - MOMS of Orange County and Health Management Associates	SYL- Finalize contracts with vendors PSS- Release RFP - Nov 15, 2017	12/31/2017	
	Kelly Rex-Kimmet		On track. Data Collection for OC Diabetes QIP will continue through 12/31/17.	Submission for the QIP update is due 1/2018.	12/31/2017	Diabetes QIP
	Kelly Rex-Kimmet		Data Collection for Readmissions OCC QIP is due 1/2018.	The Transition of Care (TOC) program is being updated by work group (CM, IS, QA staff) to target only the CCN population due to the changes with eCeda contract. The team will be making revisions to the TOC program description and member	Ongoing	Readmission QIP

V. F. Quality of Clinical Care-Quality and Performance Improvement Projects (PIP/QIP/CCIP)	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	The SMART Aim measure (the narrow focus of the PIP was CalOptima diabetic members who were assigned to Provider A) had a baseline rate of 70.15 percent and the MCP set a SMART Aim goal of 80.0 percent. The MCP documented in Module 5 that "None of the three (3) tested interventions had an impact on the SMART Aim measure rate". However, the SMART Aim was achieved for two months during the measurement period ( Dec. 2016 and Jan. 2017). As such, HSAG assigned the PIP Low Confidence because interventions were not linked to the improvement. No further action is required from CalOptima as the PIP is completed.	PIP completed. Final submission sent to DHCS on 8/15/17.	Q3	
	Kelly Rex-Kimmet		The SMART Aim measure (the narrow focus of the PIP was CalOptima members who were assigned to Provider A and B who completed an IHA) had a baseline rate of 3.4 percent and the MCP set a SMART Aim goal of 25.0 percent. The SMART Aim was achieved. Intervention 1 was successful in educating staff for Providers A and B. The MCP documented in Module 4 that Intervention 3 was abandoned due to the low impact on members receiving an IHA after the reminder call (3 of 39 members had a IHA due to the reminder call). The MCP discontinued Intervention 2 due to resource constraints and challenges with the appointment scheduler in both provider offices. HSAG assigned the PIP Confidence because not all the interventions were directly linked with the improvement in the SMART Aim measure rate. No further action is required from CalOptima as the PIP is completed	PIP completed. Final submission sent to DHCS on 8/15/17.	Q3	
	Kelly Rex-Kimmet		Pending validation results for the LTSS PIP on 10/31/17.	PIP completed. Final submission sent to CMS/HSAG on 8/15/17.	Q3	
Access & Availability						
VI. A. Quality of Service and Quality of Clinical Care-Review of notification to members	Belinda Abeyta & Laura Grigoruk	85%	Metric not met - Enrollment received late 5 PCP provider termination and 2 of those were received late from PR impacting the member notification process resulting in a KPI result of 50%	Continue monthly monitoring of Member notifications of provider terminations to ensure timely notification to the Member.	Q3	
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	73 initial credentialing files for practitioners and HDO's were processed. X% were processed within 120 days of receipt of application.	The average number of days to process an initial practitioner file is 121 days, and HDO file is 64 days. Continue to work towards reducing the processing time.	Q4	
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	117 re-credentialing files for practitioners and HDOs were processed. 100% of the files were processed within 36 months of the last credentialing date.	The average number of days to process a a recred practitioner file is 111 days, and HDO file is 69 days. Continue to work towards reducing the processing time.	Q4	

VI.D. Accessibility: Review of access to care	Marsha Choo	Appointment: 90% minimum performance level; Phone: ASA 30 seconds; Abandonment rate <5%	2017 Timely Access Survey fielded in Q3 2017. Result available in Q4 2017. Customer Service KPI Phone measures reported quarterly to the Member Experience Sub-Committee. Shared 2016 Access and Availability Results (i.e. HN Quality Forum, HN Forum, CCN Lunch and Learn, HN Quality Meeting and JOMs.)	1) Continuous monitoring of Customer Service measures 2) Receive and analyze data for 2017 Timely Access Study 4) Issue CAPS for 2016 Access Results 5) Update Access and Availability Policies	Q4	
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	Availability Reports for Q3 ran on July 1, 2017. Availability reports were reviewed by the Member Experience Sub-Committee and the following areas were of concern: Dermatology, Nephrology, and Endocrinology for Medi-Cal.	1) Continuous quarterly monitoring of availability against standards. 2) Continuous recruitment efforts by our Provider Relations Staff and collaboration with HNs to improve their network capacity. 3) Issue CAPS for 2016 Access Results 4) Update Access and Availability Policies  BH: Meeting MPGs. Continue to monitor.	Q4	
<b>Patient Safety</b>						
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	87 Total FSR/MRR/PARS site reviews were conducted. This includes educational visits, follow-ups, initials, full-scope and physical accessibility reviews. All FSR/MRR passed 80% threshold. 58% of PARS were "Basic" access.	Continue to complete FSR/MRR/PAR Site reviews per requirements to ensure initial/re-cred timeframes are met. Follow-up on CAPS that are not closed within the required timeframes.	Q4	
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	In Q3, 53% of the cases were closed in 90 days or less. However, the average number of days to close a case in Q3 was 88 days. Cases leveled severity code HDS had the longest review time, with an average of 130 days. We have made the following changes to improve the TAT: 1) Cases that are waiting for a CAP or CPRC review, are put into a separate category, 2) Cases are reviewed and closed by the nurses if QOS, and 3) Nurses have a goal of performing an Initial Review of the cases in 3-5 business days of receipt to determine and follow-up on any urgent patient needs.	Continue to review and monitor TAT.	12/31/2017	

VII. C. Safety of Clinical Care and Quality of Clinical Care-Reviewed through Pharmacy Management	Kris Gericke, PharmD	Reductions in underutilization and overutilization measures	<p>Potential Under-Utilization of Pharmaceuticals for 3Q17: Diabetes with Hypertension without an ACE, ARB, or DRI Bisphosphonate without calcium Prednisone 5mg (or equivalent) without a Bisphosphonate Asthma Long-Term Controller underutilization</p> <p>Observation: For 3Q17, there was a slight increase in potential under-utilization of pharmaceuticals for diabetes with hypertension without an ACE, ARB, or DRI. There were no changes to the under-utilization rate for members on a corticosteroid without a bisphosphonate and bisphosphonate without calcium by 0.1 per K as compared to 2Q17.</p> <p>For exemptions to the 6 Rx program and polypharmacy, the number of members increased to 0.1/thousand. For members locked into pharmacy home, there was an increase of 0.2/thousand as compared to 2Q17. Members were identified for the Prescriber Restriction Program for 3Q17 (93) vs 2Q17 (25).</p>	On target, and monitoring progress.	Q4	
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 necessary with the member or provider/HN	Favorable kick payments for Medi-Cal	On target, and monitoring progress.	Q4	
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.	Nine CBAS centers received on-site audits in Q3. Seven centers received a CAP; six of the centers have provided a CAP response.	1)Follow-up with the center that has not provided the CAP response. 2)Continue on-site audit of centers in Q4.	12/31/2017	
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.	In Q3, completed 16 on-site assessments. No facilities received a CAP, meaning that 100% of the facilities were compliant with the Plan of Correction issued by DHCS.	Continue on-site audits in Q4.	12/31/2017	
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);	See HEDIS/CAHPS Measures Worksheet	CWP: This measure tends to score low. Interventions are progress. Will continue to monitor until final rates are published.	Q4	
	Kelly Rex-Kimmet/Marsha Choo	Appropriate treatment for Children with URI: 93.38% (75th percentile)	Medi-Cal Rate: 93.56%	URI: June PR Rates: 93.56% Interventions are in progress and aligned with the correlating measures (CWP and AAB)		
	Kelly Rex-Kimmet/Marsha Choo	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) 22.25% (25th percentile)	Medi-Cal PR: 25.61%	AAB: June PR Rates: 25.51%. (On Track) PDSA project for this measure outreached to eight (8) high prescribing/low performing providers for this measure by Medical Director. Completed PDSA cycles in June, 2017.		
VII. H. Pharmacy Benefit Manager (PBM) Oversight Management	Kris Gericke, PharmD	PBM Performance Guarantees met Per Contract	PBM Performance Guarantees met Per Contract	21Q17 PBM Performance Guarantees met.	Q4	
<b>Member Experience</b>						
VIII. A. Quality of Service- Review of Member Satisfaction	Kelly Rex-Kimmet/Marsha Choo	Annual CAHPS Results	<p>All 2017 CAHPS surveys have been field for the year. All Medi-Cal surveys have been completed and results have been presented and reviewed by the Member Experience Sub-Committee.</p> <p>OneCare and OneCare Connect Surveys have been fielded and results are pending. Quarterly GARS and availability data is presented and reviewed by the Member Experience Sub-committee.</p>	Continuous review of CAHPS and other member experience data at the Member Experience Sub-Committee. Data includes, but is not limited to the following: CAHPS, Access and Availability, GARS, and Customer Service.	Q4	

VIII.B. Quality of Service- Reviewed through customer service first call resolution	Belinda Abeyta	85% of calls resolved at first call	First Call Resolution Metric Met Medi-Cal- 87%, OC - 87%, OCC - 85%	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 <3% First Call Resolution 85%	First Call Resolution Metric Met Medi-Cal- 87%, OC - 87%, OCC - 85% ASA Metric Met for OC and OCC OC - 0.9 Seconds, OCC -0.9 Seconds ASA Metric Not Met for Medi-Cal Medi-Cal - 41 Seconds	Medi-Cal - Additional temporary resources requested to be added to the Call Center to address KPI's.	Daily and Monthly Monitoring of ASA for the Medi-Cal Call Center	
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.	Trending reports in 6 month segments (Jan-Jun 2016, Jul-Dec 2016 and Jan-Jun 2017) of providers with greater than 3 PQIs, or 5 GARS were reported at CPRC in September and October. Those providers with greater than 3 PQIs or greater than 5 GARS were highlighted. Letters were sent to the highest offenders	Will report the 6 month trends again in Q1 2018.	Q1 2018	
<b>HEDIS/STARS Improvement</b>						
IX. A. Improve identified HEDIS Measures listed on "Measures" worksheet	Kelly Rex-Kimmet/ Marsha Choo	See Measures Worksheet	See HEDIS/CAHPS Measures Worksheet	All QI work team to continue with initiatives and interventions. Majority of the initiatives are on track with a few initiatives in process.	Q4	
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	See HEDIS/CAHPS Measures Worksheet	Member Experience Sub-Committee will continue to monitor CAHPS scores and to implement initiatives and interventions.	Q4	
IX. D. STARS Medication Related Measures	Kris Gericke, PharmD	Star measure scores above the national MAPD average as reported by CMS	Adherence rates CY18 report card reporting: OneCare 5 stars for two measures and 3 stars for one measure. OneCare Connect below MAPD average for all 3 measures.	Will continue interventions. Additional member mailings to be sent. Working with pharmacies to implement refill reminder program.	Q4	
IX. E. HEDIS: Health Network support of HEDIS & CAHPS Improvement	Kelly Rex-Kimmet/Marsha Choo	24.33%	Reports to Health Networks on their specific HEDIS and CAHPS performance are on-track.	1) Continue to share the annual Survey Schedule with the HNs 2) Continue to share CAHPS data with the HNs 3) Continue to share 2017 HEDIS prospective rates with patient list for interventions with the HNs 4) Continue HN Quality Forum 5) Continue HN individual Quality Meetings	Q4	
<b>Delegation Oversight</b>						
X. A. Delegation Oversight of CM	Sloane Petrillo	OCC, OC, SPD Goal 90%	OCC-FCMG has not met goal twice in reporting period.	Working on CAP for FCMG. Continue intensive review and monitoring.	Q4	
	Sloane Petrillo		OC all networks met goal.	Continue intensive review and monitoring.	Q4	
	Sloane Petrillo		SPD all networks met goal.	Continue intensive review and monitoring.	Q4	

