NOTICE OF A
SPECIAL MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS’
QUALITY ASSURANCE COMMITTEE

FRIDAY, DECEMBER 13, 2019
3:30 P.M.

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

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

CHIEF EXECUTIVE OFFICER
Michael Schrader

CHIEF COUNSEL
Gary Crockett

INTERIM CLERK OF THE BOARD
Sharon Dwiers

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

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

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

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

CONSENT CALENDAR
1. Approve Minutes of the October 17, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS
2. Consider Recommending Board of Directors’ Approval of the Calendar Year 2020 Health Network Medi-Cal Pay for Value Performance Program Incorporating the Quality Rating Methodology
3. Consider Recommending Board of Directors’ Approval of Unbudgeted Expenditures to Support Community Education Efforts to Increase Medi-Cal Provider Awareness of Trauma-Informed Care and Adverse Childhood Experiences (ACE) Screening

INFORMATION ITEMS
4. Member Experience Initiative: Improving Access and Availability
5. Intergovernmental Transfer (IGT) 9 Update
6. Quality Measures and Health Condition Attestation Program for OneCare Connect and CalOptima Community Network Members
7. OneCare and OneCare Connect Behavioral Health Implementation Update
8. PACE Member Advisory Committee Update
9. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Report

COMMITTEE MEMBER COMMENTS

ADJOURNMENT
CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:00 p.m. Chair Yost led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi

Members Absent: Alexander Nguyen M.D.

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel, Betsy Ha, Executive Director, Quality and Population Health Management; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Sharon Dwiers, Interim Clerk of the Board

PUBLIC COMMENTS
Dr. Michael Weiss, CHOC Children’s – Oral re: Agenda Item 6, Proposed Health Network Quality Rating Methodology and Pay for Value 2020 Program Update

CONSENT CALENDAR

1. Approve the Minutes of the February 20, 2019 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

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

REPORTS

None

INFORMATION ITEMS

2. Updated Homeless Health Clinical Analysis
Marie Jeannis, Enterprise Analytics Manager, provided an update on the clinical analysis of health for members experiencing homelessness. Ms. Jeannis noted that the clinical analysis for these members is derived from demographic and claims data. She also noted that when comparing the homeless population to the not-homeless population there are large disparities including the...
following: homeless members are two times as likely to have a behavioral health diagnosis without treatment, two to six times higher rate of top behavioral health diagnoses, four times as likely to have a serious mental illness condition, 11 times more likely to have an overdose and substance abuse diagnosis, five to six times more likely to visit the ER, seven times more likely to have an inpatient stay, and two times as expensive per member per month.

The Committee directed staff to see whether the same members are frequently using the ER. If so, those members may benefit from more outreach to help better manage their care.

3. Introduction to Trauma Informed Care and Building Resilience
Betsy Ha, Executive Director, Population Health Management, presented an overview of trauma informed care. Ms. Ha explained that trauma and violence are widespread, harmful and costly public health concerns. She noted that trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity or sexual orientation. Many people who have experienced trauma may have no negative effects in their lives, but many others experience substance use and mental health issues, and this affects not only the individual, but also their families. Trauma can also lead to homelessness.

Ms. Ha reported that Adverse Childhood Experiences (ACE) screening is recommended for the Health Homes pilot and the AB360 workgroup recommends universal ACE screening. Because of the significant impact that trauma can have on people throughout their lives, and the possible associated health risks, use of the ACE screening tool, is recommended.

Ms. Ha suggested developing a quality incentive around this issue and that CalOptima implement ACE screening (for adults) and the Pediatric ACEs and Related Life Screening (PEARLS) screening (for children) and train CalOptima providers on using this tool. Ms. Ha also suggested that CalOptima purchase a book called The Deepest Well: Healing the Long-Term Effects of Childhood Adversity, by Dr. Nadine Burke Harris, for primary care physicians serving CalOptima members.

4. HEDIS 2019 (MY 2018 results)
Ms. Ha presented a review of the HEDIS 2019 results for the Medi-Cal, OneCare and OneCare Connect lines of business using the Tableau tool, which enables comparisons of individual measures year to year and with other health plans. It was reported that the CalOptima Medi-Cal program met all DHCS minimum performance levels. For the OneCare program, 19% of the measures met the goal, 44% of measures were better than last year, and opportunities for improvement are in the areas of post discharge medical reconciliation and readmission measures. OneCare Connect measures were reported as follows: 37% of measures met the goal, 60% of measures were better than last year, and opportunities for improvement are in the areas of breast cancer screening, care for older adults, and readmissions measures. Next steps include raising the bar from the 25% percentile to the 50% percentile, focus on new Department of Health Care Services (DHCS) quality measures and implement strategies on low performing areas.

5. New Department of Health Care Services Managed Care Accountability Act Set (MCAS)
Ms. Ha highlighted the new requirements that were introduced by the Newsom administration, initial MCAS measures and the new minimum performance level (MPL) announced in April 2019, with the final MPL effective May 2019. Previously, for 19 of the measures, plans had to meet the 25th percentile to meet the MPL; plans will need to meet the 50th percentile for those 19 measures going forward. Financial sanctions will be applied to plans who do not achieve the MPL. Staff will be working with providers to meet these new requirements.
Ms. Ha provided an overview of the new proposed health network quality rating methodology. Staff is proposing an administrative simplification by using a consistent measurement system across all programs. The proposed new scoring is based on health network Medicaid HEDIS/Member experience results, NCQA Quality Compass Medicaid national percentiles are used as benchmarks. Scoring points would be as follows: 5>=90th percentile; 4>=66th but <90th percentile; 3>=33rd but <66th percentile; 2>=10th but <33rd percentile; 1< 10th percentile.

Ms. Ha also provided an overview of the proposed pay for value (P4V) 2020 program noting that CalOptima staff is proposing a tier-based payment. Health Networks will be required to receive a score of 2.5 or higher to be eligible to receive P4V incentive payments, and Health Networks will only receive performance-based incentive dollars. Ms. Ha noted that in the past CalOptima awarded incentive dollars for improvement in measures. However, in MY 2020 proposal, Health Networks will only receive incentive dollars for performance not for improvement. Ms. Ha also noted that in prior years, Health Networks were awarded incentive dollars retrospectively but in the proposed P4V MY 2020, Health Networks would start the year earning an additional $3.00 per member per month (PMPM) prospectively to incentive providers to implement strategies to improve performance. If Health Networks score poorly on the measures, CalOptima will take dollars back.

Expressing concern about potentially taking dollars back from providers, Chair Yost noted that staff should further refine the recommendations and provide additional detail before taking the recommendations to the Board. The Committee also raised concerns about the prepayment and possibly needing to recoup those dollars if the health network did not meet all of the performance measures, noting that staff should reach out to the health networks and ensure they understand the proposed methodology.

7. PACE Member Advisory Committee Update
This item was accepted as presented.

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

Agenda Items 8.a. and 8.b. were accepted as presented; however, with respect to Item 8.b. Chair Yost noted the results for CCN reflected in the report. Ana Aranda, Director, Grievance and Appeals Resolution Services, explained that following a recent state audit, certain member calls that were more of an inquiry or an issue that resolved at the time of a call, are reflected in the trend report as grievances. Previously, these types of calls were not categorized as grievances. Consequently, the results are not directly comparable with prior trend reports.
COMMITTEE MEMBER COMMENTS

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 4:53 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Interim Clerk of the Board

Approved: December 13, 2019
Report Item

2. Consider Recommending Board of Directors’ Approval of the Calendar Year 2020 Health Network Medi-Cal Pay for Value Performance Program Incorporating the Quality Rating Methodology

Contact
David Ramirez, M.D., Chief Medical Officer, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management 714-246-8400

Recommended Action

1. Recommend Board of Directors’ approval of the Calendar Year (MY) 2020 Health Network Medi-Cal Pay for Value Performance Program incorporating the Quality Rating Methodology, for the Measurement Period effective January 1, 2020 through December 31, 2020.

Background
CalOptima has implemented a comprehensive Health Network Pay for Value (P4V) Performance Measurement Program consisting of recognizing outstanding performance and supporting ongoing improvement that aimed to strengthen CalOptima’s mission of providing quality health care. The existing P4V Performance Measurement Program is based on a customized methodology developed by CalOptima staff and approved by the CalOptima Board of Directors. Annually, CalOptima staff conducts a review of the current measures and their performance over time. Based on a 2018 retrospective longitudinal quality improvement performance review, although CalOptima consistently met the Minimum Performance Level, overall quality performance trends have been flat over the past five years.

This trend is very consistent with California Health Care Foundation’s recently published quality report entitled: A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade. From 2009 to 2018, quality of care in Medi-Cal managed care was stagnant at best on most measures. Among 41 quality measures collected in two or more years, more than half (59 percent) remained unchanged or declined. Based on feedback from CalOptima Health Networks including, concerns with difficulty of improving selected measure due to the size of the eligible population and/or difficulty in gathering data, the proposed new methodology aims for greater transparency, consistency and administrative simplification. Finally, the proposed methodology aligns with changes to the measures that are important to CalOptima’s National Committee for Quality Assurance (NCQA) Accreditation status, Centers for Medicare and Medicaid Services (CMS) Star Rating Status, newly required DHCS managed care accountability set (MCAS) and/or overall NCQA Health Plan Rating.

Discussion
For the Medi-Cal program, staff recommends adopting and incorporating a new “Quality Rating Methodology” consistent with NCQA validated methodology in the Health Network Medi-Cal P4V Program. Having a standard Quality Rating Methodology will provide CalOptima with one reliable methodology to establish an overall quality rating score for each Health Network. The quality rating score may be used for future P4V payment methodology, incorporated into the new Auto Assignment
policy, or other future programs to improve quality health care for CalOptima members. Considering that this is a significant change, CalOptima proposed that 2020 be the baseline year.

**Measures**
- All Managed Care Accountability Set (MCAS) measures that are required for Minimum Performance Level (MPL) by the Department of Health Care Services (DHCS) are used, including 12 prevention measures and seven treatment measures.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are used for member experience.
- Measures with small denominators (HEDIS < 30; CAHPS < 100) are not used in the score calculation.

**Data and Frequency**
- Each Health Network quality rating score will be calculated annually.
- The Health Network quality rating score will be derived from the most recently available audited, plan level Healthcare Effectiveness Data and Information Set (HEDIS) results. The HEDIS results for Health Networks are based on the administrative methodology. For measures that have a hybrid method option, the additional percentage from medical records collection (difference of CalOptima’s hybrid and admin result) will be added to each Health Network’s results.
- Health Network level Adult/Child CAHPS (member survey) results will be used for member experience scoring. The highest overall score results from either the Health Network’s Adult or Child CAHPS survey results will be used.

**Benchmarks**
- NCQA Quality Compass National Medicaid percentiles

**Score Calculation**

  - **Overall Rating**
    - The overall rating is the weighted average of a health network’s HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars (see below for rounding rules).
    - The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 (5 is highest) scale in half points.

  - **Measure point calculation**
    - A measure result in the top decile (>= 90th percentile) receives 5 points.
    - A measure result in the top 3rd but not in the top 10th (>= 66th but < 90th percentile) receives 4 points.
    - A measure result in the middle 3rd (>= 33rd but < 66th percentile) receives 3 points.
    - A measure result in the bottom 3rd but not in the bottom 10th (>= 10th but < 33rd percentile) receives 2 points.
• A measure result in the bottom 10th (< 10th percentile) receives 1 point.

