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

THURSDAY, DECEMBER 10, 2020
3:00 P.M.

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

REVISED AGENDA

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
Mary Giammona, M.D., Chair
Trieu Tran, M.D.

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Richard Sanchez	Gary Crockett	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
Committee meeting audio is streamed live on the CalOptima website at www.caloptima.org.

To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:

1) **Listen to the live audio at +1 (415) 655-0060 Access Code: 369-588-178 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/1443776826390840078** rather than attending in person. Webinar instructions are provided below.

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.

MANAGEMENT REPORTS
1. Chief Medical Officer – COVID-19 Update

CONSENT CALENDAR
2. Approve Minutes of the September 16, 2020 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS
3. Consider Recommending Board of Directors' Approval of Modifications to Policy GG.1643: Minimum Physician Standards

INFORMATION ITEMS
4. Behavioral Health Interventions During COVID-19 Pandemic

5. Access and Availability Report

6. Population Health Equity Analysis

7. Trauma-Informed Care and ACEs Aware Update

8. National Committee for Quality Assurance Accreditation Preparedness Update

9. 2020 Quality Improvement Program Preliminary Evaluation

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

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

How to Join

1. Please register for The Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee on December 10, 2020 at 3:00 PM PDT at: https://attendee.gotowebinar.com/register/1443776826390840078
2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.

   Note: This link should not be shared with others; it is unique to you.

   Before joining, be sure to check system requirements to avoid any connection issues.

3. **Choose** one of the following **audio options:**

   TO USE YOUR COMPUTER'S AUDIO:

   When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.

   --OR--

   TO USE YOUR TELEPHONE:

   If you prefer to use your phone, you must select "Use Telephone" after joining the webinar and call in using the numbers below.

   United States: +1 (415) 655-0060

   Access Code: 369-588-178

   Audio PIN: Shown after joining the webinar

1. COVID-19 Update

This will be a verbal update

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 16, 2020

A Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on September 16, 2020 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

Chair Mary Giammona called the meeting to order at 3:05 p.m. and Richard Sanchez, led the Pledge of Allegiance.

Members Present: Mary Giammona, M.D., Chair; Jackie Brodsky (via teleconference)

Members Absent: Trieu Tran, M.D.

Others Present: Richard Sanchez, Interim 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, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

MANAGEMENT REPORTS

1. Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, welcome the new Quality Assurance Committee (QAC) members and provided an overview of the various committees that report up to the QAC and background on key staff members in the medical and quality departments. Dr. Ramirez also highlighted several CalOptima accomplishments that are tied directly to quality, including being rated as a top Medi-Cal Plan by the National Committee for Quality Assurance (NCQA) with a rating of 4.0 for 2019, Outstanding Performance by a Large Scale Medi-Cal Plan from the Department of Health Care Services (DHCS) for the past five years, and earning 4.5 Stars from the Centers for Medicare & Medicaid Services (CMS) for OneCare in 2019.

Chair Giammona commended staff on receiving 4.5 Stars from CMS for OneCare.

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Dr. Ramirez also referenced several opportunities for improvement and current Board-approved initiatives. In addition, he reviewed current proposed initiatives that will be coming to the Board for consideration in the future.

CONSENT CALENDAR

2. Approve the Minutes of the May 20, 2020 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

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

REPORTS

3. Consider Recommending Board of Directors' Approval to Redirect Intergovernmental Transfer (IGT) 9 Funds Allocated for Expanded Office Hours to Support Virtual Urgent Care Implementation During Coronavirus (COVID-19) Pandemic and Beyond

Betsy Ha, Executive Director, Quality and Population Health Management introduced the item.

Action: ***On motion of Director Brodsky, seconded and carried, the Committee recommended Board of Directors approval of the redirection of up to $2.0 million of IGT 9 funds originally allocated for the Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) Pilot towards contracting with a 24/7 virtual urgent care vendor for services that will include implementation and rapid deployment support for CalOptima Community Network (CCN) members during and after the COVID-19 pandemic. (Motion carried 2-0-0; Director Tran absent)***

4. Consider Recommending Board of Directors' Approval of the Calendar Year 2021 Behavioral Health Applied Behavior Analysis Pay for Value Performance Program

Edwin Poon, Ph.D., Director, Behavioral Health Services (Integration), introduced the item.

Action: ***On motion of Director Brodsky, seconded and carried, the Committee recommended Board of Directors approval of the Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Program for the Measurement Period effective January 1, 2021 through December 31, 2021. (Motion carried 2-0-0; Director Tran absent)***

INFORMATION ITEMS

5. HEDIS Update 2020

Kelly Rex-Kimmet, Director, Quality Analytics, provided an update on CalOptima's Healthcare Effectiveness Data and Information Set (HEDIS) results for 2020.

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6. Intergovernmental Transfer Overview

Candice Gomez, Executive Director, Program Implementation, provided an overview of the Intergovernmental Transfers (IGTs), noting that IGT funds for IGTs 1 through 7 were for enhanced benefits to existing Medi-Cal beneficiaries, while subsequent IGT funds are viewed by the state as part of the capitation revenue CalOptima receives. Any expenditures of these IGT dollars that do not qualify as medical expenses are counted by the state as part of CalOptima's administrative expenses.