X. B. Quality of Care & service of UM through delegation oversight reviews	Solange Marvin	98%	"Medi-Cal Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (July 2017 - September 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. OneCare Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (July 2017 - September 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. OneCare Connect Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions July 2017 - September 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.	Next Step: Corrective Action Plan issued and continued monitoring from performance Improvement."	ongoing	
X. C. Delegation Oversight of BH Services	Dr. Edwin Poon	98%	Q3 Delegation Oversight Summary (September results are not yet available for review): One claims metric (Denied Claims Accuracy) and two credentialing metrics (Credentialing File Review and Re-credentialing File Review) did not meet the set goal for over 3 consecutive months.	Continue to monitor performance. Any issues are brought up during DOC, as well as in MHQO operations meetings weekly. A&O also has a separate ongoing process to address concerns.	ongoing	Yellow
<b>Organizational Projects</b>						
XI. A. Value Based P4P 2017	Sandeep Mital	Collect final HEDIS 2017 data to assess health network performance towards Pay for Value measures; Present revised payment methodology for MY2016 to Senior Management at CalOptima and upon their approval, present methodology and scoring to health networks.	Final HEDIS 2017 results aggregated for CalOptima and then sorted at the health network level to assess performance in the P4V measures. Revised Payment Methodology for MY 2016 presented and approved by the P4V Steering Committee and Senior Management. In addition, revised scoring methodology presented to all health networks.	Collect final CAHPS survey results for Medi-Cal. Finalize payment calculations for the P4V program for all health networks. Present and get approval for the final payment for P4V measures from the P4V Steering Committee and Finance before putting in check requests. Finalize P4V Manual for roll out later this year.	Dec-17	
XI. B. MOC Dashboard 2016-2019	Tracy Hitzeman	Meet or exceed defined MOC Metrics	Dashboard is under revision with multiple departments participating.	Continue revision of MOC dashboard, including detailed review of appropriate measures for inclusion.	Q1 2018	

## HEDIS MEASURES

HEDIS Medi-Cal Measures	Objective	Planned Activity	Goal	Results/ Metrics  Medi-Cal Prospective Rates: (Claims processed through Sept, 2017)	Red: At Risk Yellow: Concern Green: On Track  (Based on PR Rates and Progress)	Monitoring and Next Steps	Target Completion
<b>Comprehensive Diabetes Care (CDC)</b> Medicaid: a) A1C Screening: 85.95% (50 <sup>th</sup> percentile) b) A1C Control <8.0%: 52.55% (75 <sup>th</sup> percentile) c) A1C Control >9.0%: 36.87% (lower score is better) (75 <sup>th</sup> percentile) d) Eye Exams: 61.5 (75 <sup>th</sup> percentile) e) Nephropathy Screening: 90.51% (50 <sup>th</sup> percentile) f) BP Control: 68.61% (75 <sup>th</sup> 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. - Explore the use of member engagement technologies to improve rates. - These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	a. 85.95% b. 52.55% c. 36.87% d. 61.5% e. 90.51% f. 68.61%	a. 80.09% b. 53.63% c. 39.47% d. 48.49% e. 87.57% f. 18.95%	<b>Yellow</b> -all sub measure rates ahead of same time last year, but most remain below the 50 <sup>th</sup> percentile.	<ul style="list-style-type: none"> <li>Implemented Diabetes PIP/QIPs to increase HbA1c testing for the MC and OC populations</li> <li>Sent PCPs list of patients in the Disease Management program to conduct outreach</li> <li>Diabetes Talk newsletter</li> <li>Diabetes workgroup (Lead by Dr. Dajee) to address uncontrolled HbA1c levels greater than 9</li> </ul>	On-going

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<b>**HEDIS/STARS</b> Improvement: Review <b>all-cause hospital readmissions</b> with Medi-Cal & OneCare Connect members <b>(PCR)</b>	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program.  A reporting mechanism will be established followed by analysis of data.	Medi-Cal <14% Readmission rate	Medi-Cal: 13.93%  OCC: 13.49%	Green	<ul style="list-style-type: none"> <li>Currently implementing the transition of care (TOC) program 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 for CCN members only.</li> <li>Update (TOC) program requirements; reassess intervention strategies, update educational materials</li> </ul>	On-going
Flu/Pneumonia (CAHPS Survey)	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	Medi-Cal: Adult: 45.9%	Yellow	<ul style="list-style-type: none"> <li>Flu article in the Medi-Cal newsletter (Sept, 2017)</li> <li></li> </ul>	Annual: Q3 and Q4
<b>HEDIS:</b> Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care	The number of prenatal and postpartum care visits will increase through	MC Prenatal: 82.25% (50th percentile)	<b>Prenatal:</b> 74.87%	Green-rates ahead of same time last year	<ul style="list-style-type: none"> <li>Maternal Health program in development (2018)</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>

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	rate for all Medi-Cal deliveries to meet goal	provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text-For-Baby custom messages to encourage member compliance.	MC Postpartum: 67.53% (75th percentile)	<b>Postpartum:</b> 49.36%		<ul style="list-style-type: none"> <li>• Postpartum member incentive approved to be extended. Eligible dates of delivery for Phase 2 is [10/1-11/05/17]</li> <li>• Launched the Postpartum Member incentive program in June, 2017. Incentive offered members a \$25 gift card and an entry into an opportunity drawing for a \$100 gift card.</li> <li>• Launched the Provider Office Incentive pilot in June, 2017. Medical chart review trainings were conducted at three (3) participating offices. Follow up medical record reviews were conducted to assess improvements.</li> <li>• Prenatal member mailings (bi-weekly)</li> <li>• Postpartum member mailings (monthly)</li> <li>• Text 4 baby program; expanding to "personalized messaging"</li> <li>• CE Healthy Birth Spacing (2/9/17)</li> <li>• PNR/MOMs database data review</li> </ul>	

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						<ul style="list-style-type: none"> <li>Developed small workgroup to improve Maternal Data Mart; goal to produce timely and accurate reports for PPC</li> </ul>	
<b>Lead Screening (Monitoring Measure)</b>	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 <sup>th</sup> percentile)	73.17%	Green-ahead of same time last year	<ul style="list-style-type: none"> <li>Healthy You Mailing (About Your Baby) – Ended as of 6/30/17.</li> <li>Currently reassessing opportunities to collaborate with internal departments on targeted member mailings</li> </ul>	
<b>HEDIS:</b> Review and assessment prescribed ADHD medication (ADD)	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% (50 <sup>th</sup> percentile) Maintenance Phase: 52.47% (50 <sup>th</sup> percentile)	Initiation: 41.41%  Maintenance: 39.21%	Yellow-Initiation at 25 <sup>th</sup> percentile; Maintenance below 25 <sup>th</sup> percentile	<ul style="list-style-type: none"> <li>Behavioral team to reassess the current intervention - ADD mailing to both members and providers for the initiation phase. Members received reminder to go in for follow up visits. PCP/Prescribers are notified of members on ADHD medication.</li> <li>ADD mailing evaluation was conducted and proves effective at improving rates. Alternative interventions being considered.</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>
<b>HEDIS:</b> Review and assessment of antidepressant	Increase the antidepressant medication	Antidepressant medication management rates will increase with the	<b>MC:</b> Acute Phase Treatment: 59.52 (75 <sup>th</sup>	<b>MC:</b> Acute: 55.19%	Green	<ul style="list-style-type: none"> <li>Provider educational faxes (monthly)</li> <li>ICT medication reconciliation tool in guiding care</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>

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medication management (AMM)	management rate in MC and OC members with a diagnosis of major depression to meet goal	distribution of member health education material.	percentile) <b>MC:</b> Continuation Phase Treatment: 41.46% (66 <sup>th</sup> percentile)	Continuation: 37.77%		<ul style="list-style-type: none"> <li>Provider incentive for screening pre-adolescents (12-year olds) is active and will continue through 2018.</li> </ul>	
<b>HEDIS:</b> Review and assessment of childhood immunization rates (CIS)	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	<p>Immunization in children by their 2<sup>nd</sup> birthday will increase through member reminders and education (Combo 10)</p> <p>This measure is also incentivized in our P4V program.</p>	MC: Combo 10: 40.9% (75 <sup>th</sup> percentile)	Combo 10: 25.66%	<b>Yellow</b> rates-ahead of same time last year but remains below 25 <sup>th</sup> percentile. Chart review contributes heavily to achieving final goal rate.	<ul style="list-style-type: none"> <li>Round 2 of CalOptima Day events (Oct-Dec, 2017)</li> <li>CE Workshop (July, 2017): Preventable adolescent infections – discussed immunizations for children.</li> <li>Health and Wellness Event (CalOptima Day) to promote well-care visits and immunizations will be conducted in August, 2017. Four participating Health networks and their selected providers have engaged in initiative.</li> <li>Promotion of immunizations as part of the Text-4 Baby program.</li> <li>Healthy You Mailings (About Your Baby (0-2 years) and children (3-12 years) and Child);</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>

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						Child Health Guide and IVR calls – Ended as of 6/30/17. <ul style="list-style-type: none"> <li>Currently reassessing opportunities to collaborate with internal departments on targeted member mailings</li> </ul>	
<b>HEDIS:</b> Review and assessment of use of imaging studies for low back pain(LBP)	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)	70.91%	Yellow-rate is lower than same time last year. Currently at 25 <sup>th</sup> percentile.	<ul style="list-style-type: none"> <li>Continue to monitor</li> <li>Add as discussion item at UMC</li> </ul>	
<b>HEDIS:</b> 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  This measure is incentivized in our P4V program.	MC: 82.15% (50 <sup>th</sup> percentile)	MC: 60.33% (all members)	Yellow rates-current rate is well below 25 <sup>th</sup> percentile.	<ul style="list-style-type: none"> <li>Medi-Cal PIP proposal approved. Focus on AAP subgroup of 45-64 years.</li> <li>Adult team to discuss possible interventions</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>
Review and assessment of children's access to primary care practitioners (CAP)	Increase children's access to primary care	Comprehensive member and provider outreach	MC: 1) 12-24 months 95.74% (50 <sup>th</sup> percentile)	1. 91.57% 2. 78.33% 3. 88.32% 4. 84.85%	Yellow rates-ages 12-24 months is below same	<ul style="list-style-type: none"> <li>Round 2 of CalOptima Day events (Oct-Dec, 2017)</li> <li>Health and Wellness Event (CalOptima Day) to promote</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>

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<ul style="list-style-type: none"> <li>12-24 months</li> <li>25mo-6 years</li> <li>7-11 years</li> <li>12-19 years</li> </ul>	practitioners to meet goal	<p>with reminders to increase access for children</p> <p>This measure has been incentivized in our P4V program.</p>	<p>2) 25 months -6 years 90.98% (75<sup>th</sup> percentile)</p> <p>3) 7-11 years 93.25% (75<sup>th</sup> percentile)</p> <p>4) 12-19 years 89.37% (50<sup>th</sup> percentile)</p>		time last year. All ages are below the 25 <sup>th</sup> percentile.	<p>well-care visits and immunizations will be conducted in August, 2017. Four participating Health networks and their selected providers have engaged in initiative.</p> <ul style="list-style-type: none"> <li>Healthy You Mailings (About Your Baby (0-2 years) and children (3-12 years) and Child); Child Health Guide and IVR calls – Ended as of 6/30/17.</li> <li>Currently reassessing opportunities to collaborate with internal departments on targeted member mailings.</li> <li>Child/Adolescent team to discuss interventions.</li> </ul>	
<b>HEDIS:</b> Review and assessment of cervical cancer screening (CCS)	Increase the cervical cancer screening in our MC female members 21-64 to meet goal	<p>Increase cervical cancer screening through member and provider outreach and education with reminders.</p> <p>This measure has been incentivized in our P4V program.</p>	MC: 55.94% (50 <sup>th</sup> percentile)	51.19%-ahead of same time last year but below the 25 <sup>th</sup> percentile	Yellow-rates	<ul style="list-style-type: none"> <li>Radio Ad launched in June, 2017 in 4 threshold languages to promote cervical cancer screening</li> <li>Print Ads launched in June, 2017. Ads were printed in local OC newspapers in E,S,V,&amp;K. (Promoted breast and cervical cancer screenings)</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>