- Health Network’s score = Σ (measure rating * measure weight) / Σ weights + Accreditation Bonus Points
- Health Network’s Rating = round the score to the nearest half point
- Final scoring will result in an overall Health Network Quality Rating for each Health Network. Based on the final overall score, Health Networks will be assigned a score from 1–5, with 5.0 representing the best possible performance.
- NCQA Rounding Rules: The overall rating is calculated and truncated to three decimal places and round according to the rules below:

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<thead>
<tr>
<th>Overall Rating</th>
<th>Rating</th>
</tr>
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<tbody>
<tr>
<td>0.000–0.249</td>
<td>0.0</td>
</tr>
<tr>
<td>0.250–0.749</td>
<td>0.5</td>
</tr>
<tr>
<td>0.750–1.249</td>
<td>1.0</td>
</tr>
<tr>
<td>1.250–1.749</td>
<td>1.5</td>
</tr>
<tr>
<td>1.750–2.249</td>
<td>2.0</td>
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<tr>
<td>2.250–2.749</td>
<td>2.5</td>
</tr>
<tr>
<td>2.750–3.249</td>
<td>3.0</td>
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<tr>
<td>3.250–3.749</td>
<td>3.5</td>
</tr>
<tr>
<td>3.750–4.249</td>
<td>4.0</td>
</tr>
<tr>
<td>4.250–4.749</td>
<td>4.5</td>
</tr>
<tr>
<td>&gt;= 4.750</td>
<td>5.0</td>
</tr>
</tbody>
</table>

**Fiscal Impact**
The recommended action to approve the 2020 Health Network Medi-Cal P4V Program to incorporate the new Health Network Quality Rating Methodology starting CY 2020 has no fiscal impact to CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019. The current budget included Health Network Medi-Cal P4V program funding in an amount not to exceed $2.00 per member per month (PMPM) through June 30, 2020. Management will include expenses related to the Health Network Medi-Cal P4V program for the period beginning July 1, 2020, and after in future operating budgets.

**Rationale for Recommendation**
CalOptima needs to pivot from stagnant performance trend to demonstrate breakthrough improvement in all measures in order to maintain its standing as one of the high performing Medi-Cal Managed Care Plans. Having a consistent Health Network Quality Rating Methodology using NCQA methodology will provide CalOptima with one consistent quality measurement system to establish an overall quality rating score for each Health Network and it may be used in the future for other programs or policies.
Consider Recommending Board of Directors’ Approval of the Calendar Year 2020 Health Network Medi-Cal Pay for Value Performance Program Incorporating the Quality Rating Methodology

**Concurrence**
Gary Crockett, Chief Counsel

**Attachment**
1. Medi-Cal Health Network Rating Methodology Presentation

/s/ Michael Schrader 12/10/2019
Authorized Signature Date
Proposed Health Network Quality Rating Methodology for CY2020 Update

Special Quality Advisory Committee Meeting
December 13, 2019

David Ramirez, M.D.
Chief Medical Officer
Proposed Health Network Quality Rating Methodology
Guiding Principles for Proposed Changes

• Align with Department of Health Care Services (DHCS). changes in Managed Care Accountability Sets (MCAS).
• Shift from “ranking” winner and loser thinking to a tiered rating system.
• Raise the tide of quality performance across all health networks (HN) to promote win-win thinking.
• Align with industry National Committee for Quality Assurance (NCQA) methodology.
• External expert consultant validation.
• Administrative simplification by using a consistent measurement system across programs.
• Leverage behavioral economics.
MCAS

• Due to the governor's recent focus on increased accountability for managed care plan performance on select measures, CalOptima is proposing a HN rating methodology and measurement set for Calendar Year (CY) 2020 (January 1, 2020 – December 31, 2020)

• Effective immediately, DHCS will require Managed Care Plans to perform at least as well as 50 percent of Medicaid plans in the US.

  ➢ We must achieve the 50th National Medicaid Benchmark for each measure to avoid sanctions.

  ➢ To achieve the new minimum performance levels, we propose adopting a new HN rating methodology and MCAS measures to the Pay for Value (P4V) program to incentivize HNs for the additional quality metrics required by DHCS
HN Rating Methodology

• NCQA Health Plan Rating method adopted for HN Rating:
  ➢ Each HN is assessed a quality score between 1 and 5.
  ➢ Score is based on HN performance on the list of DHCS Minimum Performance Level (MPL) Medicaid measures on 1–5 (5 is highest) scale.
  ➢ Healthcare Effectiveness Data and Information Set (HEDIS) measures will be weighted 1.0.
  ➢ Member Experience measures: Consumer Assessment of Healthcare Providers and Systems (CAHPS) will be weighted 1.5.
  ➢ Hybrid measures: the additional percentage from medical records collection (difference of CalOptima’s hybrid and admin result) will be added to each HN result.
  ➢ Measures having small denominator (HEDIS < 30; CAHPS <100) will be assigned “NA,” and the measure will not used in the calculation.
Proposed New Scoring

• Score calculation is based on HN Medicaid HEDIS/Member Experience results
• NCQA Quality Compass Medicaid national percentiles are used as benchmarks
• Score points
  ➢ 5 $\geq$ 90th percentile
  ➢ 4 $\geq$ 66th but <90th percentile
  ➢ 3 $\geq$ 33rd but <66th percentile
  ➢ 2 $\geq$ 10th but <33rd percentile
  ➢ 1 < 10th percentile
Proposed Measures for MY 2020

• Children’s Health
  ➢ * Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — Body Mass Index (WCC BMI)
  ➢ * Childhood Immunization Status — Combo 10 (CIS 10)
  ➢ * Well Child Visits in the first 15 months of life (W15)
  ➢ * Well Child Visits in the Third, Fourth, Fifth and Sixth years of life (W34)
  ➢ * Immunizations for Adolescents (IMA 2)
  ➢ * Adolescents Well-Care Visits (AWC)

• Behavioral Health
  ➢ Antidepressant Medication Management (AMM Acute phase)
  ➢ Antidepressant Medication Management (AMM Continuation phase)

* Measure rate may include findings from medical record review.
Measures highlighted in bold are proposed new measures for P4V MY2020.
Proposed Measures for MY 2020 (cont.)

- **Women’s Health**
  - *Cervical Cancer Screening (CCS)*
  - Chlamydia Screening in Women Ages 21–24 (CHL)
  - Breast Cancer Screening (BCS)
  - *Prenatal and Postpartum Care (PPC-Pre)*
  - *Prenatal and Postpartum Care (PPC-Post)*

- **Acute and Chronic Disease Management**
  - *Adult Body Mass Index Assessment (Adult BMI)*
  - *Comprehensive Diabetes Care HbA1c Testing (CDC HT)*
  - *Comprehensive Diabetes Care HbA1c Poor Control (CDC H9)*
  - Asthma Medication Ratio Ages 19–64 (AMR)

- **Readmissions**
  - Plan All-Cause Readmissions (PCR)

* Measure rate may include findings from medical record review.

Measures highlighted in bold are proposed new measures for P4V MY2020.
Member Satisfaction Measures

- Member Experience Performance remains an important metric (and required by DHCS)
- CAHPS measures
  - Rating of Health Care
  - Rating of Health Network
  - Rating of PCP
  - Rating of Specialist
  - Getting Needed Care
  - Getting Care Quickly
  - Care Coordination
  - Customer Service
# Health Network Quality Rating Tiers

## Overall Rating

Based on 2018 Performance and Proposed Measures

<table>
<thead>
<tr>
<th>Health Network Name (alphabetical order for tied tiers)</th>
<th>Stars</th>
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<tbody>
<tr>
<td>Kaiser Permanente</td>
<td>★★★★½</td>
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<tr>
<td>AltaMed Health Services</td>
<td>★★★★</td>
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<tr>
<td>AMVI Care Health Network</td>
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</tr>
<tr>
<td>Arta Western Health Network</td>
<td></td>
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<tr>
<td>CalOptima Overall</td>
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<tr>
<td>CHOC Health Alliance</td>
<td>★★★ ½</td>
</tr>
<tr>
<td>Monarch Family HealthCare</td>
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<tr>
<td>Talbert Medical Group</td>
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<tr>
<td>CCN</td>
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</tr>
<tr>
<td>Family Choice Health Network</td>
<td>★★★</td>
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<tr>
<td>Noble Mid-Orange County</td>
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</tr>
<tr>
<td>Prospect Medical Group</td>
<td></td>
</tr>
<tr>
<td>Heritage – Regal Medical Group</td>
<td>★★ ½</td>
</tr>
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Back to Agenda

Back to Agenda
## Health Network Quality Rating

Based on 2018 Performance and Proposed Measures

<table>
<thead>
<tr>
<th>Health Network Name</th>
<th>HEDIS</th>
<th>Member Experience</th>
<th>Overall Rating</th>
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<tbody>
<tr>
<td>AltaMed Health Services</td>
<td>★★★★</td>
<td>★★ ½</td>
<td>★★★★</td>
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<td>★ ½</td>
<td>★★★ ½</td>
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Next Steps

• Present the final recommendations for Board approval in February 2020.
CalOptima’s Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner
CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 13, 2019
Special Meeting of the CalOptima Board of Directors’
Quality Assurance Committee

Report Item
3. Consider Recommending Board of Directors’ Approval of Unbudgeted Expenditures to Support Community Education Efforts to Increase Medi-Cal Provider Awareness of Trauma-Informed Care and Adverse Childhood Experiences (ACE) Screening

Contact
David Ramirez, MD, Chief Medical Officer, 714-246-8400
Betsy Chang Ha, R.N., Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Action
Authorize unbudgeted expenditures of up to $80,000 from existing reserves for outreach and education efforts to increase Medi-Cal provider awareness of evidence-based ACE screening and Trauma-Informed Care.

Background
At the October 17, 2019, Special Quality Assurance Committee (QAC) meeting, the QAC members directed CalOptima staff to develop a Trauma-Informed Care plan of action. As a high-performing Medi-Cal managed care plan, CalOptima is positioned to increase provider awareness and position Orange County as an early adopter in support of the Office of the California Surgeon General’s (CA-OSG) statewide effort to reduce ACE and toxic stress by half in one generation, starting with Medi-Cal members.

Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing comorbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epic-genetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation.

The proposed first step to building awareness and supporting the early adopters is consistent with the Governor’s focus on increased accountability for managed care plan performance on select pediatric measures and the DHCS introduced additional requirements to screen and mitigate risk impacting children’s health and well-being. The 25th Annual Report on the Condition of Children in Orange County also pointed out that many OC children are impacted by Social Determinants of Health (SDoH). For example, one in six children lives in poverty and nearly 30,000 students experience housing insecurity. Mental health hospitalization rates grew from 87 percent over the past 10 years and 6 percent in the past year alone. The report demonstrates strong correlation between ACE, youth suicidal behaviors and emergency department visits for self-harm. Disparities continue to persist in OC among races, ethnicities, geographies, communities and school districts. Considering that most of these children experiencing child poverty, housing insecurity, homelessness and/or foster care, they are likely members of CalOptima. As the single payer for Medi-Cal, CalOptima has the unique opportunity to support community training and increase provider awareness about Trauma-Informed Care and ACE screening.