The following Information Items were received as presented:

7. Impact of COVID-19 on Population Health Management
8. PACE Member Advisory Committee Update
9. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Committee Report
   b. Program of All-Inclusive Care for the Elderly (PACE) Report
   c. Member Trend Report

COMMITTEE MEMBER COMMENTS

Committee members thanked staff for their work.

ADJOURNMENT

Hearing no further business, Chair Giammona adjourned the meeting at 5:04 p.m.

_____
Sharon Dwiers
Clerk of the Board

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 10, 2020
Special Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

3. Consider Recommending Board of Directors' Approval of Modifications to Policy GG.1643: Minimum Physician Standards

Contacts

David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-347-3261
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8574

Recommended Action

Recommend Board of Directors' Approval of modifications to Policy GG.1643: Minimum Physician Standards pursuant to CalOptima's regular review process.

Background/Discussion

Proposed Modifications to Existing Quality Improvement Policy and Procedures

CalOptima staff regularly reviews agency policies to ensure they are up to date and aligned with federal and state health care program requirements, regulatory and contractual obligations, as well as CalOptima operations.

Below is the existing Quality Improvement policy that require modifications:

- ***GG.1643: Minimum Physician Standards [Medi-Cal, OneCare, OneCare Connect and PACE]*** describes the minimum physician standards that must be met for a physician to be credentialed for participation in CalOptima programs. CalOptima staff revised this policy pursuant to the CalOptima annual review process; recommended revisions include the addition of a definition for Precluded or Preclusion and the removal of Section III.A.6, which conflicted with another section of the policy. In addition, an exception for Kaiser Foundation Health Plan, Inc. was added to the policy to accommodate its unique system, which consists of a staff model whereby most providers are employed by Kaiser and go through a specific credentialing process.

Fiscal Impact

The recommended action to approve revisions to CalOptima Policies GG.1643 is operational in nature and is not expected to have a fiscal impact.

Rationale for Recommendation

The recommended action will ensure CalOptima is compliant with contractual and regulatory guidance provided by its regulators (e.g., Department of Health Care Services and Centers for Medicare & Medicaid Services). The updated policy will supersede the prior version.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. GG.1643: Minimum Physician Standards Final Policy Packet

/s/ Richard Sanchez *12/2/2020*

Authorized Signature **Date**

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Policy:	GG.1643Δ
Title:	**Minimum Physician Standards**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	07/01/2016
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administration

I. PURPOSE

This policy identifies the minimum Physician standards that must be met for a Physician to be credentialed for participation in CalOptima programs.

II. POLICY

A. ~~Effective July 1, 2016,~~ CalOptima requires that all new Physicians ~~(as defined in Section IX of this Policy)~~ who wish to provide services to CalOptima members, whether through CalOptima Direct or a CalOptima Health Network, with the exception of Kaiser Foundation Health Plan, Inc., meet the minimum Physician standards as defined in this Policy, and be credentialed in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners. ~~Kaiser is excluded from this policy.~~ The minimum Physician standards include:

1. Current valid California license to practice.

2. Current valid Drug Enforcement Agency (DEA) certificate.

3. Current professional liability (malpractice) insurance or self-insurance (e.g., trust, escrow accounts, etc.) coverage in the minimum amounts of $1 million per occurrence and $3 million aggregate per year.

4. Not currently excluded, precluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs.

5. Not currently on probation or have an Accusation pending, with their licensing board.

6. Never been excluded from participation in Federal or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in Title 42, United States Code, §1320a-7(a) as follows:

   a. A conviction of a criminal offense related to the delivery of an item or service under Federal or State health care programs;

   b. A felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service;

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c. A felony conviction related to health care fraud; or

d. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

7. No felony conviction in the ten (10) year period prior to the date of execution of the attestation containing these minimum Physician standards.

8. Board certified in their specialty in accordance with CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians, unless exempt from the certification requirements as set forth under that policy.

B. Health Networks that are delegated to perform credentialing and recredentialing shall incorporate the minimum Physician standards into their credentialing processes.

C. A Health Network shall establish policies and procedures to evaluate and select Physician*s* to participate in CalOptima that, at minimum, meet the requirements as outlined in this Policy.

D. The minimum Physician standards will apply to all new, first-time Physician applicants to CalOptima who wish to provide covered services to CalOptima members, without exception.

E. All new Physician*s* must meet the minimum Physician standards to contract with CalOptima or its Health Network*s* to furnish services to CalOptima members and bill and receive reimbursement for such services (subject to compliance with all other applicable CalOptima policies).

III. PROCEDURE

A. For Physicians who wish to provide services to CalOptima members through CalOptima Direct, CalOptima's Provider Relations staff will distribute the minimum Physician standards attestation to Physician*s* as part of a pre-application process. Physicians must satisfy all of the minimum Physician standards to be eligible to be credentialed in CalOptima. Any incomplete attestations shall be returned to the Physician by Provider Relations staff.

1. If the Physician does not fully complete the attestation within one hundred eighty (180) days after receipt of the attestation, the Physician's attestation shall be considered expired.

2. CalOptima's Quality Improvement Department shall review the attestation and documentation and communicate results to the Provider Relations Department. A Physician shall ensure that all information included in the attestation is no more than six (6) months old.