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						<ul style="list-style-type: none"> <li>Launch of the “Good Health” landing page on the CalOptima web site.</li> <li>CCS member incentive – launch in Q2, 2017 – Extended through December, 2017.</li> <li>CCS PDSA: Provider Office Staff incentive – Extended through September, 2017.</li> <li>CCS Extended Office Hours: Expected launch in Q3, 2017</li> <li>Preconception insert in Prenatal mailings (Promoting cervical health before getting pregnant)</li> <li>Q1-2: CCS IVR calls outreach to members who have not received screening (program ended)</li> </ul>	
<b>HEDIS:</b> 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) (50 <sup>th</sup> percentile)	21.45%	Green - activities  Yellow – rates. Rates are below same time last year	<ul style="list-style-type: none"> <li>Round 2 of CalOptima Day events (Oct-Dec, 2017)</li> <li>Health and Wellness Event (CalOptima Day) to promote well-care visits and immunizations will be conducted in August, 2017. Four participating Health networks and their selected</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>

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						<p>providers have engaged in initiative.</p> <ul style="list-style-type: none"> <li>• Healthy You Mailings (About Your Baby (0-2 years) and children (3-12 years) and Child); Child Health Guide and IVR calls – Ended as of 6/30/17.</li> <li>• Currently reassessing opportunities to collaborate with internal departments on targeted member mailings.</li> <li>• Child team to discuss possible interventions.</li> </ul>	
<b>HEDIS:</b> Review and assessment of breast cancer screening (BCS)	Increase the breast cancer screening for MC and OC female members to meet goal	<p>Increase the breast cancer screening through member and provider education and outreach with reminders as ways to decrease barriers to screening</p> <p>This measure has been incentivized in our P4V program.</p>	MC: 71.52% (90 <sup>th</sup> percentile)	MC: 58.10%	Yellow rates – rate is below same time last year but is at 50 <sup>th</sup> percentile.	<ul style="list-style-type: none"> <li>• Medi-Cal member incentive Breast Cancer Screening launched in June, 2017. Targeted mailings were sent to members to promote initiative.</li> <li>• Print Ads launched in June, 2017. Ads were printed in local OC newspapers in E,S,V,&amp;K. (Promoted breast and cervical cancer screenings)</li> <li>• Breast cancer screening promotion (mail/outreach) in October, 2017.</li> </ul>	3/1/17-8/31/17
<b>HEDIS:</b> Avoidance of Antibiotic Treatment in	Increase the AAB measure for MC members above	PDSA project for this measure: Outreaching to 5 high prescribing/low	MC: 26.17% (50 <sup>th</sup> percentile)	PR: 25.61%	Yellow – may be at risk for not	<ul style="list-style-type: none"> <li>• AAB PDSA cycle completed <ul style="list-style-type: none"> <li>- Cycle 1 submission: 2/21/17</li> <li>- Cycle 2 submission: 6/23/17</li> </ul> </li> </ul>	• On-going

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Adults with Acute Bronchitis (AAB)	the minimum performance level (MPL)	performing providers for this measure by Medical Director			meeting DHCS MPL	<ul style="list-style-type: none"> <li>Provider Fax Blast sent out Q1 2017</li> <li>Potential HSAG information-sharing collaboration through 2018</li> </ul>	
<b>HEDIS:</b> Children with Pharyngitis (CWP)	Increase CWP measures for MC members	<p>Pay for Value measure. Reassess strategy for kit distribution and evaluate measure</p> <p>This measure is incentivized in our P4V program.</p>	MC: 63.24% (25th percentile)	49.83%	<b>RED</b> Current rate is below 25 <sup>th</sup> percentile and the measurement period closed 6/30. No further opportunity for improvement in MY 2017. Now focused on longer term improvement initiatives including focus on non-compliant urgent care and ERs.	<ul style="list-style-type: none"> <li>Look into opportunities for outreaching to urgent care facilities in Q4.</li> <li>Discuss with child/adolescent QI work team on strategy for pharyngitis test kit distribution</li> <li>Evaluation of the CWP measure and pharyngitis kit distribution</li> <li>Pay for Value measure</li> <li>Distribution of the AWARE toolkit</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>

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<b>HEDIS:</b> Appropriate treatment for Children with URI	Increase URI measure	<p>AWARE Toolkit distribution and continue education of appropriate treatment with antibiotics</p> <p>This measure is incentivized in our P4V program.</p>	MC: 93.38% (75th percentile)	93.56%	Green-rate is ahead of same time last year and has achieved the 75 <sup>th</sup> percentile.	<ul style="list-style-type: none"> <li>Potential HSAG information-sharing collaboration through 2018</li> <li>Discuss interventions with Child/Adolescent work team.</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>

## MEDICARE/STAR MEASURES

MEDICARE/STARS Measures	Objective	Planned Activity	OC Goal	Results/ Metrics  PR  (Sept. 2017)	Red – At Risk Yellow – Concern Green – On Target	Monitoring/Next Steps	Target Completion
<b>**MEDICARE/STARS:</b> Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures OC and OCC	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration	Medicare: 1) A1C Control >9:0 16% (lower score is better;	OC: a) 78.51% b) 66.23% c) 29.82% d) 56.58% e) 85.96%	Yellow -all rates for OC and OCC are below	<ul style="list-style-type: none"> <li>Diabetes workgroup (Lead by Dr. Dajee) to address uncontrolled HbA1c &gt;9. Medical director outreach to targeted offices (Outreach started 10/2017)</li> </ul>	On-going

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<b>OneCare/OneCare Connect</b>  <b>HEDIS Medicare:</b> a) A1C Screening: 91.4% b) A1C Control <8.0%: 72.8% c) A1C Control >9.0 18.8% (lower score is better) d) Eye Exams: 82% e) Nephropathy Screening: 95.8% f) BP Control: 79.3%	members - in conjunction with Diabetes Disease Management Program	with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	CMS 5 star goal) 2) Eye Exams: 82% (maintain 2016 above CMS 5-star goal) 3) Nephropathy Screening: 96% (CMS 4 star goal)	f) 24.12%  <b>OCC:</b> a) 82.62% b) 68.60% c) 27.03% d) 59.53% e) 92.56% f) 24.12%	25 <sup>th</sup> percentile	<ul style="list-style-type: none"> <li>Implemented Diabetes PIP/QIPs to increase HbA1c testing for the MC and OC populations</li> <li>Sent PCPs list of patients in the Disease Management program to conduct outreach</li> <li>Quarterly diabetic eye exam member mailing</li> <li>Diabetes Talk newsletter</li> <li>HbA1c levels</li> </ul>	
<b>**MEDICARE/STARS:</b> 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)	<b>OC:</b> 56.77%  <b>OCC:</b> 61.81%	Yellow	<ul style="list-style-type: none"> <li>Adult Team to discuss interventions</li> </ul>	
<b>**MEDICARE/STARS:</b> Improvement: Review Care of Older Adult	Increase the Care of Older Adult Rate in: 1) Medication Review 2) Pain Screening 3) Functional Status Assessment	Care of Older Adult measures to increase through provider education and dissemination of provider tools.	OneCare Only: 1) Medication Review: 87% (CMS 5 star goal) 2) Pain Screening: 88% (CMS 5 star goal) 3) Functional Status	<b>OC:</b> 1) 19.75% 2) 27.39% 3) 20.38% 4) 22.93%  <b>OCC:</b> 1) 16.26% 2) 21.48% 3) 19.77% 4) 21.27%	Yellow-current rate for OC and OCC below 25 <sup>th</sup> percentile, but ahead of	<ul style="list-style-type: none"> <li>Continue with Health Risk Assessments for members</li> <li>Conduct ICT meetings</li> <li>Adult Team to discuss interventions</li> </ul>	

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			Assessment: 74% (CMS 4 star goal)		same time last year.		
<b>**MEDICARE/STARS:</b> Improvement: Review all-cause hospital readmissions with OneCare & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program.  A reporting mechanism will be established followed by analysis of data.	Medicare: <10% Readmission rate (CMS 4 star goal)	OC: 0.00%  OCC:13.49%	Yellow	<ul style="list-style-type: none"> <li>Currently implementing the transition of care (TOC) program which has two interventions; 1) Health Coach outreach directly to members. Mailing kits suspended for further assessment</li> <li>Update (TOC) program requirements; reassess intervention strategies, update educational materials</li> </ul>	On-going
<b>MEDICARE:</b> 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	OC: 95.56% (50 <sup>th</sup> percentile)	OC: 91.39%  OCC: 82.63%	Yellow-current rate is below 25 <sup>th</sup> percentile	<ul style="list-style-type: none"> <li>Adult team to discuss possible interventions</li> </ul>	<ul style="list-style-type: none"> <li>On-going</li> </ul>
<b>**MEDICARE/STARS:</b> Improvement: Review of flu and pneumococcal immunization rates* (CAHPS Survey)	1. Increase the flu and pneumococcal screening rate in OC and OCC 2. OC members 65 years old and	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	Medicare: 74% (CMS 4 star goal)	Not available yet	Yellow	<ul style="list-style-type: none"> <li>CalOptima working on 1 page mailer highlighting flu/pneumococcal vaccinations; target date December, 2017.</li> <li>CMS sent OCC flu reminder postcards (Sept, 2017)</li> </ul>	<ul style="list-style-type: none"> <li>Annual Q3 and Q4</li> </ul>

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	older to meet goal members 65 years old and older to meet goal					<ul style="list-style-type: none"> <li>Flu mailing was sent to OC/OCC members at the end of February, 2017</li> </ul>	
<b>**MEDICARE/STARS:</b> 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% (50 <sup>th</sup> percentile) OC: Continuation Phase Treatment 54.76% (50 <sup>th</sup> percentile)	<b>OC:</b> Acute: 47.06% Continuation: 58.82%  <b>OCC:</b> Acute: 63.88% Continuation: 43.94%	Yellow-acute phase. Very small denominator.	<ul style="list-style-type: none"> <li>Provider educational faxes; pharmacy and provider update</li> <li>ICT medication reconciliation tool</li> </ul>	•
<b>**MEDICARE/STARS:</b> Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC and OCC 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.	Medicare: 51% (CMS 4 start goal)	<b>OC:</b> Not Available  <b>OCC:</b> 36.23%	Green	<ul style="list-style-type: none"> <li>Pharmacy Provider faxes sent with other measure faxes, on alternating schedule</li> <li>ICT medication reconciliation tool</li> <li>QA developing database to streamline provider faxes for pharmacy</li> <li>Member education mailer sent June 2017</li> </ul>	•
<b>**MEDICARE/STARS:</b> 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	OC: 67.27% (50 <sup>th</sup> percentile) Monitor for Medicaid population.	<b>OC:</b> 49.71%  <b>OCC:</b> 47.26%	Yellow-current rate is below 25 <sup>th</sup>	<ul style="list-style-type: none"> <li>March, 2017: Colorectal cancer mailing sent to targeted OC/OCC members who have not had a colorectal screenings based on our records</li> </ul>	