Back to Agenda
Separate from the provider outreach and education efforts addressed with this staff recommendation, and subject to obtaining the necessary federal approvals, the California Department of Health Care Services (DHCS) is requiring managed care plans (MCPs) including CalOptima, through the Proposition 56 payment mechanism, either directly or through their delegated entities and subcontractors, to comply with a minimum fee schedule of $29.00 for each qualifying ACE screening service by a Network Provider with dates of services on or after January 1, 2020.

**Discussion**

Considering that DHCS is still finalizing the All Plan Letter, (APL) 19-XXX: Proposition 56 Directed Payments for ACE Screening Services for MCPs. Staff recommends that CalOptima focus on building awareness and buy-in and develop a more comprehensive plan of action once DHCS releases the final APL. To this end, staff proposes to:

- Promote and support dissemination of DHCS Trauma-Informed Care and ACE screening and education materials via mailings, texting, webinars, workshops, and conferences, etc. to primary care providers serving the CalOptima Medi-Cal population;

- Support early adopters, provider training dissemination events, workshops and tool kits to CalOptima contracted providers in collaboration with DHCS, Health Networks and other community partners; and

- Sponsor training events on Trauma Informed Care and ACE screening for providers serving CalOptima Medi-Cal members.

- Establish baseline process measures in year-one:
  1. Number of providers completed ACE training in year one
  2. Number of PEARL/ACE screening completed for members

While staff is not proposing to include any incentive payments associated with this initial proposed ACE outreach and education initiative, quality incentive payments may be included in future quality programs presented to the QAC and CalOptima Board. Staff’s intent is to consider data collected related to ACE training provided as well as the number of screenings conducted under the DHCS Proposition 56 funded initiative as a broader ACE-based quality initiative(s) are formulated.

**Fiscal Impact**

The recommended action to authorize expenditures for provider education for the period of January 1, 2020, through June 30, 2020 is an unbudgeted item. A proposed allocation of up to $80,000 from existing reserves will fund this action. Management plans to include program funding to support ACEs Aware in future operating budgets.
CalOptima Board Action Agenda Referral
Consider Recommending Board of Directors’ Approval of
Unbudgeted Expenditures to Support Community Education Efforts to
Increase Medi-Cal Provider Awareness of Trauma-Informed Care and
Adverse Childhood Experiences (ACE) Screening
Page 2

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments:**
1. ACE Aware Presentation
2. Proposed Budget

_/s/ Michael Schrader_  12/10/2019
Authorized Signature  Date
Trauma-Informed Care
ACEs Aware

Special Quality Assurance Committee Meeting
December 13, 2019

Betsy Chang Ha, RN, MS, LSSMBB
Executive Director, Quality & Population Health Management
Agenda

• Call To Action
• California Office of Surgeon General (CA-OSG) and Department of Health Care Services (DHCS) Adverse Childhood Experiences (ACE) Update
• Population Health Impact
• Building Awareness
• Questions
October Special QAC Call to Actions

Build Awareness and Buy-in
- QIC and QAC
- Mental Health Awareness Week
- Awareness and Education Seminar on May 23, 2019
- Join California Surgeon General’s universal ACEs screening movement

Invest in Trauma-Informed Workforce
- Prevent secondary trauma
- Invest in employee wellness
- Building resilience in health care providers / workforce

Create a Safe Physical and Emotional Environment
- Recognize and address organizational trauma
- Building trauma-informed system of care

Engage Patient in Meaningful Ways
- Shift from judgement to empathy and compassion

Identify and Treat Trauma
- Implement prevention and Population Health Management strategy
Population Health Impact

• Children Who Experience 4 or More ACEs:

- Learning and Behavioral Problem: 32X
- Asthma, Heart Disease and Cancer: 3X
- Pulmonary Disease: 3.5X
- Depression: 4.5X
- IV Drug Use and Suicide: 12X

7 out of 10 Leading Causes of Death in the U.S. correlate with exposure to > 4 ACEs

Source: CDC–Kaiser Permanente ACEs Study, 1995-97
Condition of Children in OC

1 in 6 Poverty
8.3% Chronic school absent
87% Mental health IP rate
846 ED visit for self-harm
30,000 Insecure housing

Source: 25th Annual Report on the Condition of Children in Orange County (OC)
Condition of CalOptima Children

• CalOptima has approximately 279,000 children between the ages of 0–18 years.
  ➢ One percent (1,800) of these children are homeless
  ➢ Over 90 percent of the children were identified through the homeless source of “address”
  ➢ Nine percent of the homeless high confidence population

• Emergency Department Rates
  ➢ Overall trends are slightly higher, but rates for ED visits related to diagnosis of suicidal ideation, self-harm or attempted suicide were low

• Social Determinants (Based on ICD-10 Codes)

<table>
<thead>
<tr>
<th>Housing and Economics</th>
<th>Psychosocial</th>
<th>Social Environment</th>
<th>Support and Family</th>
<th>Upbringing</th>
</tr>
</thead>
<tbody>
<tr>
<td>363</td>
<td>449</td>
<td>106</td>
<td>996</td>
<td>1,114</td>
</tr>
</tbody>
</table>
## Population Segments at Risk for ACE

<table>
<thead>
<tr>
<th>Age</th>
<th>Membership</th>
<th>ACE Tool</th>
<th>Estimated membership with &gt;4+ ACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–5</td>
<td>82,406</td>
<td>PEARLS</td>
<td>30,000</td>
</tr>
<tr>
<td>6–18</td>
<td>216,029</td>
<td>PEARLS</td>
<td>80,000</td>
</tr>
<tr>
<td>19–40</td>
<td>192,494</td>
<td>ACE</td>
<td>71,000</td>
</tr>
<tr>
<td>41–64</td>
<td>158,892</td>
<td>ACE</td>
<td>58,000</td>
</tr>
<tr>
<td>65+</td>
<td>90,801</td>
<td>ACE</td>
<td>34,000</td>
</tr>
</tbody>
</table>

### Legend:
1. Based on 2019 Medi-Cal Membership
2. >4 ACES prevalence based on the findings from the Philadelphia Urban ACE Survey; 37 percent experienced 4 or more ACE, Robert Wood Johnson Foundation. September 2013.
3. PEARLS — Pediatric ACES and Related Life Events Screener, ACE tool for children
CA-OSG and DHCS Update

• On October 17, 2019, the Department of Health Care Services (DHCS) released Draft All-Plan Letter (APL) 19-XXX: Proposition 56 Directed Payments for Adverse Childhood Experience (ACE) Screening Services for managed care plans (MCP)

• Beginning on January 1, 2020, MCP, either directly or through their delegated entities or subcontractors, to pay $29 per ACE screen completed by a Medi-Cal provider.

• Screening by provider is optional through July 2020 per CA-OSG.
CA-OSG and DHCS Update (cont.)

- CA-OSG to provide and/or authorize trauma-informed care training, in-person trainings, online learnings and regional convenings
- Positive ACE screens will need to be referred to a behavioral health specialist, manage by counseling, resiliency strategies, and/or referrals to mental health professionals.
- CA-OSG and DHCS jointly kicked off ACEs Aware Initiative on December 4, 2019.
ACEs Aware: Opportunities to Collaborate on Provider Engagement

• Provider training (kicked off on December 4, 2019)
  ➢ Phase 1: CA-OSG and DHCS worked with Clinical Advisory Subcommittee (CAS) and developed a 2-hour online CME training via ACEsAware.org
    ▪ ACE screening tools
    ▪ Billing codes
  ➢ Phase 2: CA-OSG and DHCS are interested in partnering with organizations to provide additional certified training opportunities.
    ▪ Targeted to specific provider specialties
    ▪ Offer different modalities (such as in-person)
ACES Aware (cont.)

• Provider Outreach and Communication
  ➢ Look for partner and leverage existing communication channels on outreach and developing resources with guidance on incorporating ACE screening into clinical work.
  ➢ Identify ACES Aware Champions.

• Phase 3: Learning and Quality Improvement (QI) Collaborative
  ➢ Implement a data driven, iterative evaluation and QI process
  ➢ Provide technical assistance to implement evidence-based best practices
  ➢ Disseminate best practices to health systems across the state via ACEsAware.org
Build Awareness and Buy-In

• Promote and support dissemination of DHCS Trauma-Informed Care and ACE screening member and provider education materials via mailing, texting, website, workshop, conferences, etc.

• Support early adopter provider training dissemination events, workshops and tool kits, in collaboration with DHCS, community partners and health networks

• Sponsor community training event in partnership with academic institutions, professional associations and other key stakeholders

• Establish baseline process measures:
  • Number of providers completed ACE training
  • Number of PEARL/ACE screenings completed
Requested Unbudgeted Fund

• Estimated Provider Awareness Promotion budget = $80,000 for 6 months for the following expenditures:
  ➢ Support outreach, community training, and CME events related to Trauma-Informed Care and ACE screening in addition to CA-OSG and DHCS-offered webinar
  ➢ Distribute provider education materials
Questions
CalOptima’s Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner
## ACEs Aware 1 Year Budget Summary

<table>
<thead>
<tr>
<th></th>
<th>CY2020 - Year 1</th>
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</thead>
<tbody>
<tr>
<td><strong>Medical Expenses</strong></td>
<td></td>
</tr>
<tr>
<td>Provider Education Material (Book/PCP)</td>
<td>15,000</td>
</tr>
<tr>
<td>Provider Education Events Sponsorship</td>
<td>20,000</td>
</tr>
<tr>
<td><strong>Total Medical Expenses</strong></td>
<td>35,000</td>
</tr>
<tr>
<td><strong>Administrative Expenses</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total Admin Expenses</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total:</strong></td>
<td>35,000</td>
</tr>
</tbody>
</table>

$125,000
CalOptima annually fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess member’s experiences from our adult and child members. The survey results are based upon a prescribed systematic sample of 1,350 members and is fielded in English and Spanish for 10 weeks using a mail and telephone mixed-mode protocol. The CAHPS survey is a standardized survey tool used by health plans across the nation.

While benchmarks nationwide are rising, CalOptima scored below the 25th percentile in 2019 for the following access-related measures: Getting Needed Care and Getting Care Quickly. More than 75 percent of health plans scored better than CalOptima despite having approximately 80 percent of members feeling satisfied with the above measures and that member satisfaction is related to a member’s ability to access care. As a result, CalOptima’s Member Experience Subcommittee, an agency-wide committee focused on improving member experience, is working closely with the Access and Availability Workgroup to focus on improving access to care for our members.

This presentation describes how CalOptima monitors member access in accordance with Department of Health Care Services (DHCS) standards* and describes our performance on key access and availability standards. Improving member access is key to improving member experience.

DHCS access and availability monitoring includes the following components:

1. Provider to Member Ratio: Do we have enough providers?
2. Mandatory Provider Types: Do we have the right providers?
3. Distance and Time: Are providers located where members can access them?
4. Timely Access (Appointment Availability and Wait Times): Can members get timely access to care?

*Standards can be found in Policy GG.1600: Medi-Cal Access and Availability and Policy MA.7007: OneCare and OneCare Connect Access and Availability.

CalOptima has met all the DHCS access standards except for Timely Access, and monitoring activities suggest members are not receiving timely access to care.