3. A Physician whose completed attestation reflects that he or she meets all of the minimum Physician standards is eligible to receive a credentialing application, and if the credentialing application is approved, a contract to participate in the CalOptima program.

4. A Physician whose attestation reflects that he or she does not meet one (1) or more of the minimum Physician standards shall not be eligible to participate in the CalOptima program.

5. CalOptima's Quality Improvement ~~(QI)~~ Department shall verify all answers and notify the Physician by certified mail that the Physician did not meet the minimum Physician standards within ~~three~~ five (5~~3~~) business days of receipt of a signed and completed attestation.

~~6. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days after receipt of the attestation for any Physician, the Physician's attestation shall be considered expired.~~

B. Health Networks that are delegated to perform credentialing and recredentialing shall adopt a procedure to ensure that new Physicians seeking to contract with that Health Network to provide services to CalOptima members satisfy all minimum Physician standards.

C. CalOptima or a Health Network shall verify the information provided through primary or secondary source verification using industry-recognized verification sources or a credentials verification organization, in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

IV. ATTACHMENT(S)

A. CalOptima Minimum Physician Standards Attestation

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~D.~~E. CalOptima PACE Program Agreement
F. Contract for Health Care Services
~~E.~~G. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
~~F.~~H. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
~~G.A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~H.A. Contract for Health Care Services~~
I. Title 42, United States Code (USC), §1320a-7(a)
J. Welfare and Institutions Code (WIC), §14043.36

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
09/07/2016	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
03/23/2016	Regular Meeting of the CalOptima Board of Directors
04/07/2016	Regular Meeting of the CalOptima Board of Directors
05/18/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2016	GG.1643Δ	Minimum Physician Standards	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	GG.1643Δ	Minimum Physician Standards	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1643Δ	Minimum Physician Standards	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Accusation	A legal document that begins the formal disciplinary process after an investigation finds evidence that the Physician has violated the laws governing the Physician's practice area, and the violation warrants disciplinary action. An accusation lists the charges and/or the section(s) of law alleged to have been violated, and is served on the Physician.
Health Network	A Physician Hospital Consortium (PHC), ~~Physician Medical Group (PMC),~~ physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Physician	For the purposes of this policy, a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Podiatric Medicine (DPM).
Precluded or Preclusion	A type of exclusion, specific to Medicare program. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Policy:	GG.1643Δ
Title:	**Minimum Physician Standards**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	07/01/2016
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administration

I. PURPOSE

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1. Current valid California license to practice.

2. Current valid Drug Enforcement Agency (DEA) certificate.

3. Current professional liability (malpractice) insurance or self-insurance (e.g., trust, escrow accounts, etc.) coverage in the minimum amounts of $1 million per occurrence and $3 million aggregate per year.

4. Not currently excluded, precluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs.

5. Not currently on probation or have an Accusation pending, with their licensing board.

6. Never been excluded from participation in Federal or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in Title 42, United States Code, §1320a-7(a) as follows:

   a. A conviction of a criminal offense related to the delivery of an item or service under Federal or State health care programs;

   b. A felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service;

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c. A felony conviction related to health care fraud; or

d. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

7. No felony conviction in the ten (10) year period prior to the date of execution of the attestation containing these minimum Physician standards.

8. Board certified in their specialty in accordance with CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians, unless exempt from the certification requirements as set forth under that policy.

B. Health Networks that are delegated to perform credentialing and recredentialing shall incorporate the minimum Physician standards into their credentialing processes.

C. A Health Network shall establish policies and procedures to evaluate and select Physicians to participate in CalOptima that, at minimum, meet the requirements as outlined in this Policy.

D. The minimum Physician standards will apply to all new, first-time Physician applicants to CalOptima who wish to provide covered services to CalOptima members, without exception.

E. All new Physicians must meet the minimum Physician standards to contract with CalOptima or its Health Networks to furnish services to CalOptima members and bill and receive reimbursement for such services (subject to compliance with all other applicable CalOptima policies).

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I. Title 42, United States Code (USC), §1320a-7(a)
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Date	Regulatory Agency
09/07/2016	Department of Health Care Services (DHCS)

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Effective	07/01/2016	GG.1643Δ	Minimum Physician Standards	Medi-Cal OneCare OneCare Connect PACE

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1

IX. GLOSSARY

Term	Definition
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Physician	For the purposes of this policy, a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Podiatric Medicine (DPM).
Precluded or Preclusion	A type of exclusion, specific to Medicare program. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

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CalOptima Minimum Physician Standards Attestation

CalOptima's Board of Directors approved "minimum physician standards" for medical doctors, doctors of osteopathic medicine, and doctors of podiatric medicine, who wish to contract with CalOptima to provide services to CalOptima Members. All physicians in these categories who wish to participate in the CalOptima program must meet all minimum physician standards in order to submit an application for credentialing, the successful approval of which is a pre-requisite to contracting with CalOptima or its contracted Health Networks. All potential providers who have not contracted with CalOptima prior to July 1, 2016 must submit this Attestation in order to be considered for issuance of a credentialing application.

Please answer the following questions either Yes (Y) or No (N).