MEDICARE/STARS Measures	Objective	Planned Activity	OC Goal	Results/ Metrics  PR  (Sept. 2017)	Red – At Risk Yellow – Concern Green – On Target	Monitoring/Next Steps	Target Completion
		to decrease barriers to screening	Develop internal benchmark as National Medicaid Benchmark does not exist.		percentile for both populations.		
<b>**MEDICARE/STARS:</b> 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	OC: 71.36% (50 <sup>th</sup> percentile)	OC: 62.87%  OCC: 61.85%	Yellow-current rate for both populations is <25 <sup>th</sup> percentile	<ul style="list-style-type: none"> <li>Print Ads launched in June, 2017. Ads were printed in local OC newspapers in E,S,V,&amp;K. (Promoted breast and cervical cancer screenings)</li> <li>Breast cancer screening promotion (mail/outreach) in October, 2017.</li> </ul>	
<b>**MEDICARE/STARS:</b> 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 (HOS Survey results pending)	Yellow	<ul style="list-style-type: none"> <li>Provider education</li> </ul>	
<b>**MEDICARE/STARS:</b> 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)	Not available yet-can only be reported annually.  (Medical chart review measure)	Green	<ul style="list-style-type: none"> <li>Disease Management health coaches –distribute blood pressure cuffs for eligible members</li> </ul>	

MEDICARE/STARS Measures	Objective	Planned Activity	OC Goal	Results/ Metrics  PR  (Sept. 2017)	Red – At Risk Yellow – Concern Green – On Target	Monitoring/Next Steps	Target Completion
<b>**MEDICARE/STARS:</b> Improvement: Rheumatoid Arthritis Management (ART)	Increase of rheumatoid arthritis management rate	Increase of rheumatoid arthritis management through provider education	Medicare: 72% (CMS 3 star goal)	<b>OC:</b> 100.00%  <b>OCC:</b> 76.81%	Green	<ul style="list-style-type: none"> <li>Pharmacy Provider faxes sent with other measure faxes, on alternating schedule</li> <li>QA developing database to streamline provider faxes for pharmacy</li> </ul>	On-going
<b>**MEDICARE/STARS:</b> Follow-up after Hospitalization for Mental Illness (7 days / 30 days) (FUH)	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)	<b>OC:</b> (very small denominator) 7-day: 0.00% 30-day: 0.00%  <b>OCC:</b> 7-day: 22.50% 30-day: 32.5%  OCC Quality Withhold for this measure at risk	Yellow	<ul style="list-style-type: none"> <li>Behavioral health team to discuss possible interventions with Magellan.</li> </ul>	
<b>**HOS/STARS:</b> Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1) Reducing Risk of Falls 2) Improving Physical Health Status 3) Improving Mental Health Status	Medicare: 1) Reducing Risk of Falls: 73% (CMS 5 star goal) 2) Improving Physical Health Status: 72%	For OCC HOS, rates not yet available.	Green	<ul style="list-style-type: none"> <li>For OC HOS, there were only two respondents. Sample was too low to obtain valid data results.</li> <li>Continue with Health Risk Assessments for members</li> <li>Conduct ICT meetings</li> </ul>	On-going

MEDICARE/STARS Measures	Objective	Planned Activity	OC Goal	Results/ Metrics  PR  (Sept. 2017)	Red – At Risk Yellow – Concern Green – On Target	Monitoring/Next Steps	Target Completion
			(CMS 4 star goal) 3) Improving Mental Health Status: 87% (CMS 5 star goal)			<ul style="list-style-type: none"> <li>Adult Team to discuss intervention</li> </ul>	

## CAHPS MEASURES

STARS Measures	Objective	Planned Activity	Goal	Results/ Metrics  (based on 2016 MY)	Red – At Risk Yellow – Concern Green – On Target (based on projects)	Monitoring/Next Steps	Target Completion
CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	Medicaid: 50th Percentile or higher Medicare: 82% (CMS 3 star goal)	MC Child: 25 <sup>th</sup> percentile – Not met  MC Adult: 25 <sup>th</sup> percentile – Not met  OC: 84% (3 star)	Yellow	<ul style="list-style-type: none"> <li>Shared CAHPS results with the HNs at the individual Quality Meetings or JOMs</li> <li>Issued RFP for Provider Coaching</li> <li>Continue to monitor and analyze data to improve this area. Initiatives to be developed through the Member Experience Sub-Committee</li> <li>Continue to RFP process to select a vendor for provider coaching.</li> </ul>	Q4

STARS Measures	Objective	Planned Activity	Goal	Results/ Metrics  (based on 2016 MY)	Red – At Risk Yellow – Concern Green – On Target (based on projects)	Monitoring/Next Steps	Target Completion
				OCC: 83.8% achievement score (baseline)			
CAHPS: Getting Needed Care	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.	Medicaid: 50th Percentile or higher (2.52) Medicare: 79% (CMS 2 star goal)	MC Child: below 25 <sup>th</sup> percentile – Not met  MC Adult: below 25 <sup>th</sup> percentile – Not met  OC: 80% (2 star)  OCC: 75.2% achievement score (baseline)	Yellow	<ul style="list-style-type: none"> <li>Shared CAHPS results with the HNs at the individual Quality Meetings or JOMs</li> <li>Shared Timely Access Study results with HNs</li> <li>Shared quarterly Network Adequacy Reports with the HNs</li> <li>Issue corrective action plans on access and availability to the HNs</li> </ul>	Q4
CAHPS: Getting Care Quickly	Increase CAHPS score on Getting Care Quickly	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will	Medicaid: 50th Percentile or higher Medicare: 72% (CMS 2 star goal)	MC Child: below 25 <sup>th</sup> percentile – Not met  MC Adult: below 25 <sup>th</sup>	Yellow	<ul style="list-style-type: none"> <li>Shared CAHPS results with the HNs at the individual Quality Meetings or JOMs</li> <li>Shared Timely Access Study results with HNs</li> <li>Shared quarterly Network Adequacy Reports with the HNs</li> </ul>	Q4

STARS Measures	Objective	Planned Activity	Goal	Results/ Metrics  (based on 2016 MY)	Red – At Risk Yellow – Concern Green – On Target (based on projects)	Monitoring/Next Steps	Target Completion
		improve rating of Getting Care Quickly.		percentile – Not met  OC: 77% (3 star)  OCC: 70.9% achievemen t score (baseline)		<ul style="list-style-type: none"> <li>Issue corrective action plans on access and availability to the HNs</li> </ul>	
CAHPS: How Well Doctors Communicate	Increase CAHPS score on How Well Doctors Communicate	Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.	Medicaid: 50th percentile or higher	MC Child: below 25 <sup>th</sup> percentile – Not met  MC Adult: 50 <sup>th</sup> percentile – Not met  OC: 88.0% achievement score  OCC: 83.8% achievement score (baseline)	Yellow	<ul style="list-style-type: none"> <li>Shared CAHPS results with the HNs at the individual Quality Meetings or JOMs</li> <li>Issued RFP for provider coaching Continue to RFP process to select a vendor for provider coaching.</li> </ul>	Q4

STARS Measures	Objective	Planned Activity	Goal	Results/ Metrics  (based on 2016 MY)	Red – At Risk Yellow – Concern Green – On Target (based on projects)	Monitoring/Next Steps	Target Completion
CAHPS: Customer Service Increase CAHPS score on Customer Service	Increase CAHPS score on Customer Service	Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.	Medicaid: 50th percentile or higher Medicare: 86% (CMS 3 star goal)	MC Child: below 25 <sup>th</sup> percentile – Not met  MC Adult: 25 <sup>th</sup> percentile – Not met  OC: 88%(2 STAR)  OCC: 77.3% achievement score (baseline)	Yellow	<ul style="list-style-type: none"> <li>Shared CAHPS results with the HNs at the individual Quality Meetings or JOMs</li> <li>Continuous monitoring of customer service metrics</li> <li>Continuous training of customer service staff</li> </ul>	Q4
CAHPS: Getting Needed Prescription Drugs	Increase CAHPS score on Getting Needed Prescription Drugs		Medicare: 89% (CMS 3 star goal)	OC: 88% (2 star)  OCC: 88.2% achievement score (baseline)	Green	<ul style="list-style-type: none"> <li>Continue to monitor and analyze data to improve this area. Initiatives to be developed through the Member Experience Sub-Committee</li> </ul>	Q4
CAHPS: Care Coordination	Increase CAHPS score on Care Coordination	Provider and office staff in-service on best practices to better coordinate care for	Medicare: 82% (CMS 2 star goal)	OC:82% (1 star)	Yellow	<ul style="list-style-type: none"> <li>Continue to monitor and analyze data to improve this area. Initiatives to be developed</li> </ul>	Q4

STARS Measures	Objective	Planned Activity	Goal	Results/ Metrics  (based on 2016 MY)	Red – At Risk Yellow – Concern Green – On Target (based on projects)	Monitoring/Next Steps	Target Completion
		members will improve rating on Care Coordination.		OCC: 82.1% achievement score (baseline)		through the Member Experience Sub-Committee	
CAHPS: Overall Rating of Health Care Quality	Increase CAHPS score on Overall Rating of Health Care Quality	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	Medicare: 82% (CMS 2 star goal)	OC: 83% (2 star)  OCC: 80.7% achievement score (baseline)	Green	<ul style="list-style-type: none"> <li>Continue to monitor and analyze data to improve this area. Initiatives to be developed through the Member Experience Sub-Committee</li> </ul>	Q4

# 2017 Quarter 3 HRA Collection

Attachment c

## Quarterly Summary

OCC Newly Eligible HRA Quarterly Averages	
<u>High - Goal 56%</u>	
80%	Collected
20%	Non-Responders
<u>Low - Goal 43%</u>	
69%	Collected
17%	Non-Responders
<u>Goal 100%</u>	
93%	Complete

## Monthly Details

OCC Newly Eligible	July	% of Risk Level Volume	% of Overall Volume	Aug	% of Risk Level Volume	% of Overall Volume	Sept	% of Risk Level Volume	% of Overa Volume
High - Collected	111	79%	56%	93	85%	53%	101	75%	53%
High - Non-Responders	29	21%		17	15%		33	25%	
High - Incomplete	0	0%		0	0%		0	0%	
Low - Collected	84	75%	44%	71	72%	47%	72	60%	47%
Low - Non-Responders	28	25%		16	16%		11	9%	
Low - Incomplete	0	0%		12	12%		37	31%	
Overall Monthly Total # and % Complete	252	100%		209	94%		254	85%	
Total # and % Collected	195	77%		164	78%		173	68%	

July High Due Date: 08/15/2017

Aug High Due Date: 09/15/2017

Sept High Due Date: 10/16/2017

July Low Due Date: 09/29/2017

Aug Low Due Date: 10/30/2017

Sept Low Due Date: 11/30/2017

OCC Annual HRA Quarterly Averages	
<u>Goal 50%</u>	
48%	Collected
52%	Non-Responders
<u>Goal 80%</u>	
100%	Complete

OCC Annual	July	% of Volume	Aug	% of Monthly Volume	Sept	% of Monthly Volume
Collected	303	47%	283	52%	197	47%
Non-Responders	348	53%	264	48%	224	53%
Incomplete	0	0%	0	0%	0	0%
<b>Overall Monthly Total # and % Complete</b>	<b>651</b>	<b>100%</b>	<b>547</b>	<b>100%</b>	<b>421</b>	<b>100%</b>
<b>Total # and % Collected</b>	<b>303</b>	<b>47%</b>	<b>283</b>	<b>52%</b>	<b>197</b>	<b>47%</b>

July Due Date: 06/30/2017

Aug Due Date: 07/31/2017

Sept Due Date: 08/31/2017

OC Newly Eligible HRA Quarterly Averages	
<u>Goal 78%</u>	
66%	Collected
17%	Non-Responders
<u>Goal 100%</u>	
83%	Complete