When using DHCS Access Standards to monitor access to care, there are limitations. This presentation describes these limitations and how CalOptima staff elected to do a deeper dive into access by reviewing approximately 3,000 quality of service, access and quality of care grievances between January–June 2019 and establishing grievance “themes” and potential root
causes related to accessing services. The presentation also describes actions CalOptima is taking or has already completed to improve our access and availability barriers and challenges for our members. These actions include:

- **Improving Data and Access to Data**
  - Provider data initiative
  - Member portal
  - Provider Directory — urgent care services section
  - Mapping providers (e.g. behavioral health providers)

- **Improving Access to Specialists**
  - Increase payment rates for hard to access specialists (potential)
  - Telehealth* (potential)

- **Improving Access to PCPs and Specialists**
  - Minimum physician hours (potential)
  - Health network corrective action plans
  - Incentives for hard to access primary care providers (PCPs) and specialists to open their panels (potential)

- **Improving Access to PCPs**
  - CalOptima Days for PCP visits
  - CalOptima Community Network (CCN) PCP provider report card
  - PCP overcapacity monitoring — close panels

- **Improving Communication**
  - Provider coaching
  - Customer Service workshops for providers (staff, manager and physicians)

- **Other**
  - Member expectation education
  - Quality rating methodology
  - Review all auto authorization rules in our authorization system
Member Experience Initiative: Improving Access and Availability

Special Quality Assurance Committee Meeting
December 13, 2019

Marsha Choo, MPH, CHES
Manager, Quality Analytics
**Agenda**

- CalOptima Member Experience Performance
- How Does CalOptima Monitor Access?
  - Provider to Member Ratio
  - Time and Distance Standards
  - Timely Access
  - Mandatory Provider Types
- CalOptima Access Monitoring and Deeper Dive
  - Grievances
- What Are We Doing?
CalOptima Member Experience Performance
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

- A standardized survey tool used by health plans across the nation to measure member experience.
- CalOptima annually fields the CAHPS survey to assess member’s experiences from our adult and child members.
- Surveys are administered over a 10-week period using a mail and telephone mixed-mode protocol.
- A random sample of 1,350 cases was used for the survey.
- Response rates average: 20 percent.
- Surveys are fielded in English and Spanish.
# 2019 Medi-Cal Member Experience Survey Results

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Rating of All Health Care</td>
<td>75th</td>
<td>25th</td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>90th</td>
<td>25th</td>
</tr>
<tr>
<td>Rating of Specialist</td>
<td>75th</td>
<td>NA</td>
</tr>
<tr>
<td>Rating of Health Plan</td>
<td>25th</td>
<td>&lt;25th</td>
</tr>
<tr>
<td>Getting Needed Care</td>
<td>&lt;25th</td>
<td>&lt;25th</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>&lt;25th</td>
<td>&lt;25th</td>
</tr>
<tr>
<td>Customer Service</td>
<td>NA</td>
<td>&lt;25th</td>
</tr>
</tbody>
</table>

Note: For comparison, the National Medicaid Benchmarks were used.
CalOptima Member Experience Survey Pain Points

• Member Experience Benchmarks have risen across the nation (bar continues to be raised).

• Member Experience survey’s lowest performing areas are related to members accessing care:
  ➢ Getting Needed Care: Approximately 78 percent of members felt that they “got the care they needed.”
  ➢ Getting Care Quickly: Approximately 81 percent of members felt that they “got care quickly” or “as soon as needed.”
  ➢ Both measures are <25th percentile: More than 75 percent of health plans scored better than CalOptima despite having approximately 80 percent of members feeling satisfied with the measures above.

• Members’ satisfaction is related to a members’ ability to access care.
Member Experience Subcommittee Focus: To improve access to care for our members

- Improve Member Experience
- Improve Access to Care
- Focused Member Experience Measures

Subcommittee:
- Access and Availability Workgroup
  - Getting Needed Care
  - Getting Care Quickly
How Does CalOptima Monitor Access?
Access Monitoring Components

- CAHPS
- Provider to Member Ratios*
- Time and Distance Standards*
- Member Access to Care
- Timely Access*
- Grievances*
- Mandatory Provider Types*

* Components are part of the annual Department of Health Care Services (DHCS) Network Certification
DHCS Access Monitoring Components

CalOptima and its health networks shall meet all the following requirements:

- Can member get timely access to care?
- Are providers located where members can access them?
- Do we have enough providers?
- Can members get timely access to care?
- Do we have the right providers?
- Time and Distance
- Provider to Member Ratios
- Mandatory Provider Types
## Provider to Member Ratios

### Do we have enough providers?

<table>
<thead>
<tr>
<th>Standards</th>
<th>Monitoring</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medi-Cal (MC): One primary care provider (PCP) to every 2,000 members</td>
<td>- DHCS: Annual Network Certification (plan level)</td>
<td>- Met all areas at the plan and health network level</td>
</tr>
<tr>
<td>- Medi-Cal: One total network physician to every 1,200 members.</td>
<td>- CMS: Three-Year Provider Network Adequacy Review</td>
<td>- Identified PCPs who have exceeded their member capacity</td>
</tr>
<tr>
<td>- OneCare (OC) and OneCare Connect (OCC): Minimum number of providers as</td>
<td>- CalOptima: Quarterly reports (plan, health network and individual PCP</td>
<td></td>
</tr>
<tr>
<td>determined by Center for Medicare and Medicaid Services (CMS)</td>
<td>level)</td>
<td></td>
</tr>
</tbody>
</table>

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[Back to Agenda]
### DHCS Mandatory Provider Types

Do we have the right providers?

<table>
<thead>
<tr>
<th>Standards</th>
<th>Monitoring</th>
<th>Findings</th>
</tr>
</thead>
</table>
| • Medi-Cal: At least one of each of the following are available:  
  ➢ Federally qualified health centers (FQHC)  
  ➢ Rural health clinics (RHC)  
  ➢ Indian health facilities (IHF)  
  ➢ Free-standing birth center (FBC)  
  ➢ Certified nurse midwife (CNM)  
  ➢ Licensed midwife (LM)  
| • DHCS: Annual Network Certification (plan level)  
  • CalOptima: Quarterly reports (plan level)  
| • Met All Areas |
### Distance and Time Standards

Are providers located where members can access them?

<table>
<thead>
<tr>
<th>Standards</th>
<th>Monitoring</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 10 miles or 30 minutes from the member’s residence&lt;br&gt;➢ Primary care including obstetrics / gynecology (OB/GYN)&lt;br&gt;➢ Pharmacy&lt;br&gt;• 15 miles or 30 minutes from the member’s residence&lt;br&gt;➢ Specialty care including (OB/GYN)&lt;br&gt;➢ Mental health outpatient services&lt;br&gt;➢ Hospitals</td>
<td>• DHCS: Annual Network Certification (plan level)&lt;br&gt;• CMS: Three-Year Provider Network Adequacy Review&lt;br&gt;• CalOptima: Quarterly reports (plan and health network level)</td>
<td>• Not met OB/GYN-PCP (MC) in South County&lt;br&gt;• Not met at the health network level</td>
</tr>
</tbody>
</table>

Note: CMS distance/time standards vary by provider specialty type
Timely Access — Appointment Availability

• Urgent and/or routine visits appointment availability for the following appointment types:
  ➢ Primary care including OB/GYN
  ➢ Specialty care including OB/GYN
  ➢ Routine physical exams and health assessments
  ➢ Initial health assessment (IHA)
  ➢ First prenatal visit
  ➢ Mental health (non-psychiatry) outpatient services
  ➢ Follow-up care with a physician behavioral health care provider and/or mental health (non-psychiatry) outpatient services
  ➢ Ancillary services (i.e. physical therapy, mammography providers and diagnostic imaging providers)

* Appointment availability wait time standards vary by appointment type.
### Timely Access — Appointment Availability

Can members get timely access to care?

<table>
<thead>
<tr>
<th>Standards</th>
<th>Monitoring</th>
<th>Findings</th>
</tr>
</thead>
</table>
| • Timely Access or Appointment Availability for urgent and/or routine visits appointment types | • DHCS: Quarterly Timely Access Survey aggregated to an annual report.  
➢ Telephone survey  
➢ DHCS Core Medi-Cal providers  
➢ Small quarterly sample (N=105)  
• CalOptima: Annual Timely Access Survey  
➢ Mystery shopper  
➢ All PCPs and CalOptima identified specialists (no sampling) | • Unable to reach providers during business hours  
➢ Incorrect provider information  
➢ Long hold / no answer / answering machine  
• Urgent appointments and appointments with specialists are not timely* |

* DHCS has not officially set a minimum threshold for compliance.
## Timely Access — Wait Times

Can member get timely access to care?

<table>
<thead>
<tr>
<th>Provider Types</th>
<th>Medi-Cal Standards</th>
<th>Monitoring</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to and wait time for triage and screening</td>
<td>Available 24 hours a day, 7 days a week; wait time shall not exceed 30 minutes</td>
<td>• DHCS: Quarterly Timely Access Survey</td>
<td>• Unable to reach providers during business and after hours</td>
</tr>
<tr>
<td>Customer service call center wait time</td>
<td>Shall not exceed 10 minutes</td>
<td>• CalOptima:</td>
<td>• Provider not returning calls timely</td>
</tr>
<tr>
<td>In office wait time</td>
<td>Shall not exceed 45 minutes to see a provider</td>
<td>➢ Annual Timely Access Survey</td>
<td></td>
</tr>
<tr>
<td>Wait time for return call from provider</td>
<td>Within 30 minutes (urgent) or 24 hours (non-urgent) after time of message</td>
<td>➢ Annual PCP Experience Survey: Facility Site Review</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ CAHPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Nurse advice line</td>
<td></td>
</tr>
</tbody>
</table>
## Provider Specialties Monitored

<table>
<thead>
<tr>
<th>DHCS Adult and Pediatric Core Specialists*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology/Interventional Cardiology</td>
<td>Nephrology</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Neurology</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Oncology</td>
</tr>
<tr>
<td>ENT/Otolaryngology</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Orthopedic Surgery</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Physical Medicine and Rehabilitation</td>
</tr>
<tr>
<td>Hematology</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>HIV/AIDS Specialists/Infectious Diseases</td>
<td>Pulmonology</td>
</tr>
</tbody>
</table>

### Additional Specialists Monitored by CalOptima

| Podiatry |  |

Note: These provider specialties are included for timely access and time/distance monitoring.
Summary of DHCS Access Performance

- Can member get timely access to care? **No**
- Are providers located where members can access them? **Yes**
- Do we have enough providers? **Yes**
- Can member get timely access to care?