A. Do you have a current valid California license to practice the profession for which you are seeking participation in CalOptima?	**Y**☐ **N**☐
B. Do you possess a current valid DEA certificate?	**Y**☐ **N**☐
C. (1) were you certified in your specialty within five years of the completion of your residency training, and do you continue to be so certified, by a CalOptima-approved specialty Board, or (2) has it been less than five years since completion of your residency training, and you have been making adequate progress towards being so certified before the expiration of five years from the completion of my residency training.	**Y**☐ **N**☐
D. Do you have current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of $1 million per occurrence and $3 million aggregate per year that covers all aspects of your practice?	**Y**☐ **N**☐
E. Are you currently excluded, precluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs?	**Y**☐ **N**☐
F. Are you currently on probation with the board that issued your license to practice?	**Y**☐ **N**☐
G. Do you currently have an accusation or other disciplinary proceeding pending against you with the board that issued your license to practice?	**Y**☐ **N**☐

(over)

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H. Have you ever been excluded from participation in Federal and/or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in 42 U.S.C. § 1396a-7(a) as follows: (1) a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care programs; (2) a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; (3) a felony conviction related to health care fraud and/or (4) a felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance?

Y☐ **N**☐

I. Do you have any felony convictions in the ten (10)-year period prior to the date of execution of this questionnaire set forth below?

Y☐ **N**☐

By signing this attestation, I hereby: (1) give CalOptima permission to investigate and verify the accuracy of any and all statements and representations in this Attestation; and (2) authorize any relevant person or entity to provide information requested by CalOptima that may be related to any and all statements and representations made in this Attestation.

I declare, under penalty of perjury, under the laws of the State of California, that all statements contained in this Attestation are true and correct. I understand that any and all statements made in this Attestation are subject to verification and that any false or dishonest statement may be grounds for limiting or terminating my participation in CalOptima programs.

Print Name Here: _____**License #**:_____

Physician Signature: _____**Date:**_____
(Stamped Signature is NOT acceptable)

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CalOptima Minimum Physician Standards Attestation

CalOptima's Board of Directors approved "minimum physician standards" for medical doctors, doctors of osteopathic medicine, and doctors of podiatric medicine, who wish to contract with CalOptima to provide services to CalOptima Members. All physicians in these categories who wish to participate in the CalOptima program must meet all minimum physician standards in order to submit an application for credentialing, the successful approval of which is a pre-requisite to contracting with CalOptima or its contracted Health Networks. All potential providers who have not contracted with CalOptima prior to July 1, 2016 must submit this Attestation in order to be considered for issuance of a credentialing application.

Please answer the following questions either Yes (Y) or No (N).

A. Do you have a current valid California license to practice the profession for which you are seeking participation in CalOptima?	**Y**☐ **N**☐
B. Do you possess a current valid DEA certificate?	**Y**☐ **N**☐
C. (1) were you certified in your specialty within five years of the completion of your residency training, and do you continue to be so certified, by a CalOptima-approved specialty Board, or (2) has it been less than five years since completion of your residency training, and you have been making adequate progress towards being so certified before the expiration of five years from the completion of my residency training.	**Y**☐ **N**☐
D. Do you have current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of $1 million per occurrence and $3 million aggregate per year that covers all aspects of your practice?	**Y**☐ **N**☐
E. Are you currently excluded, precluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs?	**Y**☐ **N**☐
F. Are you currently on probation with the board that issued your license to practice?	**Y**☐ **N**☐
G. Do you currently have an accusation or other disciplinary proceeding pending against you with the board that issued your license to practice?	**Y**☐ **N**☐

(over)

H. Have you ever been excluded from participation in Federal and/or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in 42 U.S.C. § 1396a-7(a) as follows: (1) a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care programs; (2) a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; (3) a felony conviction related to health care fraud and/or (4) a felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance?

Y☐ **N**☐

I. Do you have any felony convictions in the ten (10)-year period prior to the date of execution of this questionnaire set forth below?

Y☐ **N**☐

By signing this attestation, I hereby: (1) give CalOptima permission to investigate and verify the accuracy of any and all statements and representations in this Attestation; and (2) authorize any relevant person or entity to provide information requested by CalOptima that may be related to any and all statements and representations made in this Attestation.

I declare, under penalty of perjury, under the laws of the State of California, that all statements contained in this Attestation are true and correct. I understand that any and all statements made in this Attestation are subject to verification and that any false or dishonest statement may be grounds for limiting or terminating my participation in CalOptima programs.

Print Name Here: _____**License #**:_____

Physician Signature: _____**Date:**_____
(Stamped Signature is NOT acceptable)

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BH Interventions during COVID-19 Pandemic

Special Quality Assurance Committee
December 10, 2020

Edwin Poon, Ph.D., Director, Behavioral Health Services

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COVID-19 and Behavioral Health

- One in seven parents reported worsening behavioral problems in their child due to loss of school, child care, jobs and food insecurity.[1]
- More than 25% of parents said their mental health has worsened since the pandemic.[1]
- CalOptima Behavioral Health (BH) Line
  - There were 534 COVID-19 related calls since March 2020.
  - COVID-19 BH callers reported anxiety (22%), depression (21%) and isolation/loneliness (9%).
  - This is a 156% increase in therapy referrals compared with same period last year.