OC Newly Eligible	July	% of Volume	Aug	% of Monthly Volume	Sept	% of Monthly Volume
Collected	65	77%	51	72%	39	48%
Non-Responders	19	23%	20	28%	0	0%
Incomplete	0	0%	0	0%	42	52%
<b>Overall Monthly Total # and % Complete</b>	<b>84</b>	<b>100%</b>	<b>71</b>	<b>100%</b>	<b>81</b>	<b>48%</b>
<b>Total # and % Collected</b>	<b>65</b>	<b>77%</b>	<b>51</b>	<b>72%</b>	<b>39</b>	<b>48%</b>

July Due Date: 09/29/2017

Aug Due Date: 10/30/2017

Sept Due Date: 11/30/2017

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OC Annual HRA Quarterly Averages	
<u>Goal 34%</u>	
55%	Collected
45%	Non-Responders
<u>Goal 80%</u>	
100%	Complete

OC Annual	July	% of Volume	Aug	% of Monthly Volume	Sept	% of Monthly Volume
Collected	76	64%	33	49%	38	52%
Non-Responders	43	36%	34	51%	35	48%
Incomplete	0	0%	0	0%	0	0%
<b>Overall Monthly Total # and % Complete</b>	<b>119</b>	<b>100%</b>	<b>67</b>	<b>100%</b>	<b>73</b>	<b>100%</b>
<b>Total # and % Collected</b>	<b>76</b>	<b>64%</b>	<b>33</b>	<b>49%</b>	<b>38</b>	<b>52%</b>

July Due Date: 06/30/2017 Aug Due Date: 07/31/2017 Sept Due Date: 08/31/2017

SPD Newly Eligible - Adult HRA Quarterly Averages	
<u>High - Goal 63%</u>	
65%	Collected
35%	Non-Responders
<u>Low - Goal 63%</u>	
62%	Collected
38%	Non-Responders
<u>Goal 100%</u>	
100%	Complete

SPD Newly Eligible - Adult	July	% of Risk Level Volume	% of Overall Volume	Aug	% of Risk Level Volume	% of Overall Volume	Sept	% of Risk Level Volume	% of Overall Volume
High - Collected	123	64%	31%	114	66%	26%	118	63%	30%
High - Non-Responders	68	36%		58	34%		69	37%	
High - Incomplete	0	0%		0	0%		0	0%	
Low - Collected	253	59%	69%	292	59%	74%	299	67%	70%
Low - Non-Responders	176	41%		199	41%		146	33%	
Low - Incomplete	0	0%		0	0%		0	0%	
<b>Overall Monthly Total # and % Complete</b>	<b>620</b>	<b>100%</b>		<b>663</b>	<b>100%</b>		<b>632</b>	<b>100%</b>	
<b>Total # and % Collected</b>	<b>376</b>	<b>61%</b>		<b>406</b>	<b>61%</b>		<b>417</b>	<b>66%</b>	

July High Due Date: 08/15/2017

Aug High Due Date: 09/15/2017

Sept High Due Date: 10/16/2017

July Low Due Date: 09/29/2017

Aug Low Due Date: 10/30/2017

Sept Low Due Date: 11/30/2017

SPD Newly Eligible - Pediatric HRA Quarterly Averages	
<u>High - Goal 63%</u>	
71%	Collected
29%	Non-Responders
<u>Low - Goal 63%</u>	
73%	Collected
27%	Non-Responders
<u>Goal 100%</u>	
100%	Complete

SPD Newly Eligible - Pediatric	July	% of Risk Level Volume	% of Overall Volume	Aug	% of Risk Level Volume	% of Overall Volume	Sept	% of Risk Level Volume	% of Overall Volume
High - Collected	23	77%	22%	14	58%	21%	17	77%	16%
High - Non-Responders	7	23%		10	42%		5	23%	
High - Incomplete	0	0%		0	0%		0	0%	
Low - Collected	80	75%	78%	63	68%	79%	87	76%	84%
Low - Non-Responders	27	25%		30	32%		27	24%	
Low - Incomplete	0	0%		0	0%		0	0%	
<b>Overall Monthly Total # and % Complete</b>	<b>137</b>	<b>100%</b>		<b>117</b>	<b>100%</b>		<b>136</b>	<b>100%</b>	
<b>Total # and % Collected</b>	<b>103</b>	<b>75%</b>		<b>77</b>	<b>66%</b>		<b>104</b>	<b>76%</b>	

July High Due Date: 08/15/2017

Aug High Due Date: 09/15/2017

Sept High Due Date: 10/16/2017

July Low Due Date: 09/29/2017

Aug Low Due Date: 10/30/2017

Sept Low Due Date: 11/30/2017

SPD Annual Mailings	Adult - # Mailed	Adult - # Received	Peds - # Mailed	Peds - # Received
July				
Aug				
Sept	2031	519	557	118
<b>Overall Quarterly Total</b>	<b>2,031</b>	<b>519</b>	<b>557</b>	<b>118</b>

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## BEHAVIORIAL HEALTH

JULY				
OCC				
	Participation	Invitation(s) (denom.)	%	
Participation in ICT for BHI	38	38	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)	1	1	100.00%	
Magellan Individual Provider Participation in ICT (CCN)				
<b>Total Participation</b>	<b>1</b>	<b>1</b>	<b>100.00%</b>	
Magellan Participation in ICT (HN-OCC)	5	5	100.00%	
Magellan Individual Provider Participation in ICT (HN-OCC)				
<b>Total Participation</b>	<b>5</b>	<b>5</b>	<b>100.00%</b>	

OCC				
	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)	0	0	0.00%	
Magellan Individual Provider Participation in ICT (CCN)	0	0	0.00%	
<b>Total Participation</b>				
Magellan Participation in ICT (HN-OC)	27	28	96.43%	
Magellan Individual Provider Participation in ICT (HN-OC)	1			
<b>Total Participation</b>	<b>28</b>	<b>28</b>	<b>100.00%</b>	

SPD				
	Participation	Invitation(s) (denom.)	%	
Participation in ICT for BHI	84	84	100.00%	
Participation in ICT for County MH Adult	1	1	100.00%	
Participation in ICT for County MH Children and Youth	0	0	0.00%	
Participation in ICT for FSP	0	1	0.00%	
Participation in ICT for ASO	0	3	0.00%	
Magellan Participation in ICT (CCN)	4	5	80.00%	
Magellan Individual Provider Participation in ICT (CCN)	1	1	100.00%	
<b>Total Participation</b>	<b>5</b>	<b>5</b>	<b>100.00%</b>	
Magellan Participation in ICT (HN-SPD)	14	17	82.35%	
Magellan Individual Provider Participation in ICT (HN-SPD)	2			
<b>Total Participation</b>	<b>16</b>	<b>17</b>	<b>94.12%</b>	

AUGUST				
OCC				
	Participation	Invitation(s) (denom.)	%	
Participation in ICT for BHI	39	39	100.00%	
Participation in ICT for County MH Adult	0	1	0.00%	
Participation in ICT for County MH Children and Youth				
Participation in ICT for FSP				
Magellan Participation in ICT (CCN)	2	2	100.00%	
Magellan Individual Provider Participation in ICT (CCN)				
<b>Total Participation</b>	<b>2</b>	<b>2</b>	<b>100.00%</b>	
Magellan Participation in ICT (HN-OCC)	28	28	100.00%	
Magellan Individual Provider Participation in ICT (HN-OCC)				
<b>Total Participation</b>	<b>28</b>	<b>28</b>	<b>100.00%</b>	

OCC				
	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)	0	0		
Magellan Individual Provider Participation in ICT (CCN)				
<b>Total Participation</b>				
Magellan Participation in ICT (HN-OC)	23	23	100.00%	
Magellan Individual Provider Participation in ICT (HN-OC)				
<b>Total Participation</b>	<b>23</b>	<b>23</b>	<b>100.00%</b>	

SPD				
	Participation	Invitation(s) (denom.)	%	
Participation in ICT for BHI	114	114	100.00%	
Participation in ICT for County MH Adult	2	2	100.00%	
Participation in ICT for County MH Children and Youth	0	0	N/A	
Participation in ICT for FSP	1	1	100.00%	
Participation in ICT for ASO	0	3	0.00%	
Magellan Participation in ICT (CCN)	7	7	100.00%	
Magellan Individual Provider Participation in ICT (CCN)	0	0	0.00%	
<b>Total Participation</b>	<b>7</b>	<b>7</b>	<b>100.00%</b>	
Magellan Participation in ICT (HN-SPD)	16	17	94.12%	
Magellan Individual Provider Participation in ICT (HN-SPD)	1			
<b>Total Participation</b>	<b>17</b>	<b>17</b>	<b>100.00%</b>	

SEPTEMBER				
OCC				
	Participation	Invitation(s) (denom.)	%	
Participation in ICT for BHI	27	27	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)	1	1	100.00%	
Magellan Individual Provider Participation in ICT (CCN)				
<b>Total Participation</b>	<b>1</b>	<b>1</b>	<b>100.00%</b>	
Magellan Participation in ICT (HN-OCC)	26	26	100.00%	
Magellan Individual Provider Participation in ICT (HN-OCC)				
<b>Total Participation</b>	<b>26</b>	<b>26</b>	<b>100.00%</b>	

OCC				
	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)	0	0		
Magellan Individual Provider Participation in ICT (CCN)				
<b>Total Participation</b>				
Magellan Participation in ICT (HN-OC)	23	23	100.00%	
Magellan Individual Provider Participation in ICT (HN-OC)				
<b>Total Participation</b>	<b>23</b>	<b>23</b>	<b>100.00%</b>	

SPD				
	Participation	Invitation(s) (denom.)	%	
Participation in ICT for BHI	107	107	100.00%	
Participation in ICT for County MH Adult	2	5	40.00%	
Participation in ICT for County MH Children and Youth	0	0	N/A	
Participation in ICT for FSP	0	1		
Participation in ICT for ASO	0	1		
Magellan Participation in ICT (CCN)	2	2	100.00%	
Magellan Individual Provider Participation in ICT (CCN)				
<b>Total Participation</b>	<b>2</b>	<b>2</b>	<b>100.00%</b>	
Magellan Participation in ICT (HN-SPD)	15	15	100.00%	
Magellan Individual Provider Participation in ICT (HN-SPD)				
<b>Total Participation</b>	<b>15</b>	<b>15</b>	<b>100.00%</b>	

### Top ED Utilizers 1/1/2017-9/30/2017

Ranking										
	<a href="#">1</a>	<a href="#">2</a>	<a href="#">3</a>	<a href="#">4</a>	<a href="#">5</a>	<a href="#">6</a>	<a href="#">7</a>	<a href="#">8</a>	<a href="#">9</a>	<a href="#">10</a>
CIN										
NAME										
LOB	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-cal	Medi-Cal	Medi-Cal
ER VISIT Count	140	32	40	34	21	27	18	25	16	24
Q2	51	23	29	21	26	12	18	11	8	8
Q3	86	2	22	18	2	0	14	1	13	1
Aid Code	M1	M3	64	M3	M1	60	M1	M1	60	M1
Program	CC	CC	CC	CC		CC		CC	CC	CC
Case Manager	<i>Cierra</i>	<i>Roseann W</i>	<i>Karen H</i>	<i>Noushin</i>	<i>Cierra</i>	<i>Roseann</i>	<i>Cierra</i>	<i>Noushin D</i>	<i>RoseannW</i>	<i>Karen H</i>
BH										
Substance use										
Homeless										
Eligibility Issues										
Engaged w/PCP										
Out of Area										
Valid Phone #										
Notes										