Timely Access

Provider to Member Ratios

Time and Distance

Mandatory Provider Types

Back to Agenda
Limitations of DHCS Access Standards

- Do not tell us whether there are enough specialists (no specialist-to-member ratio)
- Do not tell us whether specialists have capacity
- Do not monitor all provider specialties (only DHCS Core specialties)
- Do not tell us why members are not accessing care timely
- Do not tell why members are not satisfied
CalOptima Access Monitoring and Deeper Dive: Grievances
Grievances Review

- CalOptima monitors grievances for trends quarterly.
- Staff reviewed grievances between January–June, 2019.
- Approximately 3,000 grievances were reviewed.
- Reviewed the following categories for trends:
  - Quality of Service
  - Access
  - Quality of Care
- Established grievance “themes” and potential root causes.
Members’ Experience When Accessing Care

- Calling for appointment
- Appointment scheduling

Pre-Visit Stage

- Authorization
- Request for referral
- Referral submission
- Notification of authorization/denial

Prior Authorization Process

- From arrival to departure of appointment

During Visit Stage

- Appointment follow-up actions

Post Visit and Follow-Up Stage
Themes and Potential Root Causes

**Pre-Visit: Provider Appointment Availability**
- Incorrect data in the provider directory
- Provider data on availability not pro-activity captured or accessible
- Behavioral health practitioner vs. medical business model
- Telephone access
- Not enough specialists

**During Visit: Sense of Provider Engagement**
- Unmet member expectations
- Not enough time
- Concerns not heard
- Poor communication between provider and member
- Member not able to see assigned provider

**Post-Visit: Communication of Test Results**
- Member not getting test results
- No follow-up from the provider office
- Poor communication on outcome of test results

**PA Process: Delay In Access To Services Via Prior Authorization Process**
- Incorrect / Incomplete systems data
- Inaccessibility of internal data
- Re-authorizations required due to improper initial prior authorizations
- Member not aware of provider’s notification process for authorization approvals
What Are We Doing?

**Improving Data and Access to Data**
- Provider data initiative
- Member portal
- Provider Directory — Urgent Care Services
- Mapping providers (e.g. behavioral health providers)

**Improving Access to Specialists**
- Increase payment rates for hard to access specialists*
- Telehealth*

**Improving Access to PCPs and Specialists**
- Minimum physician hours*
- Health network corrective action plans
- Incentives for hard to access PCPs and specialists to open their panels*

* Potential interventions to improve access
## What Are We Doing? (cont.)

<table>
<thead>
<tr>
<th>Improving Access to PCPs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CalOptima Days for PCP Visits</td>
<td></td>
</tr>
<tr>
<td>CalOptima Community Network (CCN) PCP Provider report card</td>
<td></td>
</tr>
<tr>
<td>PCP overcapacity monitoring — close panels</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving Communication</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider coaching</td>
<td></td>
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<tr>
<td>Customer Service workshops for providers (staff, manager and physicians)</td>
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</table>

<table>
<thead>
<tr>
<th>Other</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member expectation education</td>
<td></td>
</tr>
<tr>
<td>Quality rating methodology</td>
<td></td>
</tr>
<tr>
<td>Review all auto authorization rules in our authorization system</td>
<td></td>
</tr>
</tbody>
</table>

* Potential interventions to improve access
References

- Policy GG.1600: Access and Availability Standards (Medi-Cal)
- Policy MA.7007: Access and Availability Standards (OneCare and OneCare Connect)
CalOptima’s Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner
Intergovernmental Transfer (IGT) 9 Update

Special Quality Assurance Committee Meeting
December 13, 2019

David Ramirez, M.D., Chief Medical Officer
Candice Gomez, Executive Director, Program Implementation
IGT Background

• IGT process enables CalOptima to secure additional federal revenue to increase California’s low Medi-Cal managed care capitation rates
  ➢ IGTs 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
    ▪ Funds are outside of operating income and expenses
  ➢ IGTs 8–9: Funds must be used for Medi-Cal covered services for the Medi-Cal population
    ▪ Funds are part of operating income and expenses

• No guarantee of future availability of IGT funds
  ➢ Best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries
## IGT Funding Process

**High-Level Steps:**

1. CalOptima receives DHCS notice announcing IGT opportunity

2. CalOptima secures funding partnership commitments (e.g., UCI, Children and Families Commission, et al)

3. CalOptima submits Letter of Interest (LOI) to DHCS listing funding partners and their respective contribution amounts

4. Funding partners wire their contribution amount and additional 20% fee to DHCS

5. CMS provides matching funds to DHCS

6. DHCS sends total amount to CalOptima

7. From the total amount, CalOptima returns each funding partner’s original contribution

8. From the total amount, CalOptima also reimburses each funding partner’s 20% fee and where applicable, retained amount for MCO tax (IGT 1–6 only)

9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees
## CalOptima Share Totals to Date

<table>
<thead>
<tr>
<th>IGTs</th>
<th>CalOptima Share</th>
<th>Date Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>IGT 1</td>
<td>$12.43 million</td>
<td>September 2012</td>
</tr>
<tr>
<td>IGT 2</td>
<td>$8.70 million</td>
<td>June 2013</td>
</tr>
<tr>
<td>IGT 3</td>
<td>$4.88 million</td>
<td>September 2014</td>
</tr>
<tr>
<td>IGT 4</td>
<td>$6.97 million</td>
<td>October 2015 (Classic)/March 2016 (MCE)</td>
</tr>
<tr>
<td>IGT 5</td>
<td>$14.42 million</td>
<td>December 2016</td>
</tr>
<tr>
<td>IGT 6</td>
<td>$15.24 million</td>
<td>September 2017</td>
</tr>
<tr>
<td>IGT 7</td>
<td>$15.91 million</td>
<td>May 2018</td>
</tr>
<tr>
<td>IGT 8</td>
<td>$42.76 million</td>
<td>April 2019</td>
</tr>
<tr>
<td>IGT 9*</td>
<td>TBD</td>
<td>TBD (Spring 2020)</td>
</tr>
</tbody>
</table>

**Total Received** $121.31 million

* Pending DHCS guidance
IGT 9 Status

• CalOptima’s estimated share is approximately $45 million
  ➢ Expect receipt of funding in calendar year 2020
  ➢ Funds used for Medi-Cal programs, services and operations
  ➢ Funds are part of operating income and expenses
    ▪ Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR) apply
    ▪ Managed through the fiscal year budget

• Recommended focus areas for IGT9 funds
  ➢ Quality performance
  ➢ Access to care
  ➢ Data exchange and support
Next Steps

• Discuss potential expenditures of IGT 9 funds with advisory committees and other stakeholders
• Present recommendations during the February 2020 Board of Directors’ Quality Assurance Committee
• Present final recommendations during the March 2020 Board of Directors Meeting
CalOptima’s Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner
Quality Measures and Health Condition Attestation Program

OneCare Connect (OCC) CalOptima Community Network (CCN) Members

Special Quality Assurance Committee Meeting

December 13, 2019
David Ramirez, MD, Chief Medical Officer
Overview

• Background

• Medicare Attestation Programs

• CalOptima’s Focus Areas
   Quality: Potential Focus Area
   Risk Adjustment Factors (RAF)

• Proposed Quality Measures and Health Condition Attestation Program
   Program Goals
   Payment Requirements
   Anticipated Costs

• Next Steps
Background

- CalOptima monitors diagnosis codes and utilization data submitted by providers through claim submissions or encounter data
  - Allows monitoring of Member health status
  - Enables plan to assign a risk status to members in order to identify the right level of care and services that promote improvement of health outcomes
  - Ensures targeted quality improvement programs are designed towards Member needs

- CalOptima is required to regularly submit diagnosis data to CMS for OCC members
  - All health networks are obligated to submit timely and accurate data
Background (Cont.)

• CMS uses diagnosis data to assess program quality and to calculate expected health care costs
  - Quality: HEDIS quality measures are used to determine annual Medicare Star Ratings
  - Revenue: Plans receive payments based on each enrollee’s expected health care costs based on risk adjustment factors
    - Based on demographic and health status to reflect the acuity within the OCC membership population
    - CMS calculates CalOptima’s revenue by multiplying the base rate by a risk score

• CMS conducts medical record audit periodically to validate the accuracy of data submitted by the plans
Medicare Attestation Programs

- Recognized industry standard practice for Medicare
- Ensures proper coding to improve HEDIS quality measure reporting
- Improves care coordination by incentivizing providers to perform member outreach
- Produces an accurate reflection of population acuity and risk stratification
  - Enhances population health management efforts
- Improves data submission and chart review
  - Streamlines chart retrieval for members with chronic conditions
  - Increases accessibility to charts during the annual HEDIS Chart Review and CMS Risk Adjustment Data Validation Audit
- Results in a positive financial impact from CMS
# Quality: Potential Focus Area

## HEDIS Measurement Year 2018
**Measure: Comprehensive Diabetes Care (CDC)**

<table>
<thead>
<tr>
<th>CDC</th>
<th>CCN</th>
<th>HNs</th>
<th>CalOptima</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Eye Exam</td>
<td>62.32%</td>
<td>73.31%</td>
<td>71.88%</td>
</tr>
<tr>
<td>Medicare A1c Test</td>
<td>81.87%</td>
<td>90.91%</td>
<td>89.27%</td>
</tr>
<tr>
<td>Medicare HbA1c Adequate Control (&lt;8)</td>
<td>45.61%</td>
<td>57.01%</td>
<td>55.59%</td>
</tr>
<tr>
<td>Medicare Monitoring for Nephropathy</td>
<td>91.78%</td>
<td>96.29%</td>
<td>95.72%</td>
</tr>
</tbody>
</table>

Note: Rates are based on claims/encounters (admin rate)
## HEDIS Measurement Year 2018

**Measure: Adults’ Access to Preventive/Ambulatory Health Services (AAP)**

<table>
<thead>
<tr>
<th>AAP -Total</th>
<th>Rate</th>
<th>Medicare National 10th percentile</th>
<th>Medicare National 25th percentile</th>
<th>Medicare National 50th percentile</th>
<th>Medicare National 75th percentile</th>
<th>Medicare National 90th percentile</th>
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</thead>
<tbody>
<tr>
<td>CCN</td>
<td>89.99%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Networks</td>
<td>90.22%</td>
<td>90.24%</td>
<td>93.70%</td>
<td>95.66%</td>
<td>96.91%</td>
<td>98.45%</td>
</tr>
<tr>
<td>CalOptima</td>
<td>90.12%</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
## Risk Adjustment Factors

### Risk Adjustment Factors (RAF) Score Comparison (Calendar Year 2019)

<table>
<thead>
<tr>
<th>Delegation Assignment</th>
<th>Member Month</th>
<th>Average RAF</th>
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</thead>
<tbody>
<tr>
<td>CCN</td>
<td>10,607</td>
<td>1.180</td>
</tr>
<tr>
<td>Health Networks</td>
<td>89,830</td>
<td>1.431</td>
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</table>

- CCN’s average RAF is 18% (0.251) below the HN average
Risk Adjustment Factors (Cont.)