[1]Kaiser Family Foundation Health Tracking Poll conducted between July 14–19, 2020, published on July 27, 2020

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COVID-19 Activities

Member-Focused Activities	Provider-Focused Activities
Expand telehealth to increase access to behavioral health.	Identify online resources/supports for providers and health networks.
Identify behavioral health providers who specialize in trauma-informed care and anxiety disorders (e.g., PTSD, OCD).	Alert providers and health networks about trainings on Adverse Childhood Experiences (ACEs), trauma-informed care, emotional resilience, and other topics on stress related to COVID-19.
BH clinicians available in real time to assist members in crisis	Educate health networks, providers and internal staff on how to support members with mental health concerns due to COVID-19.

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Behavioral Health Community Engagement

- CalOptima is sharing valuable resources and information
  - Parenting OC
  - Orange County Register
  - Angels Radio
  - CalOptima social media accounts

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Behavioral Health (BH) Contact

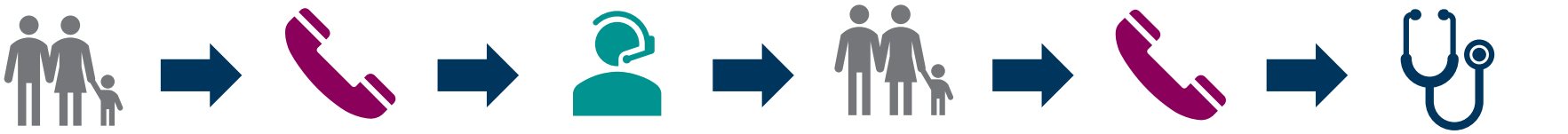
CalOptima Behavioral Health:

855-877-3885

For screening and referral to mental health services

Available 24 hours a day, 7 days a week

TTY: **711**



Call BH Line **855-877-3885**

Call Center Gives BH Provider Info

Member

Call BH Provider to Schedule Appointment

Start Services with BH Provider

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Access and Availability Report

Special Quality Assurance Committee
December 10, 2020

Marsha Choo, Manager, Quality Analytics

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Agenda

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member Experience Results
- Timely Access Results by Vendor
- Member Grievances
- Barriers and Root Causes
- CalOptima Actions
- 2021 Quality Initiative Recommendations

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CalOptima's Member Experience Survey Results

CAHPS Survey Measures	MY 2019 Medi-Cal Adult CAHPS Performance	MY 2019 Medi-Cal Child CAHPS Performance
Rating of All Health Care	50th	<25th
Rating of Personal Doctor	50th	25th
Rating of Specialist	75th	<25th
Rating of Health Plan	25th	25th
Getting Needed Care	<25th	<25th
Getting Care Quickly	25th	<25th
Customer Service	25th	75th

Note: For comparison, the National Medicaid Benchmarks were used.

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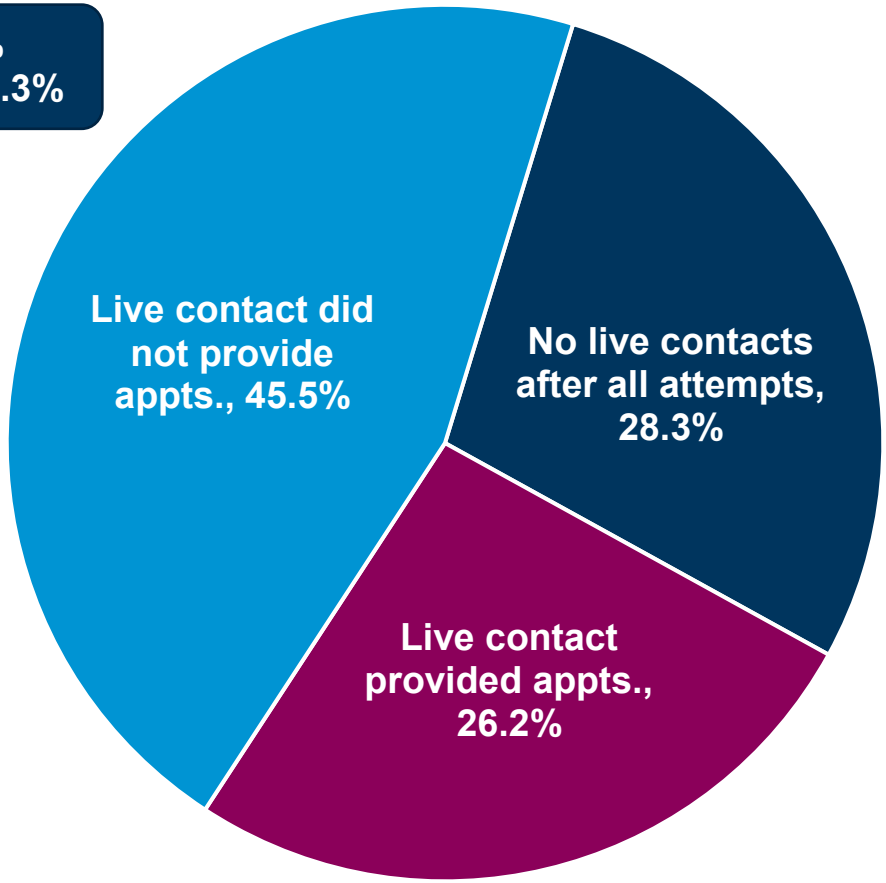
2019 Timely Access Survey