Q1	584
Q2	207
Q3	159
Q4	

### Top ED Utilizers 1/1/2017-9/30/2017

Ranking										
	1	2	3	4	5	6	7	8	9	10
CIN										
NAME										
LOB	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal
ER VISIT Count Q1	15	9	2	0	8	9	5	11	4	7
Q2	22	21	21	12	20	7	11	8	11	10
Q3	12	8	5	0	9	1	1	2	7	9
Aid Code	M3	M1	M1	M3	60	60	26	30	M1	60
Program	CC	CC	Diabetes L	Diabetes L	CC					
Case Manager	Roseann	Roseann								
BH										
Substance use										
Homeless										
Eligibility Issues										
Engaged w/PCP										
Out of Area										
Valid Phone #										
Notes			change of HN							

Q1	70
Q2	143
Q3	54
Q4	

### Member Satisfaction Q3 2017

Results			
<i>Member Satisfaction</i>			
	Score	Num	Den
Overall Satisfaction with CM	82%	18	22
Case Management was beneficial	100%	22	22
Educational materials were helpful	77%	17	22
CM was helpful with medical questions	86%	19	22
Community resources were helpful	91%	20	22
Questions were answered to Satsifaction	100%	22	22

22 Completed

Complex case management Q3 2017

Mbrs referred to CCM Complex Cases									
Health Network	July			August			*September		
	# of cases reported	# of Cases reviewed	Score %	# of cases reported	# of Cases reviewed	Score %	# of cases reported	# of Cases reviewed	Score %
AltaMed	4	1	56%	4	1	100%			
AMVI	0	0	n/a	7	0	n/a			
Arta Western	1	1	94%	2	1	94%			
CCN	59	5	80%	66	5	90%			
CHOC	1	0	n/a	0	0	n/a			
FCMG	4	3	94%	5	3	100%			
Hertiage Regal	1	1	89%	1	1	89%			
Kaiser	5	4	94%	4	4	92%			
Monarch	10	5	94%	5	5	100%			
Noble	3	0	n/a	3	3	100%			
OCA	0	0	n/a	1	0	n/a			
Prospect	3	1	72%	3	1	61%			
Talbert	2	2	94%	2	2	94%			
UCMG	2	1	78%	8	0	n/a			
<b>Totals:</b>	<b>95</b>	<b>24</b>		<b>111</b>	<b>26</b>		<b>0</b>	<b>0</b>	
* Pending completion									

### HN Performance Q3 2017

Results			
<i>OneCare Connect (OCC)</i>			
HN	July	August	September
AltaMed	97.50%	92.50%	100.00%
AMVI	100.00%	97.50%	100.00%
Arta	100.00%	95.00%	98.10%
Heritage Regal	100.00%	100.00%	100.00%
FCMG	85.70%	91.00%	86.60%
OCA	100.00%	100.00%	*0%
Talbert	97.50%	95.00%	97.50%
Monarch	94.80%	91.20%	93.50%
Prospect	95.00%	97.50%	92.70%
Noble	100.00%	100.00%	100.00%
UCMG	91.00%	60.00%	90.00%
CCN	91.40%	94.20%	92.30%
* No bundles due or returned			
Indicates payment Modifier <80%			

### HN Performance Q3 2017

Results			
SPD			
HN	July	August	September
AltaMed	98.61%	98.37%	100.00%
AMVI	96.00%	97.00%	96.00%
Arta	98.83%	99.03%	98.04%
CHOC	100.00%	100.00%	99.48%
Heritage Regal	88.00%	94.00%	96.00%
FCMG	94.89%	98.20%	98.29%
OCA	87.00%	94.00%	*0%
Talbert	97.55%	99.48%	89.64%
Monarch	98.23%	99.24%	97.45%
Prospect	97.91%	97.73%	100.00%
Noble	88.25%	97.00%	100.00%
UCMG	93.50%	94.83%	95.43%
CCN	94.98%	95.77%	96.60%
* No bundles due or returned			
Indicates payment Modifier <80%			

### HN Performance Q3 2017

Results			
<i>OneCare (OC)</i>			
HN	July	August	September
FCMG	99.20%	98.00%	97.33%
AltaMed	100.00%	100.00%	100.00%
AMVI/Prospect	96.37%	97.28%	98.98%
Arta Western	100.00%	97.60%	98.00%
Monarch	98.20%	99.84%	98.98%
Noble	100.00%	*0%	92.00%
Talbert	100.00%	97.50%	98.29%
UCMG	100.00%	100.00%	100.00%
* No bundles due or returned			
Indicates payment Modifier <80%			



**CalOptima**  
Better. Together.

# **Member Trend Report 3rd Quarter 2017**

**Board of Directors' Quality Assurance Committee Meeting  
February 20, 2018**

**Ana Aranda**

**Interim Director, Grievance and Appeals**

# Overview

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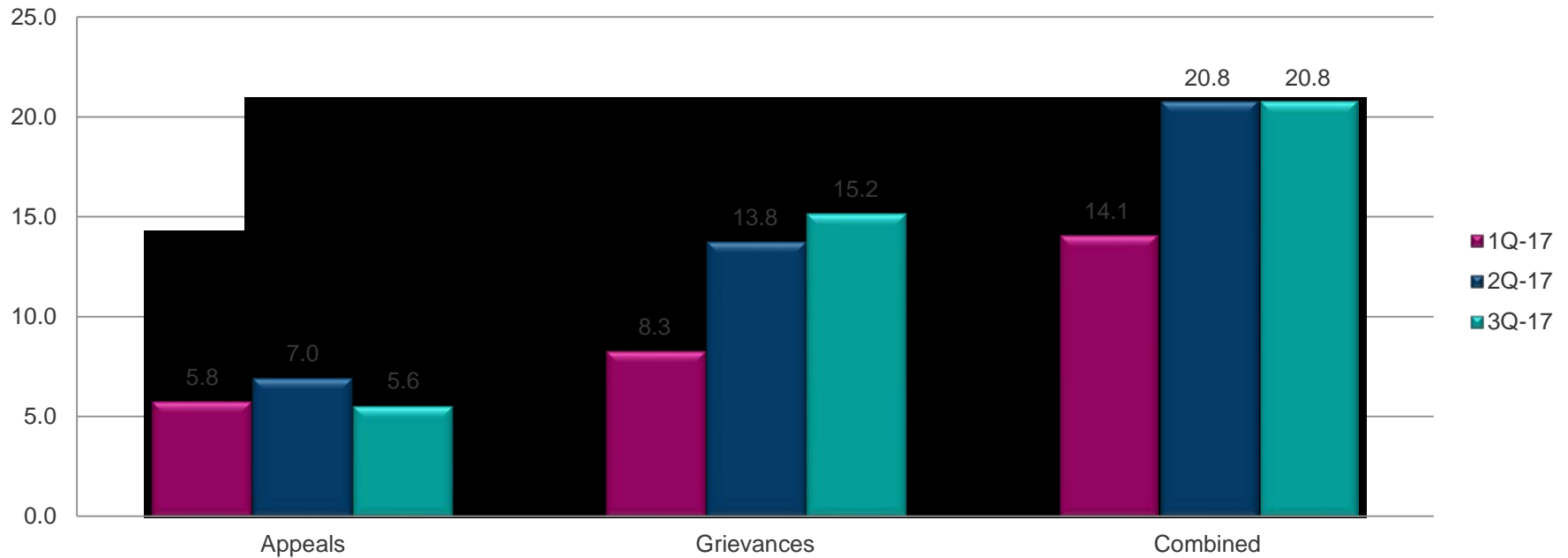
- Trend of the rate of complaints (appeals/grievances) per thousand members for all CalOptima programs for the third quarter in 2017.
  - Appeal — A request by the member for review of any decision to deny, modify or discontinue a covered service
  - Grievance — An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program
- Breakdown of the complaints by type
- Interventions based on trends, as appropriate

# Quality of Service and Quality of Care

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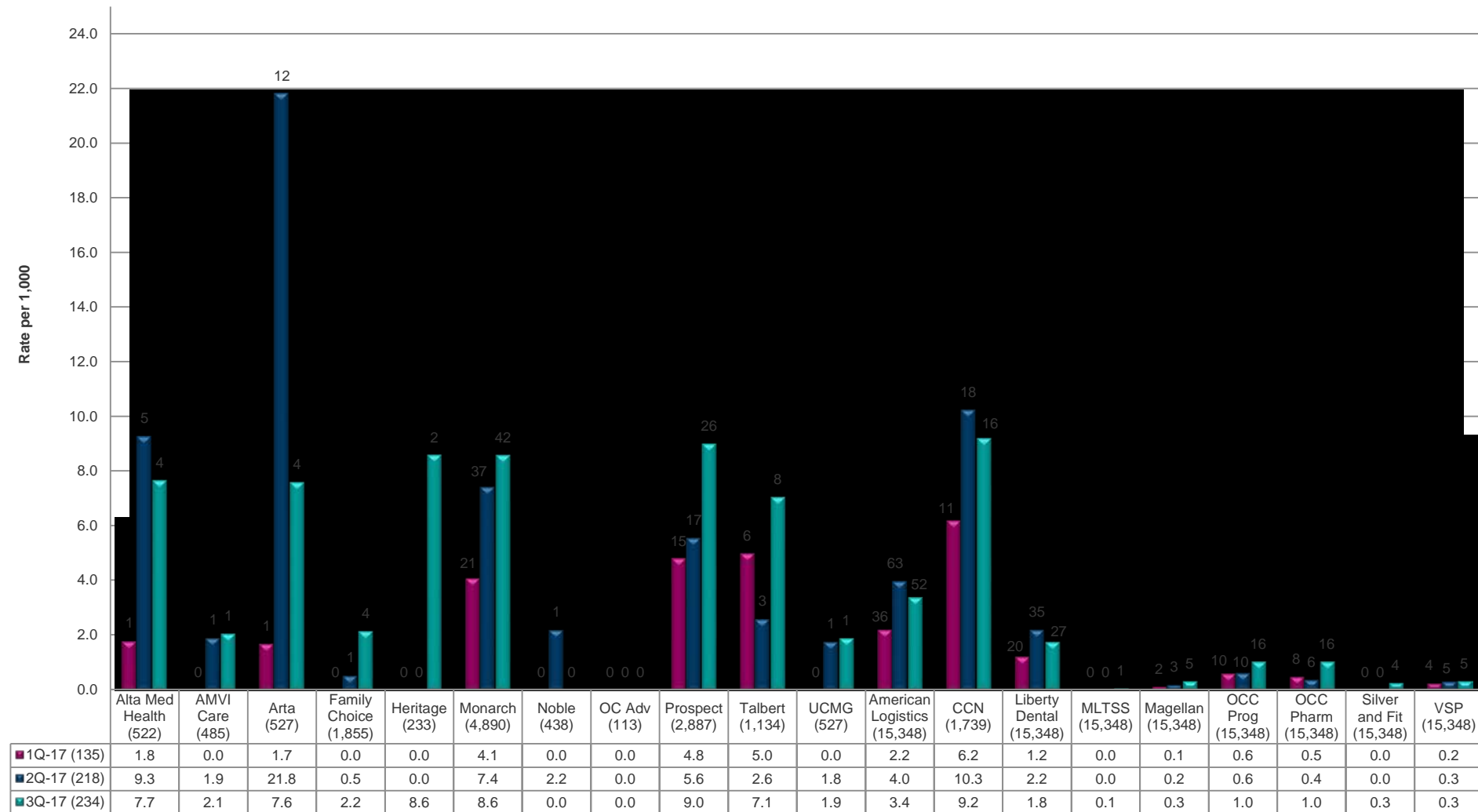
- Quality of Service (QOS) are issues resulting in inconvenience or dissatisfaction to the member.
- Quality of Care (QOC) concerns occur if the member feels there was a problem with the care they received or that they did not receive enough care.