Inpatient Day Utilization (1000 members/year) vs. RAF

<table>
<thead>
<tr>
<th>Risk</th>
<th>Member Months</th>
<th>RAF</th>
<th>Inpatient Days PTMPY</th>
<th>RAF Based on I/P Risk</th>
<th>RAF Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCN</td>
<td>10,607</td>
<td>1.180</td>
<td>141.81</td>
<td>1.921</td>
<td>-0.741</td>
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<tr>
<td>SRG</td>
<td>33,418</td>
<td>1.241</td>
<td>86.24</td>
<td>1.168</td>
<td>0.073</td>
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<tr>
<td>PHC</td>
<td>3,371</td>
<td>0.922</td>
<td>102.47</td>
<td>1.388</td>
<td>-0.466</td>
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<tr>
<td>HMO</td>
<td>53,041</td>
<td>1.582</td>
<td>107.09</td>
<td>1.451</td>
<td>0.132</td>
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<tr>
<td>TOTAL</td>
<td>100,437</td>
<td>1.404</td>
<td>103.66</td>
<td>1.404</td>
<td>0.000</td>
</tr>
</tbody>
</table>

- In using Inpatient Day utilization per thousand members per year (PTMPY) as a determinant of risk within a health network, the underlying risk within CCN far exceeds the reported RAF score.
Proposed Attestation Program

• Establish Medicare Attestation Program for CalOptima Community Network (CCN) Primary Care Providers (PCP)

• Program Goals
  ➢ Increase number of members receiving annual comprehensive visits
  ➢ Accurately identify conditions and diagnosis codes to CMS
  ➢ Review charts in real time
  ➢ Improve overall member health outcome
Next Steps

• Approval Timeline
  ➢ Dec 2019 QAC: Information Item
  ➢ Jan 2020 PRC: CalOptima Internal Policy Review
  ➢ Feb 2020 Board of Directors meeting: Final Approval
CalOptima’s Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner
OneCare and OneCare Connect
Behavioral Health Implementation Update

Special Quality Assurance Committee Meeting
December 13, 2019

Edwin Poon, Ph.D.
Director, Behavioral Health Services (Integration)
OneCare (OC)/OneCare Connect (OCC) Behavioral Health (BH) Transition

- Magellan is the current Managed Behavioral Health Organization for OC and OCC behavioral health services.
- On May 2, 2019, the CalOptima Board approved the integration of OC and OCC covered BH services within CalOptima internal operations effective January 1, 2020.
- The overall goal is to minimize member impact.
Transition project began May 3, 2019.
Formal notification sent to Magellan June 3, 2019.
Transition meeting with Magellan began June 24, 2019.
Bi-Monthly CalOptima BH Transition Workgroup meetings
Weekly contracting sub-workgroup meetings
Bi-Monthly meetings with Magellan planning team
OC/OCC BH Transition (cont.)

• Focus on network contracting:
  ➢ Credentialing and contracting with all Magellan OC/OCC BH providers (heavy emphasis on the providers with encounters within the past year)
  ➢ Ensure network adequacy levels continue to be met.
  ➢ Expanding Medi-Cal network by offering MC/OC/OCC contracts to providers who are Medi-Cal enrolled

• Operational transition areas:
  ➢ Call Center
  ➢ Prior authorizations/concurrent review
  ➢ Care management
## OC/OCC BH Network Progress

<table>
<thead>
<tr>
<th>Group*</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Count</td>
<td>157</td>
<td>54</td>
<td>150</td>
</tr>
<tr>
<td>Active</td>
<td>120</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Pending</td>
<td>0</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Have not returned</td>
<td>30</td>
<td>23</td>
<td>111</td>
</tr>
<tr>
<td>Canceled</td>
<td>6</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Declined</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

* Group 1 — Magellan providers already contracted with CalOptima Medi-Cal BH
Group 2 — Magellan providers eligible for all programs
Group 3 — Magellan providers eligible for OC/OCC only
Next Steps

• Continue with BH contracts
• Hospital and health network orientations
• Hire additional staff to support new/expanded functions
• Staff training
• Finalize inpatient concurrent review process
• System configuration
CalOptima’s Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner
**Board of Director’s Quality Assurance Committee Meeting**  
**December 13, 2019**  

**PACE Member Advisory Committee Update**

**PMAC Meeting September 11, 2019**

- **Updates from the Director**
  - Director Elizabeth Lee notified members that PACE has transitioned from using UCI physicians and nurse practitioners in the PACE clinic. Dr. Le and Dr. Arghami transitioned their patients to Dr. Omid Moussavi, Dr. Henry Nguyen and Dr. Thuy Nguyen as of September 2019. If there was a change, clinic staff were scheduling visits for participants to meet their new doctor. PACE participants still have access to UCI specialists in the community. The change is only related to on-site UCI doctors at the PACE center.

- **Items Discussed**
  - Program Enhancements: PACE Center Manager Monica Macias, LCSW, provided an update on program enhancements at the PACE center:
    - Activities: special entertainment and BINGO for morning and afternoon shifts
    - Nursing: diabetes education class for participants
    - Social Work: reminiscence group
    - Rehabilitation Therapy: ‘Boxing Champs’ group, life skills education, therapeutic dance
  
  A member commented that meals are “really good” and that he likes the new vendor who offers meal enhancements, more ethnic foods, and more sides, like guacamole and sour cream, to enhance food flavors. Ms. Macias shared that monthly meal satisfaction rate is 96%. Another member shared that she likes that the Dieticians walk around and ask how participants are enjoying meals at mealtimes.

  - Potential Schedule Change: Director Lee requested feedback about potentially extending PACE center hours and adding Saturday hours. Most participants agreed that they did not want pickups before 6:30 or 7 AM and no later than 5 or 6 PM. Saturday hours elicited mixed opinion. Participants like the idea of Saturday hours, but many would not like it for themselves.

  - PMAC Member Forum:
    - One participant wanted to compliment everyone at PACE but expressed issues with transportation and requested follow up regarding late or missed pickups. The committee agreed that transportation would be the topic of the next meeting.
Board of Directors’ Quality Assurance Committee Meeting
December 13, 2019

Quality Improvement Committee (QIC) Quarter 3 Update

QIC Meeting Dates: July 09, 2019; August 13, 2019; and September 10, 2019

- **Summary**
  - The following report to the QIC quarterly through various committees and subcommittees:
    - Behavioral Health Integration (BHI)
    - Grievance and Appeals (GARS)
    - Utilization Management (UM)
    - Credentialing and Peer Review Committee (CPRC)
    - Member Experience (MEMX)
    - Whole-Child Model Clinical Advisory Committee (WCM CAC)
  - Accepted minutes from the following committees and subcommittees:
    - Utilization Management Committee (UMC): May 23, 2019
    - Behavioral Health QI Committee (BHQIC): June 18, 2019
    - Grievance and Appeals Committee (GARS): May 28, 2019
    - Member Experience Subcommittee (MEMX): June 27, 2019; July 25, 2019
    - PACE Quality Improvement Committee (PACE QIC): May 21, 2019; June 04, 2019
    - Whole-Child Model Clinical Advisory Committee (WCM CAC): April 16, 2019; May 21, 2019; June 18, 2019

- **QIC Highlights**
  - Policies reviewed and approved:
    - Quality Improvement Committee Policy GG.1620 presented by Esther Okajima was reviewed and approved
    - Post-Hospital Discharge Medication Supply Policy GG.1639 presented by Laura Guest, RN, ANP, was reviewed and approved
    - Full Scope Site Review – Policy GG.1608 presented by Esther Okajima was reviewed and approved
  - Healthcare Effectiveness Data and Information Set (HEDIS) and Member Experience Results for Measurement Year (MY) 2018 Performance presented by Miles Masatsugu, MD was reviewed and approved
  - David Ramirez, MD announced that CalOptima’s Member Portal went live and is working on the provider portal
  - David Ramirez, MD announced that CalOptima is working on policies and procedures to make services more accessible and convenient to members thru telehealth
- 2019 Healthcare Effectiveness Data and Information Set (HEDIS) /(CAHPS) results for measurement year 2018 presented by Miles Masatsugu, MD and Kelly Rex-Kimmet, and was approved
- Updated Population Health Management Strategy (PHM) presented by Pshyra Jones was reviewed and approved
- CalOptima Homeless Clinic Access Program presented by Pshyra Jones
- Post-Acute Infection Prevention Quality Initiative (PIQI) SHIELD Protocol update presented by Emily Fonda, MD was reviewed and approved
- Credentialing, Facility Site Review and Potential Quality of Care (PQI) activity presented by Esther Okajima was reviewed and approved
- Facility Site Review Tool update presented by Esther Okajima at the August QIC
- Minimum outpatient provider hours presented by Miles Masatsugu, MD, additional review was required by network operations for further action
- Member and Provider Complaints 2Q, 2019 presented by Ana Aranda was reviewed and approved
- Member Experience (CAHPS) Adult Survey Results for Medi-Cal LOB presented by Marsha Choo was reviewed and approved. Focus on access measures (Getting Needed Care and Getting Care Quickly) are being addressed with the Access Workgroup. Updates on actions such as overcapacity letters, and report cards will follow with next Member Experience update.
- 2019 Quality Improvement Work Plan 2Q presented by Esther Okajima was reviewed and approved

**Attachments**

1. 2019 Quality Improvement Work Plan 2Q
<table>
<thead>
<tr>
<th>Evaluation Category</th>
<th>Objective/Log Measures</th>
<th>Planned Activities</th>
<th>Target Date(s) for Completion</th>
<th>Results/Metrics: Assessments, Findings, and Monitoring of Outcomes</th>
<th>Next Steps</th>
<th>Real - AI Risk: Low - None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Oversight</td>
<td>QI QI Annual Oversight of Program and Work Plan</td>
<td>Obtain Board Approval of 2019 QI Program Agenda by February 2019</td>
<td>QI Program and Work Plan will be approved on an annual basis; QI Program Oversight/QIC: QI Plan OIC/QIC</td>
<td>Ad hoc</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Program Oversight</td>
<td>QI QI Program Evaluation</td>
<td>Complete Evaluation of 2018 QI Program by January 2019</td>
<td>QI Program and Work Plan will be evaluated for effectiveness on an annual basis</td>
<td>Annual Evaluation</td>
<td>Approved by QIC 2/14/19; QIC 2/29/19; BOD on 3/1/19</td>
<td></td>
</tr>
<tr>
<td>Program Oversight</td>
<td>QI QI Program Evaluation</td>
<td>Complete Evaluation of 2018 QI Program by December 2018</td>
<td>QI Program and Work Plan will be evaluated for effectiveness on an annual basis</td>
<td>Annual Evaluation</td>
<td>Approved by QIC 2/14/19; BOD 2/29/19</td>
<td></td>
</tr>
<tr>
<td>Program Oversight</td>
<td>Population Health Management Strategy</td>
<td>Obtain Board Approval of 2019 Population Health Management Strategy and draft implementation by May 1, 2019</td>
<td>Implement PHM Strategy, and make adj to an annual basis</td>
<td>Annual Adoption</td>
<td>Approved as attachment C to the 2019 QI Program OIC 2/14/19, QIC 2/29/19; BOD 3/1/19</td>
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<tr>
<td>Program Oversight</td>
<td>Undertaking Peer Review Committee (PPC) Oversight</td>
<td>Conduct Peer Review of Provider folders for regulatory and contract requirement</td>
<td>Review of and making the re-investigation file, and Quality of Care and Quality of Service rates related to CalOptima’s provider network</td>
<td>Quarterly Adoption</td>
<td>Report all PPC meeting minutes to QIC quarterly</td>
<td></td>
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<tr>
<td>Program Oversight</td>
<td>Initiating Health Care Improvement Committee (HCIC) Oversight</td>
<td>Conduct internal and external oversight at all QI Activities per regulatory and contract requirement</td>
<td>Review the internal and external re-investigations for an annual basis and Quality of Care and Quality of Service rates related to CalOptima’s provider network</td>
<td>Quarterly Adoption</td>
<td>Report all HCIC meeting minutes to QIC quarterly</td>
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</tr>
<tr>
<td>Program Oversight</td>
<td>Leadership Management Committee (LMC) Oversight</td>
<td>Conduct Internal and External oversight at all LMC Activities per regulatory and contract requirement</td>
<td>Review the internal and external re-investigations for an annual basis and Quality of Care and Quality of Service rates related to CalOptima’s provider network</td>
<td>Quarterly Adoption</td>
<td>Report all LMC meeting minutes to QIC quarterly</td>
<td></td>
</tr>
<tr>
<td>Program Oversight</td>
<td>Leadership Experience (LE) Subcommittees Oversight</td>
<td>Conduct Internal and External oversight at all LE Activities per regulatory and contract requirement</td>
<td>Conduct the re-exam and re-investigation of the LE in the field</td>
<td>Quarterly Adoption</td>
<td>Report all LE meeting minutes to QIC quarterly</td>
<td></td>
</tr>
<tr>
<td>Program Oversight</td>
<td>Long Term Services and Supports Quality Improvement Sub-Committee (LTSO QI) Oversight</td>
<td>Conduct Internal and External oversight at all LTSO Activities per regulatory and contract requirement</td>
<td>Monitor and review the quality and outcomes of service provider in California Statewide Long Term Services and Supports (LTSS) for Long-Term and Supportive Services</td>
<td>Quarterly Adoption</td>
<td>LTSO OIC reported Q2 to QIC June 2019, 2019 Q2 PHS Audit, Access &amp; Member Experience; Quality of Care LTSS Workgroup, 2019 LTSS Health Performance (PSP) - Adverse Event Screening</td>
<td></td>
</tr>
<tr>
<td>Program Oversight</td>
<td>Whole Child Model - Clinical Advisory Committee (WCM CAM) Oversight</td>
<td>Conduct Clinical Oversight for WCM on regulatory and contract requirement</td>
<td>Transfer clinical advice for issues related to Whole Child Model</td>
<td>Quarterly Adoption</td>
<td>Report WCM OIC quarterly updated Q3/19; Being forward in 2019, LTSO minutes will be reported as part of LTSO</td>
<td></td>
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</tbody>
</table>
### Program Oversight