Contact Disposition

- Live Contacts, 71.7%
- No Live Contacts, 28.3%



Source: CalOptima Mystery Shopper Plan Report (MY2019); Provider Types: Primary Care, OB/GYN, Behavioral Health, Core Specialty and Ancillary Providers

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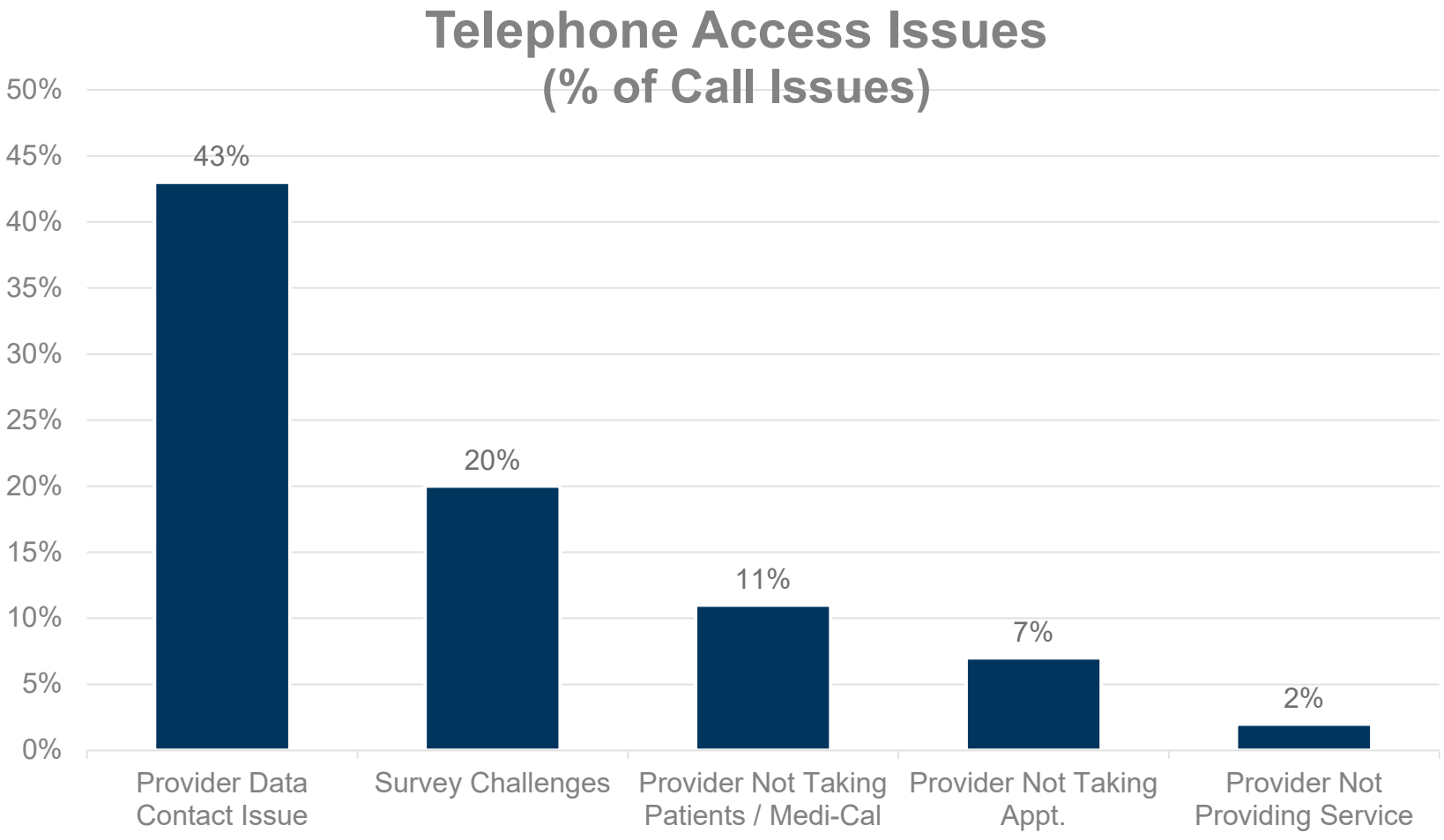
2019 Timely Access Survey (cont.)



Source: CalOptima Mystery Shopper Plan Report (MY2019); Individual contact records can have multiple issues; Sum of percentage not to equal 100%

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Timely Access (cont.)