# Overall OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) (OCC) Member Complaints



	Total Complaints	Appeals	Grievances	Membership
1Q-2017	38	95	135	16,297
2Q-2017	18	110	218	15,810
3Q-2017	22	86	234	15,348

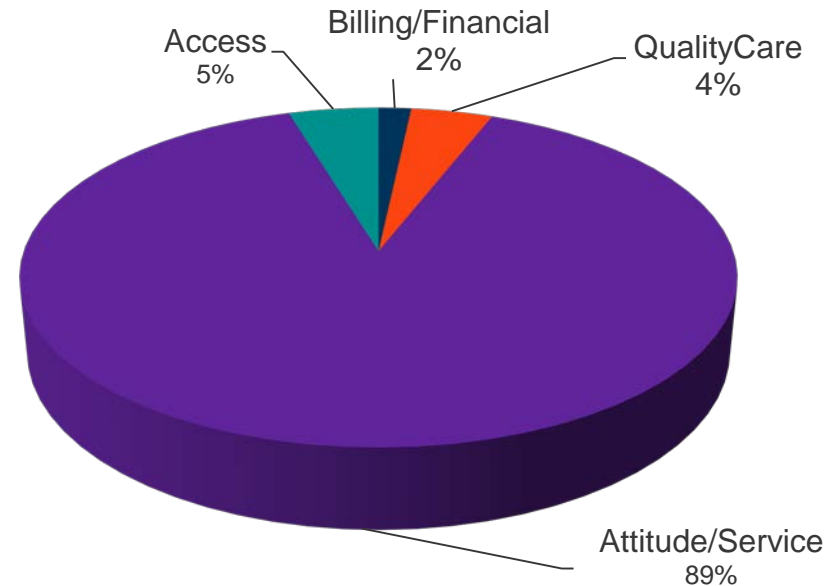
# OCC Member Grievances Quarterly Rate/1,000



[Back to Agenda](#)

# OCC Grievances by Category

- Total of 234 grievances filed by 198 unique members in Q3 2017.
  - Of these, 209 grievances (89 percent) were related to QOS, and 10 grievances (four percent) 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.



# Common QOS and QOC Concerns

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- Delay in service (QOS)
  - Referral/test results/DME
- Dental (QOS)
  - Dissatisfied with dental services and dental provider and/or staff
- Transportation vendor (QOS)
  - Late pick-ups/no show
  - Poor customer service
- Question diagnosis/treatment (QOC)
  - Inadequate care provided
  - Dissatisfied with diagnosis provided

# OCC Summary

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- Overall slight increase in grievances filed from 218 in Q2 to 234 in Q3 2017.
- Increase in volume was found in the area of Quality of Service grievances related to the following providers/health networks:
  - American Logistics (52)
  - Monarch (34)
  - Prospect (24)
  - LIBERTY Dental (22)
  - OCC Program (16)
  - OCC Pharmacy (15)

# OCC Summary (cont.)

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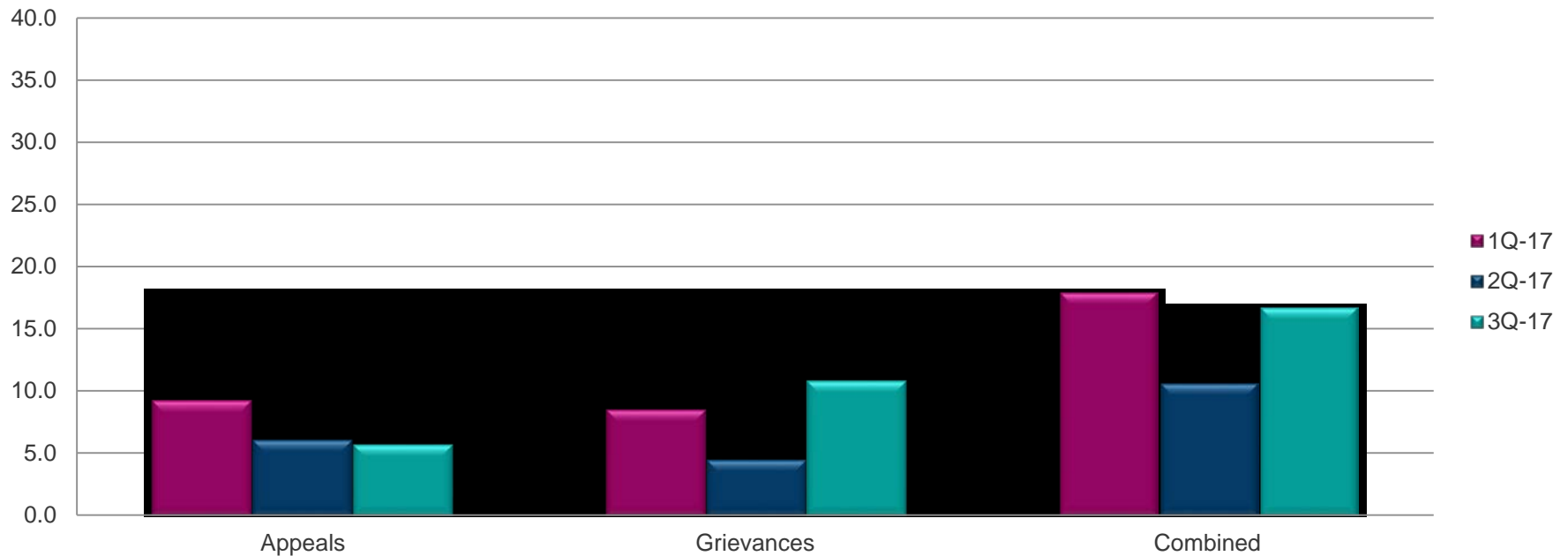
- American Logistics and LIBERTY Dental account for the increase in grievances from Q1 to Q2. However, both are trending down from Q2 to Q3.
  - This decline may be attributed to the multi-departmental outreach and education provided to both vendors.
  - Monthly/ad-hoc meetings are held with American Logistics to address any issues in order to better serve CalOptima's members.

# Interventions

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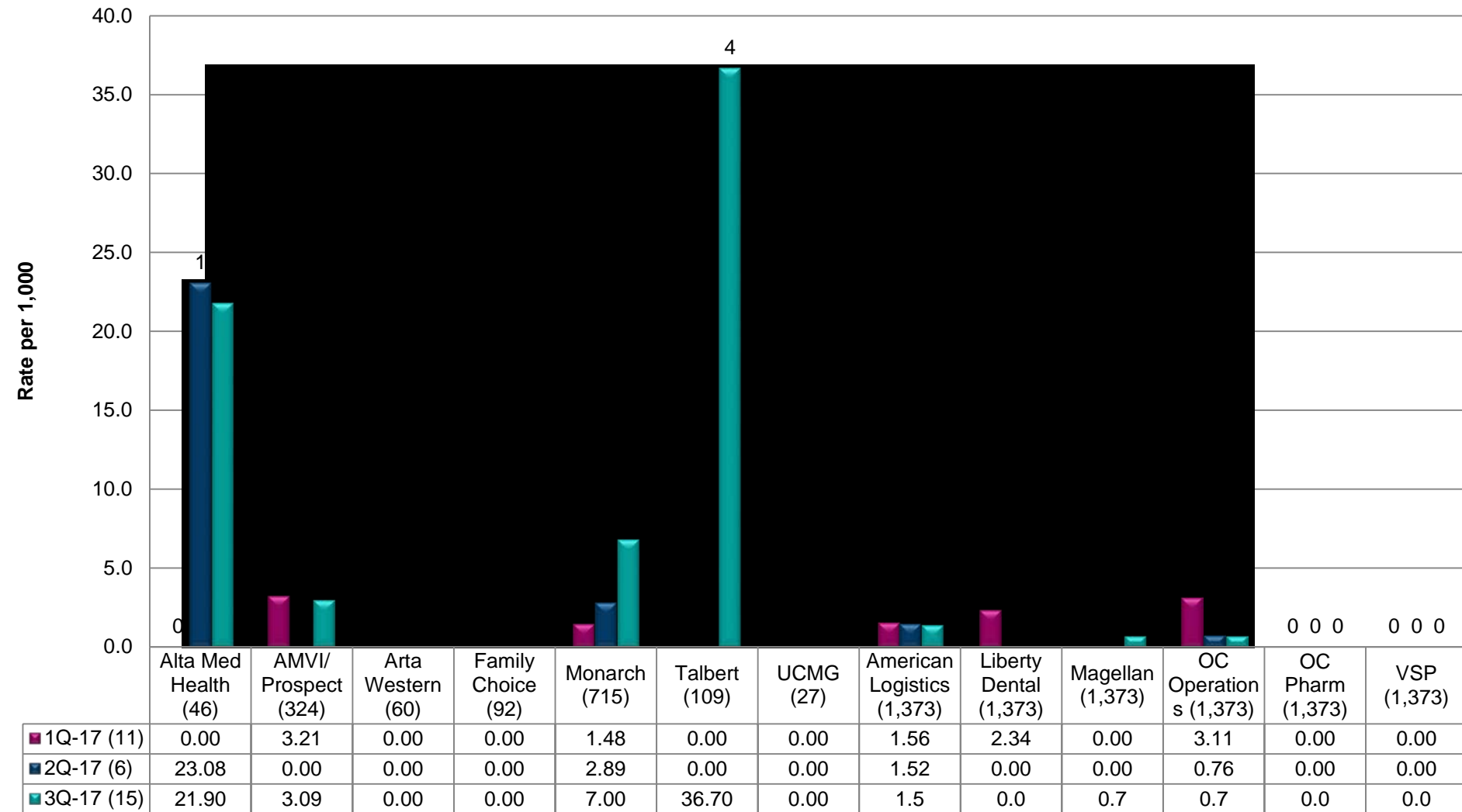
- A series of collaborative meetings between CalOptima and Liberty Dental took place.
  - Liberty Dental began educating their dental providers about requesting Denti-Cal benefits through Denti-Cal, which has decreased the number of denials causing unnecessary appeals.
- As a result of monthly meetings with American Logistics, an action plan was implemented by American Logistics to improve member satisfaction.
- Both, Liberty Dental and American Logistics, have proven a positive trend since these actions were applied.

# Overall OneCare (OC) Member Complaints



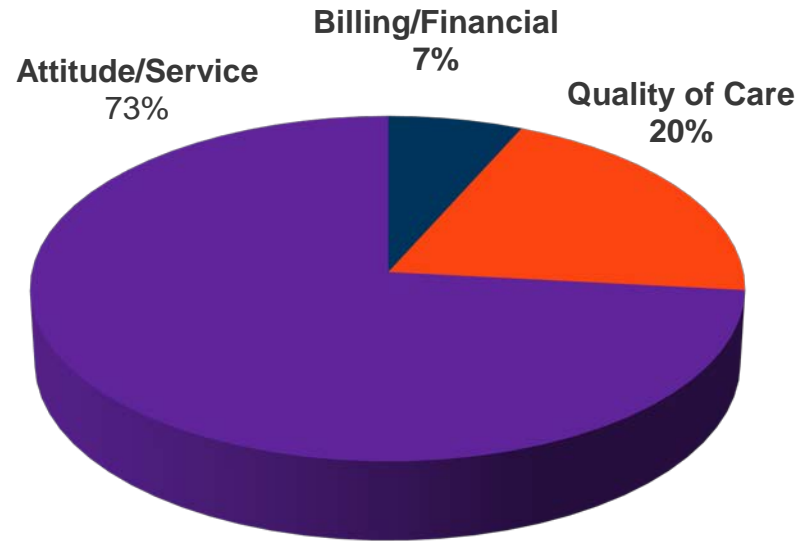
	Total Complaints	Appeals	Grievances	Membership
1Q-2017	18	12	11	1,285
2Q-2017	14	8	6	1,320
3Q-2017	23	8	15	1,373

# OC Member Grievances Quarterly Rate/1,000



# OC Grievances by Category

- Total of 15 grievances filed by 13 unique members in Q3 2017.
  - Of these, 11 grievances (73 percent) were related to QOS, and three grievances (20 percent) were related to QOC concerns.
- The QI department continues to review for QOC issues and potential trending.