**1. Scrupulous Response Resolution Services (SRRS) Overview - Global - oversight of grievances and appeals per regulatory and contractual requirement**

<table>
<thead>
<tr>
<th>Objective/Log Measures</th>
<th>Planned Activities</th>
<th>Target Date(s) for Completion</th>
<th>Results/Measurements: Assessments, Findings, and Monitoring of Promises/Issues</th>
<th>Next Steps</th>
</tr>
</thead>
</table>
| Red | Risk | Category | 2019 | Date(s) for Completion | for }
<table>
<thead>
<tr>
<th>Evaluation Category</th>
<th>QI Project Plan Statement</th>
<th>Objective(s)/Log Measures</th>
<th>Planned Activities</th>
<th>Target Dates for Completion</th>
<th>Results/Outcomes: Assessments, Findings, and Monitoring of Performance</th>
<th>Next Steps</th>
<th>Red: At Risk</th>
<th>Yellow: Concern</th>
<th>Green: On Track</th>
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</thead>
<tbody>
<tr>
<td>Quality of Clinical Care</td>
<td>Use of Imaging Studies for Lower Back Pain (LBP)</td>
<td>PIP: 73.7% 95% percentile</td>
<td>Targeted outreach of 120</td>
<td>1/31/2020</td>
<td>Medical plan effective in addressing root cause to improve imaging use and accuracy</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Quality of Clinical Care</td>
<td>In-Office Care for Children with Prescribed Medication (PM)</td>
<td>PIP: 65.6% 95% percentile</td>
<td>Targeted outreach of 120</td>
<td>1/31/2020</td>
<td>Medical plan effective in addressing root cause to improve medication adherence</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Quality of Clinical Care</td>
<td>Improve HEDIS measures related to Asthma (ADD)</td>
<td>PIP: 75% 95% percentile</td>
<td>Targeted outreach of 120</td>
<td>1/31/2020</td>
<td>Medical plan effective in addressing root cause to improve asthma management</td>
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<td></td>
<td></td>
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<tr>
<td>Quality of Clinical Care</td>
<td>Prevents access to real-time data for CalOptima members</td>
<td>PIP: 75% 95% percentile</td>
<td>Targeted outreach of 120</td>
<td>1/31/2020</td>
<td>Medical plan effective in addressing root cause to improve access to real-time data for CalOptima members</td>
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<tr>
<td>Quality of Clinical Care</td>
<td>Expand outreach of non-enrolled beneficiaries</td>
<td>PIP: 75% 95% percentile</td>
<td>Targeted outreach of 120</td>
<td>1/31/2020</td>
<td>Medical plan effective in addressing root cause to improve expansion of non-enrolled beneficiaries</td>
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<td></td>
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</tr>
<tr>
<td>Quality of Clinical Care</td>
<td>Improve clinical care for Psychiatric ER (ADD)</td>
<td>PIP: 75% 95% percentile</td>
<td>Targeted outreach of 120</td>
<td>1/31/2020</td>
<td>Medical plan effective in addressing root cause to improve clinical care for Psychiatric ER (ADD)</td>
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<tr>
<td>Evaluation Category</td>
<td>QI Work Plan Description</td>
<td>Objective/Metric</td>
<td>Planned Activities</td>
<td>Target Date for Completion</td>
<td>Results Monitor</td>
<td>Next Steps</td>
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<tr>
<td>Quality of In-Home Care</td>
<td>Colorectal Cancer Screening (OCC)</td>
<td>OC 75% 15-year</td>
<td>Biyearly screening incentive for OCC (OCC)</td>
<td>12/31/2020</td>
<td>Not to exceed 10%</td>
<td>(1) OCC members for colorectal cancer screening are up to date by October 2019. Health networks card use promotions provide incentive. Program is expanded to Q3 2019. (2) Colorectal cancer screening incentives are up in all campaigns across all months.</td>
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<tr>
<td>Quality of In-Home Care</td>
<td>Breast Cancer Screening (BCC)</td>
<td>MC 75% 70-year 6000 identified</td>
<td>CalOptima Say’s targeting patient lifestyle and children Continuous enrollment initiatives</td>
<td>12/31/2020</td>
<td>Not to exceed 10%</td>
<td>(1) OCC member incentive will be increased to $20.00 starting September 1, 2019. (2) OCC members with breast cancer will be identified as per campaign outreach efforts.</td>
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<tr>
<td>Quality of In-Home Care</td>
<td>Asthma Control</td>
<td>Multi-Site</td>
<td>Influenza Care Center Provider education, 30 percent</td>
<td>12/31/2019</td>
<td>Not to exceed 10%</td>
<td>(1) Referral for all members and not greater than 10% for CHES. Will still be a CHES measure. (2) Exempted to ensure redemption of $20.00 for all members and not greater than 10% for CHES. Will still be a CHES measure.</td>
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<tr>
<td>Quality of In-Home Care</td>
<td>Asthma Control</td>
<td>Multi-Site</td>
<td>Influenza Care Center Provider education, 30 percent</td>
<td>12/31/2019</td>
<td>Not to exceed 10%</td>
<td>(1) Referral for all members and not greater than 10% for CHES. Will still be a CHES measure. (2) Exempted to ensure redemption of $20.00 for all members and not greater than 10% for CHES. Will still be a CHES measure.</td>
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<tr>
<td>Quality of In-Home Care</td>
<td>Diabetes Control</td>
<td>Multi-Site</td>
<td>Provider-identified diabetes interventions, 30 percent</td>
<td>12/31/2019</td>
<td>Not to exceed 10%</td>
<td>(1) Referral for all members and not greater than 10% for CHES. Will still be a CHES measure. (2) Exempted to ensure redemption of $20.00 for all members and not greater than 10% for CHES. Will still be a CHES measure.</td>
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<tr>
<td>Evaluation Category</td>
<td>OIIE QI Work Plan Element Description</td>
<td>Objective/Log Measures</td>
<td>Planned Activities</td>
<td>Target Date(s) for Completion</td>
<td>Next Steps</td>
<td>Red – At Risk/Green – On Target</td>
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<tr>
<td>Quality of Clinical Care 1</td>
<td>Blueprints and referrals related to diabetes prevention (CDC) - (MC) <em>Intervention</em>: Health from Within (MC)</td>
<td>1. Aims: 1. <strong>Increase clinical diabetes screening for patients newly enrolled in the program and continue to refer patients to diabetes education.</strong></td>
<td><strong>Chronic disease prevention bundles were not created due to the lack of feasibility in execution.</strong></td>
<td>10/31/2019</td>
<td>Continue implementing and sustaining.</td>
<td>Red – at risk/Green – On target</td>
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<tr>
<td>Quality of Clinical Care 2</td>
<td>Blueprints and referrals related to diabetes prevention (CDC) - (MC) <em>Intervention</em>: Health from Within (MC)</td>
<td>1. Aims: 1. <strong>Increase clinical diabetes screening for patients newly enrolled in the program and continue to refer patients to diabetes education.</strong></td>
<td><strong>Chronic disease prevention bundles were not created due to the lack of feasibility in execution.</strong></td>
<td>10/31/2019</td>
<td>Continue implementing and sustaining.</td>
<td>Red – at risk/Green – On target</td>
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<tr>
<td>Quality of Clinical Care 3</td>
<td>Blueprints and referrals related to diabetes prevention (CDC) - (MC) <em>Intervention</em>: Health from Within (MC)</td>
<td>1. Aims: 1. <strong>Increase clinical diabetes screening for patients newly enrolled in the program and continue to refer patients to diabetes education.</strong></td>
<td><strong>Chronic disease prevention bundles were not created due to the lack of feasibility in execution.</strong></td>
<td>10/31/2019</td>
<td>Continue implementing and sustaining.</td>
<td>Red – at risk/Green – On target</td>
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<tr>
<td>Quality of Clinical Care 4</td>
<td>Blueprints and referrals related to diabetes prevention (CDC) - (MC) <em>Intervention</em>: Health from Within (MC)</td>
<td>1. Aims: 1. <strong>Increase clinical diabetes screening for patients newly enrolled in the program and continue to refer patients to diabetes education.</strong></td>
<td><strong>Chronic disease prevention bundles were not created due to the lack of feasibility in execution.</strong></td>
<td>10/31/2019</td>
<td>Continue implementing and sustaining.</td>
<td>Red – at risk/Green – On target</td>
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<td>Evaluation Category</td>
<td>OEX 1Q Work Plan Element Description</td>
<td>Objective/Log Measures</td>
<td>Planned Activities</td>
<td>Target Date(s) for Completion</td>
<td>Results/Metrics: Assessments, Findings, and Monitoring of Progress/Outcomes</td>
<td>Next Steps</td>
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<tr>
<td>Quality of Clinical Care</td>
<td>Prenatal and Postpartum Care (PPC)</td>
<td>Prevalence of Prenatal Care and Postpartum Care</td>
<td>Increase PPC score meeting 25% to 318</td>
<td>1/17/2019</td>
<td>(a) Bright Step: evaluate health programs was implemented in the spring 2019 (Bright Step member newsletter).</td>
<td>Next steps:</td>
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<td>(b) Prenatal Care (PPC) (Member incentive):</td>
<td>Next steps:</td>
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<td>First PPC member incentive paid in 4Q 2020. 1 incentive were approved in June 2019. 18 incentives were approved in July and August. The incentive is growing awareness and being more actively promoted to Health Network by directly.</td>
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<td>Prenatal Care (PPC) (Pay Per Participation: Rate: 10%).</td>
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<tr>
<td>Quality of Clinical Care</td>
<td>1. Dependent/Outpatient Provider Management (DAPM)</td>
<td>Outpatient Phase Treatment: Increase utilization and access to PPC needs goals through patient referrals that are aligned with current program and technological options.</td>
<td>Increase member physician and patient satisfaction.</td>
<td>1/17/2019</td>
<td>(a) Outpatient Phase: measure for 3 follow-up incentiv: within 6 months (open ended).</td>
<td>Next steps:</td>
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<td>(b) Outpatient Phase: measure for 3 follow-up incentiv: within 6 months (open ended).</td>
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<td>(c) Outpatient Phase: measure for 3 follow-up incentiv: within 6 months (open ended).</td>
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<tr>
<td>Quality of Clinical Care</td>
<td>Repression screening and Follow-up for Neonates (0-3) and Adults (18+)</td>
<td>Tests in 2019: (25%) required for WCC, no external earning.</td>
<td>Proposed incentive (to exist within 90 days for those who come to test)</td>
<td>6/18/2019</td>
<td>90% of suspected solicited codes on data available for request measure as small. Developing work as an idea to capture data/perform outreach to members. &amp; provide population message sharing &amp; follow up.</td>
<td>Next steps:</td>
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<td>&amp; (b) Repression screening and Follow-up for Neonates (0-3) and Adults (18+).</td>
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<td>&amp; (c) Repression screening and Follow-up for Neonates (0-3) and Adults (18+).</td>
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<tr>
<td>Quality of Clinical Care</td>
<td>Childhood Immunization Status (CIS) (Cambodia):</td>
<td>Meas: Complete 18</td>
<td>Complete at least 18</td>
<td>7/15/2019</td>
<td>CalOptima Days targeting adult's and children</td>
<td>Next steps:</td>
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<td>CalOptima Days targeting adult's and children</td>
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<td>CalOptima Days targeting adult's and children</td>
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<tr>
<td>Quality of Clinical Care</td>
<td>Well child visits in line by: 2018, 2019, and 2020 visits for adult and children (18+).</td>
<td>2018: 75%</td>
<td>CalOptima Days targeting adults and children</td>
<td>7/15/2019</td>
<td>(a) Consistent with the findings of the 2019 Cambodia 1st phase events in July 2019: (25%) were found in the 18 event targeted areas for the PPC measure. There will be 22 full day and 2 half days completed for the Cambodia 1st phase events.</td>
<td>Next steps:</td>
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<td>(b) PPC incentive will impact 25% measure as it isn't administered during well care visits.</td>
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<td>(c) Health Study with transmission to Well child schedule &gt; 1 to all members (0-14) - in Q2 of 2019.</td>
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<td>(d) Cal Optma member newsletter spring 2019 highlighted at home promoting scheduling for health exam for new members, well child visits and immunization.</td>
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<td>(e) Prospective Rate (PR): WCC: 10%</td>
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<td>(f) Meas: performing better than zone lower last year.</td>
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<td>(g) Evaluation of Cambodia Days (Apr) - April shows no significant impact to plan or health network</td>
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<td>&amp; (h) well child visits in line by: 2018, 2019, and 2020 visits for adult and children (18+).</td>
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<td>&amp; (i) Evaluation of Cambodia Days (Apr) - April shows no significant impact to plan or health network</td>
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<td>(m) Well child visits in line by: 2018, 2019, and 2020 visits for adult and children (18+).</td>
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<td>(s) Well child visits in line by: 2018, 2019, and 2020 visits for adult and children (18+).</td>
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</table>
### Quality of Clinical Care