# Common QOS and QOC Concerns

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- Delay in service (QOS)
  - Referral delays
  - Office wait time
- Question/Delay in treatment (QOC)

# OC Summary

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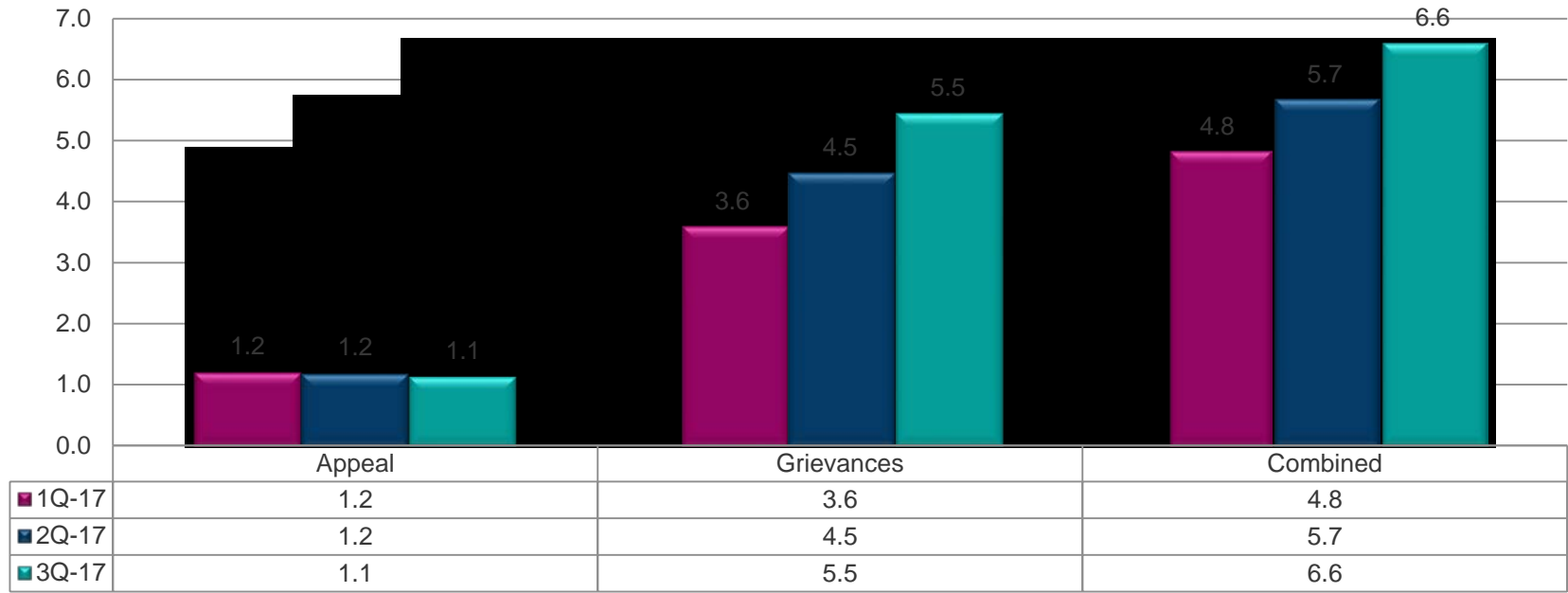
- Overall increase in grievances filed from 6 in Q2 to 15 in Q3 2017
- Increase in volume was found in Quality of Care and Quality of Service grievances related to the following providers/health networks:
  - Monarch (4)
  - Talbert (4)
  - Magellan (1)

# Interventions

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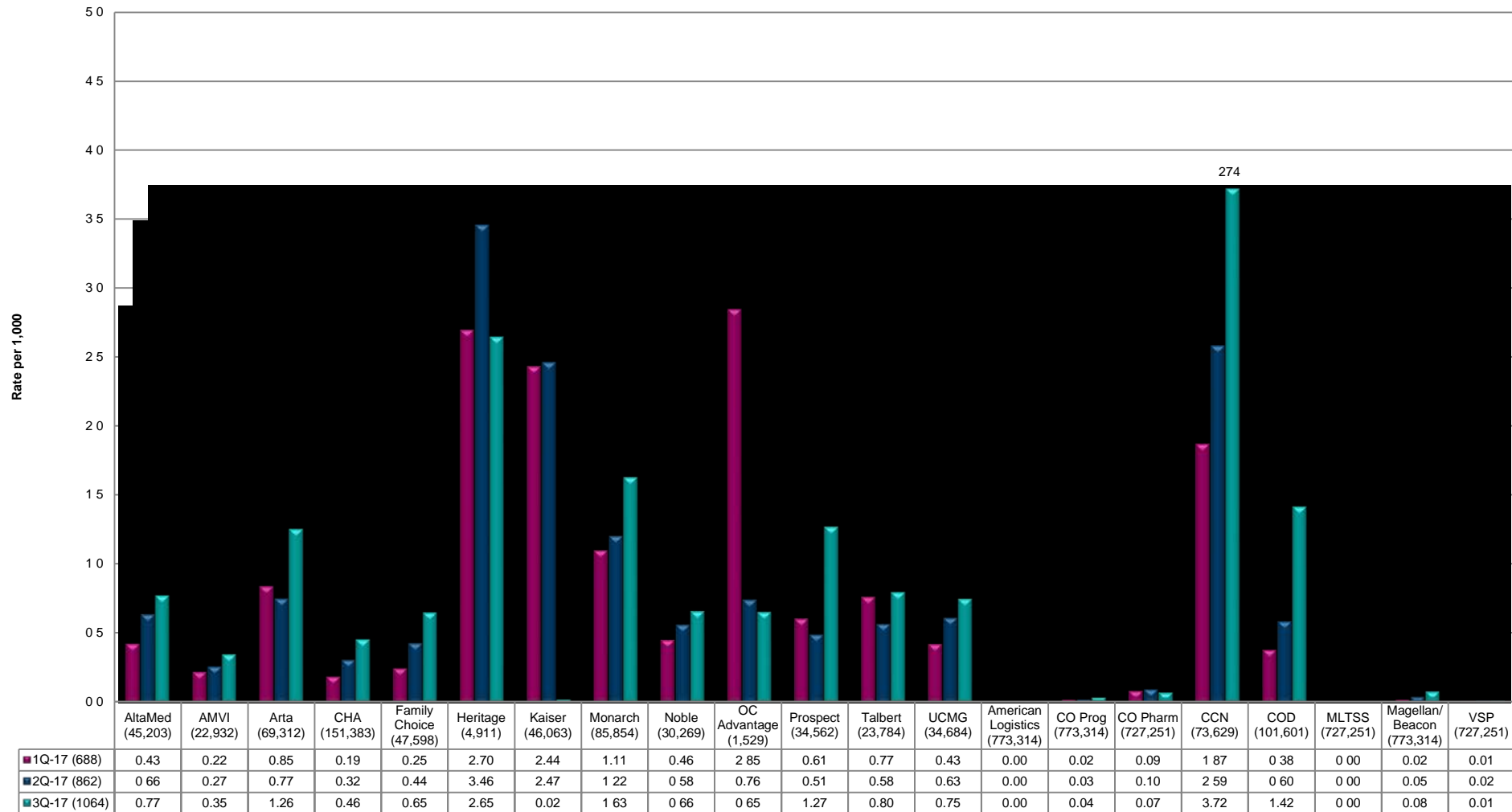
- QOC concerns were escalated to the Quality Improvement department for further review.
- A provider agreed to communicate appointment changes via electronic mail to a member with hearing impairments in order to ensure timely communication.

# Medi-Cal Member Complaints



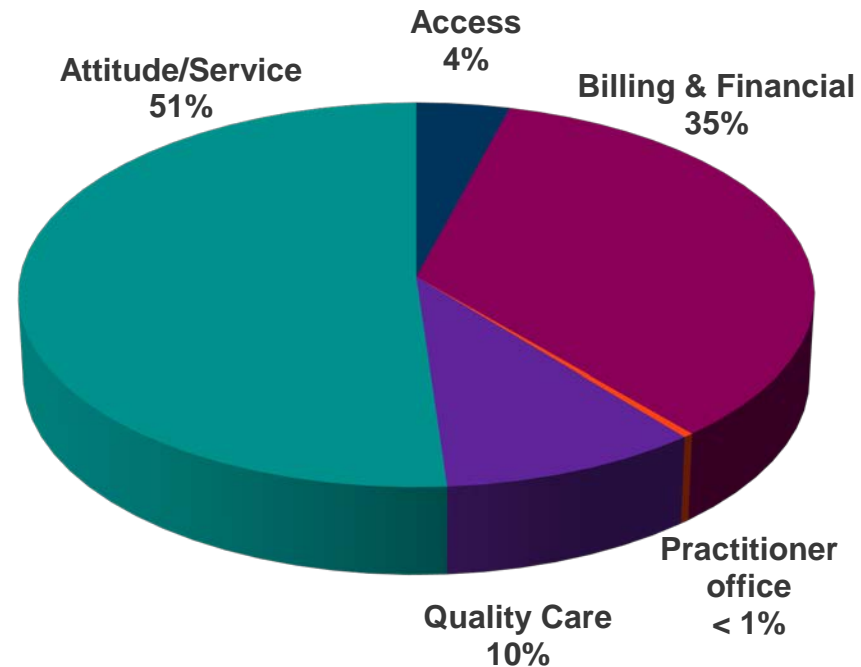
	Total Complaints	Appeals	Grievances	Membership
1Q-2017	921	233	688	774,750
2Q-2017	1094	232	862	772,074
3Q-2017	1288	224	1064	773,314

# MC Member Grievances Quarterly Rate/1,000



# Medi-Cal Grievances by Category

- Total of 1,064 grievances filed by 904 unique members in Q3 2017.
  - Of these, 544 grievances (51 percent) were related to QOS and 103 grievances (10 percent) 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.



# Common QOS Concerns

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- Delay in service
  - Referrals and/or test results
- Provider and/or staff attitude
- Rudeness

# Common QOC Concerns

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- Question diagnosis
- Question treatment
- Delay in treatment impacting member's care
- Refuse to treat

# Summary

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- Member billing grievances increased by 67 percent from Q2 to Q3.
  - This is where the increase of overall grievances is found.
- Billing issues were previously resolved by CalOptima's Customer Service department
  - Due to a regulatory audit finding — billing issues not resolved by the next business day are categorized as standard grievances — and are sent to the Grievance and Appeals department for handling under the grievance process.
- Billing grievances include, but are not limited to:
  - Reimbursement requests, urgent care visits, out-of-state emergency room services, non-authorized services and out-of-network office visits.

# Summary (cont.)

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- The increases in member billing issues are driving up the rates/1,000 members for many of the health networks.
  - Health networks with the largest increases were:
    - COD: 107
    - CCN: 77
    - Monarch: 40
    - CHA: 37
    - Arta: 26
    - Family Choice: 19

# Interventions

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- Members were educated in the importance of providing their Medi-Cal or CalOptima Identification (ID) card prior to receiving services.
- Providers were educated about the federal and state guidelines that forbid them from billing Medi-Cal members.
- Providers that refused to stop billing members were referred to the Compliance department for further action.
  - This process has been successful in enforcing the state and federal billing guidelines.

# CalOptima's Mission

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