#### Well-Care Visits in first 3-5 months of life (HEDIS)

**AT**: 58.5% 95% percentile

**CalOptima Days targeting adults and children**

12/31/2019: 5850 completed at 6 weeks or 100 for first month, and 5088 for completing.

#### Next Steps: Red: At Risk - Yellow: Concern - Green: On Track

- Continue to prioritizeWell-care visits in the first 3-5 months of life during 2019.
- CalOptima Days targeting adults and children.
- There were 12 Full Days and 6 Half Day events completed for the pediatric California Day events.

### Quality of Clinical Care

#### Neonate Well-Care Visits (HEDIS)

**AT**: 54.57% 95% percentile

**CalOptima Days targeting adults and children**

12/31/2019: 5187 completed at 12-15 year olds.

#### Next Steps: Red: At Risk - Yellow: Concern - Green: On Track

- Continue to prioritize Well-care visits in the first 6 months of life during 2019.
- CalOptima Days targeting neonate.
- There were 12 Full Days and 6 Half Day events completed for the pediatric California Day events.

### Quality of Clinical Care

#### Maternal/Child Care Visits (HEDIS)

**AT**: 73.12% 95% percentile

**CalOptima Days targeting adults and children**

12/31/2019: 5187 completed at 12-15 year olds.

#### Next Steps: Red: At Risk - Yellow: Concern - Green: On Track

- Continue to prioritize Well-care visits in the first 6 months of life during 2019.
- CalOptima Days targeting neonate.
- There were 12 Full Days and 6 Half Day events completed for the pediatric California Day events.

### Quality of Clinical Care

#### Maternal/Child Care Visits (HEDIS)

**AT**: 73.12% 95% percentile

**CalOptima Days targeting adults and children**

12/31/2019: 5187 completed at 12-15 year olds.

#### Next Steps: Red: At Risk - Yellow: Concern - Green: On Track

- Continue to prioritize Well-care visits in the first 6 months of life during 2019.
- CalOptima Days targeting neonate.
- There were 12 Full Days and 6 Half Day events completed for the pediatric California Day events.

### Quality of Clinical Care

#### Maternal/Child Care Visits (HEDIS)

**AT**: 73.12% 95% percentile

**CalOptima Days targeting adults and children**

12/31/2019: 5187 completed at 12-15 year olds.

#### Next Steps: Red: At Risk - Yellow: Concern - Green: On Track

- Continue to prioritize Well-care visits in the first 6 months of life during 2019.
- CalOptima Days targeting neonate.
- There were 12 Full Days and 6 Half Day events completed for the pediatric California Day events.
<table>
<thead>
<tr>
<th>Evaluation Category</th>
<th>2018 Q2 Work Plan Item Description</th>
<th>Objective/Log Measures</th>
<th>Planned Activities</th>
<th>Target Date(s) for Completion</th>
<th>Next Steps</th>
</tr>
</thead>
</table>
| Quality of Clinical Care | Childhood & Adolescent Access to Primary Care for Boys (CPB) | Enhance childhood & adolescent access to primary care for boys | Childhood & Adolescent Access to Primary Care for Boys | 2Q18 | Complete at 100% of target for the CPB.
| Safety of Services | Use of Inpatient Service Lines in Clinical Care | Inpatient care utilization to improve patient safety and efficiency | Use of Inpatient Service Lines in Clinical Care | 3Q18 | Complete at 100% of target for the Inpatient.
| Member Experience | Review of Member Experience (MEMX) - License CRMP & Score on Setting Needed Care from 25th to 50th percentile | Improve Member Experience Score on Setting Needed Care from 25th to 50th percentile | Review of Member Experience (MEMX) - License CRMP & Score on Setting Needed Care from 25th to 50th percentile | 3Q18 | Complete at 100% of target for MEMX.
| Member Experience | Review of Member Experience (MEMX) - Increased HealthCare الإمارات & Score on New WellVisits Communicate from 25th to 50th percentile | Improve Member Experience Score on New WellVisits Communicate from 25th to 50th percentile | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | 3Q18 | Complete at 100% of target for MEMX.
| Member Experience | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | Improve Member Experience Score on New WellVisits Communicate from 25th to 50th percentile | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | 3Q18 | Complete at 100% of target for MEMX.

**Q2 2018 Work Plan**

| Quality of Clinical Care | Childhood & Adolescent Access to Primary Care for Boys (CPB) | Enhance childhood & adolescent access to primary care for boys | Childhood & Adolescent Access to Primary Care for Boys | 2Q18 | Complete at 100% of target for the CPB.
| Safety of Services | Use of Inpatient Service Lines in Clinical Care | Inpatient care utilization to improve patient safety and efficiency | Use of Inpatient Service Lines in Clinical Care | 3Q18 | Complete at 100% of target for the Inpatient.
| Member Experience | Review of Member Experience (MEMX) - License CRMP & Score on Setting Needed Care from 25th to 50th percentile | Improve Member Experience Score on Setting Needed Care from 25th to 50th percentile | Review of Member Experience (MEMX) - License CRMP & Score on Setting Needed Care from 25th to 50th percentile | 3Q18 | Complete at 100% of target for MEMX.
| Member Experience | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | Improve Member Experience Score on New WellVisits Communicate from 25th to 50th percentile | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | 3Q18 | Complete at 100% of target for MEMX.
| Member Experience | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | Improve Member Experience Score on New WellVisits Communicate from 25th to 50th percentile | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | 3Q18 | Complete at 100% of target for MEMX.

**Q2 2018 Work Plan**

| Quality of Clinical Care | Childhood & Adolescent Access to Primary Care for Boys (CPB) | Enhance childhood & adolescent access to primary care for boys | Childhood & Adolescent Access to Primary Care for Boys | 2Q18 | Complete at 100% of target for the CPB.
| Safety of Services | Use of Inpatient Service Lines in Clinical Care | Inpatient care utilization to improve patient safety and efficiency | Use of Inpatient Service Lines in Clinical Care | 3Q18 | Complete at 100% of target for the Inpatient.
| Member Experience | Review of Member Experience (MEMX) - License CRMP & Score on Setting Needed Care from 25th to 50th percentile | Improve Member Experience Score on Setting Needed Care from 25th to 50th percentile | Review of Member Experience (MEMX) - License CRMP & Score on Setting Needed Care from 25th to 50th percentile | 3Q18 | Complete at 100% of target for MEMX.
| Member Experience | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | Improve Member Experience Score on New WellVisits Communicate from 25th to 50th percentile | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | 3Q18 | Complete at 100% of target for MEMX.
| Member Experience | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | Improve Member Experience Score on New WellVisits Communicate from 25th to 50th percentile | Review of Member Experience (MEMX) - Increased HealthCare Emirates & Score on New WellVisits Communicate from 25th to 50th percentile | 3Q18 | Complete at 100% of target for MEMX.
<table>
<thead>
<tr>
<th>Resolution Category</th>
<th>2019 Q1 Work Plan Statement/Description</th>
<th>Objective/Log Measures</th>
<th>Planned Activities</th>
<th>Target Date(s) for Completion</th>
<th>Results/Metrics: Assessments, Findings, and Monitoring of Priorities/Issues</th>
<th>Next Steps</th>
<th>Red - At Risk</th>
<th>Yellow - Concern</th>
<th>Green - On Target</th>
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<tbody>
<tr>
<td>Compliance</td>
<td>Delegation Oversight of HN Compliance (UM, CR, Claims)</td>
<td>Delegation Oversight of Health Networks to assess compliance of UM, CR, Claims</td>
<td>Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as Prior Authorizations, Credentialing, Claims etc.</td>
<td>12/31/2019</td>
<td>Reported to AOC</td>
<td>Please refer to AOC for corrective actions issued</td>
<td>Green - On Target</td>
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<tr>
<td>Compliance</td>
<td>HN Compliance with CMMIC/NCQA Standards</td>
<td>Delegation Oversight of Health Networks to assess compliance of CMM</td>
<td>Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as CMM</td>
<td>12/31/2019</td>
<td>Reported to AOC</td>
<td>Please refer to AOC for corrective actions issued</td>
<td>Green - On Target</td>
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