Timely Access Standards					
	Non-Urgent Appts.	Urgent Appts.	Physical Exams	Prenatal Appts.	Follow-up Appts.
Primary Care	Within 10 business days	Within 48 hours	Within 30 calendar days		
Specialist	Within 15 business days	Within 96 hours			
Ancillary	Within 15 business days				
OB/GYN				Within 2 weeks	
Non-Physician Behavioral Health	Within 10 business days				Within 10 business days

Source: DHCS Regulatory Requirements from APL 20-003 Network Certification Requirements and MCP Contract, Exhibit A, Attachment 9, Access and Availability

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2019 Timely Access Survey Results

2019 Timely Access Survey Compliance Rates					
	Non-Urgent Appts.	Urgent Appts.	Physical Exams	Prenatal Appts	Follow-up Appts
Total Primary Care	67%	21%	81%		
Subcategory — Pediatrics	84%	31%	90%		
Specialist	58%	16%			
Ancillary	75%	44%			
OB/GYN				70%	
Non-Physician Behavioral Health	75%				97%

Source: MY2019 Timely Access Survey; Red = Below the internal benchmark of 80%

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Member Grievances

- In 2019, there were 1,383 access-related grievances (10.2%)
- Top access-related grievances:
  - Appointment Availability
  - Referral Related
  - Specialty Care

Source: Grievance Data 2019

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Root Cause: Appointment Availability

- Some PCPs have more than 2,000 assigned CalOptima members.
- Not enough specialists in service area (e.g. oral maxillofacial surgeons)
  - Approximately 1,300 Letters of Agreement (LOAs) are completed each year by CalOptima to ensure access to care with non-contracted providers.
  - 37% of LOAs are for outpatient services, including specialist and behavioral health providers.
- Other providers are not willing to contract with CalOptima at the current Medi-Cal based rates.
- Members may need to travel farther than 10 miles to see their PCP and 15 miles to see their specialists.

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Root Cause: Provider Data Quality

- Members are not always able to reach their providers when calling to make an appointment.
  - Approximately 43% of the call issues are related to provider data contact issues.*
  - In addition, approximately 28.3% of members do not reach the provider, but instead reach a voicemail, an answering service or get no answer at all.
- Members may be referred to and approvals sent to specialists who cannot see the patient for the service they require.
- Provider data is collected and housed across multiple databases at CalOptima and at the health networks.
  - Provider data may not be completed or updated timely and consistently across all platforms.

*Data from the 2019 Timely Access Survey

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Root Cause: Referrals and Authorizations for Specialty Care

- An approved authorization from the member's health network is required prior to most specialist visits.
- Authorization requests for specialist referrals must be submitted by the PCP and are reviewed by the member's health network.
- Review requirements may lead to delays in approvals.
- Approved authorizations may expire before the scheduled appointment occurs.

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CalOptima Actions

- eConsult vendor and Specialist Network (CCN pilot)
  - Request for proposal (RFP) has been issued by CalOptima, and vendor selection is in progress.
  - Platform allows PCPs and specialists to securely share health information and discuss patient care virtually.
  - Will significantly augment specialist network capacity
  - Expected to significantly reduce the number of required specialty visits for existing specialty network
- Expand Auto Authorizations (CCN only)
  - Effective April 1, 2020, an additional nine specialties were identified as having 98%+ approval rate and auto authorization rules developed and implemented for initial consults.
  - Will result in instantaneous approval for appropriate requests

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CalOptima Action (cont.)

- eVisit Platform (CCN pilot)
  - CalOptima obtained Board approval for funding to issue an RFI by November 2020 with a target to contract with a vendor with a virtual provider network.
  - Will augment network capacity and reduce demand for PCP visits
- Behavioral Health (BH) e-visits (all members)
  - Bright Heart providers have been credentialed and e-visits began on June 1, 2020.
  - E-visit platform will be required to include BH services.
  - Will augment network capacity and reduce demand for BH visits on existing providers

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CalOptima Actions (cont.)

- Provider Data Validation
  - CalOptima conducts monthly and quarterly provider data monitoring and data remediation through data quality audits.
  - Contracted providers are required to sign provider attestations on an annual basis to ensure data accuracy and integrity.
  - CalOptima distributes two provider communications per year to remind providers to validate or request data updates, and attest to the accuracy of their data.
  - Non-compliant providers who do not participate in the provider data validation process and do not submit attestations will receive a letter of non-compliance beginning Quarter 1, 2021.

2021 Quality Initiative Recommendations

- Consider increasing prioritization of provider data quality efforts.
  - Important to prevent potential delays in care
- Continue 2021 virtual care strategies to expand the provider network.
  - Pilot eConsult vendor and specialist provider network for CCN with consideration of extending to all health networks.
  - Pilot e-visit vendor for CCN with consideration of extending to all health networks*
  - Promote virtual care services.
- Evaluate impact of CCN Auto Authorization pilot.

* Requiring vendor to offer the same services and terms in the CCN contract available to all interested networks.

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Timely Access Standards

Access to Emergent/Urgent Medical Care:

Type of Care	Standard
Emergency Services	Immediately, 24 hours a day, 7 days a week
Urgent Care Services	Within 24 hours of request

Access to Primary Care:

Type of Care	Standard
Urgent Appointments that DO NOT Require Prior Authorization	Within 48 hours of request
Non-Urgent Primary Care	Within 10 business days of request
Routine Physical Exams and Wellness Visits	Within 30 calendar days of request
Medi-Cal Only Initial Health Assessment (IHA) or Individual Health Education Behavioral Assessment (IHEBA)	Medi-Cal Only: Within 120 calendar days of Medi-Cal Enrollment

Access to Specialty and Ancillary Care:

Type of Care	Standard
Urgent Appointments that DO Require Prior Authorization	Within 96 hours of request
Non-Urgent Specialty Care	Within 15 business days of request
First Prenatal Visit	Medi-Cal: Within 10 business days of request OCC/OC: Within 2 weeks of request
Non-Urgent Ancillary Services	Within 15 business days of request

Access to Behavioral Health Care:

Type of Care	Standard
Routine Care with a Non-Physician Behavioral Health Provider	Within 10 business days of request
Follow-up Routine Care with a Non-Physician Behavioral Health Provider	Members have a follow-up visit with a non-physician behavioral health care provider within twenty (20) calendar days of initial visit for a specific condition)
Appointment for follow-up routine care with a physician behavioral health care provider	Members have a follow-up visit with a physician behavioral health care provider within thirty (30) calendar days of initial visit for a specific condition

Telephone Access Standards:

Description	Standard
Telephone Triage	Telephone triage shall be available 24 hours a day, seven days a week. Telephone triage or screening waiting time shall not exceed 30 minutes.
Telephone wait time during business hours	A non-recorded voice within 30 seconds
Urgent message during business hours	Practitioner returns the call within 30 minutes after the time of message.
Non-emergency and non-urgent messages during business hours	Practitioner returns the call within 24 hours after the time of message.
Telephone access after business hours for emergencies	The phone message and/or live person must instruct members to dial 911 or go to the nearest emergency room.
After-hours access	A primary care provider (PCP) or designee shall be available 24 hours a day, seven days a week to respond to after-hours member calls or to a hospital emergency room practitioner.

Other Access Standards:

Description	Standard
In-office wait time for appointments	Less than 45 minutes before being seen by a provider
Rescheduling appointments	Appointments will be rescheduled in a manner appropriate to the member's health care needs and that ensures continuity of care is consistent with good professional practice.

CalOptima Policies and Procedures:
GG.1600: Access and Availability Standards
MA.7007: Access and Availability Standards

Updated 9/4/2020

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Population Health Equity Analysis

Special Quality Assurance Committee
December 10, 2020

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

Marie Jeannis, RN, MS, CCM, Director, Enterprise Analytics

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Agenda

- What are Health Care Disparities?
- Equality, Equity and Justice
- Purpose of Population Health Equity Analysis
- Methodology and Approach
- Race and Ethnicity Profiles
- Health Disparities Across Ethnic Groups
- Targeted Population Outreach and Intervention
- Health Equity Recommendation for Consideration

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What Are Health Care Disparities?

- Health and health care disparities refer to differences in health and health care between groups that are closely linked with social, economic and/or environmental disadvantage. Disparities occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status and sexual orientation.

Source: Kaiser Family Foundation. Disparities in Health and Health Care: Five Key Questions and Answers, August 14, 2020

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Equality, Equity and Justice

Equality

The assumption is that everyone benefits from the same supports. This is equal treatment.

Equity

Everyone gets the supports they need, thus producing equity.

Justice

All three can see the game without supports or accommodations because the cause(s) of the inequity was addressed. The systemic barrier has been removed.

Source: GMA Foundations

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Purpose of Population Health Equity Analysis

- Provide a comprehensive look at CalOptima's diverse ethnic membership to identify health disparities among races and ethnicities, focusing on CalOptima's black population in response to the Black Lives Matter movement's emphasis on societal inequity toward the black population.
- Identify opportunities to address population health disparities and promote health equity for all CalOptima members.

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Methodology and Approach

- The purpose is to provide a comprehensive look at CalOptima's diverse ethnic membership.
- This is a perusal of the relevant data marts, focusing on CalOptima's black population.
- CalOptima's ethnic population are grouped:
  - Using groupings that exist in submitted membership files, and
  - In accordance with the 1997 Office of Management and Budget (OMB) standards on race and ethnicity
- The dashboard and the selected time frame are identified in the bottom banner for each graphical slide.

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Methodology and Approach (cont.)

- 1997 OMB standards on race and ethnicity
  - White: Europe (original), the Middle East or North Africa
  - Black or African American: Black racial groups of Africa
  - Alaska Native or American Indian: North and South America (including Central America) and who maintains tribal affiliation or community attachment
  - Asian: Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam
  - Hispanic (Latinx): Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin
  - Native Hawaiian or Other Pacific Islander: Hawaii, Guam, Samoa or other Pacific Islands

Source: Office of Management and Budget. (1997b) Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, Federal Register: 62: No.210, October 30. Retrieved from https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf (accessed August 12, 2020)

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Methodology and Approach (cont.)

Ethnicity / Race Classification

1997 OMB Ethnicity Classification (modified)	Member Ethnicity	
Alaskan Nat / Amer Indian	Alaskan Native or American Indian	1,353
Asian	Amerasian	113
	Asian Indian	5,249
	Asian or Pacific Islander	12,742
	Cambodian	1,929
	Chinese	10,052
	Filipino	11,538
	Guamanian	176
	Hawaiian	1,004
	Japanese	1,706
	Korean	18,965
	Laotian	625
	Samoan	1,174
	Vietnamese	98,211
Black	Black	14,247
Hispanic	Hispanic	348,552
Others	No response, client declined to state	72,946
	Other	34,660
	UNKNOWN	687
White	White	138,028

- CalOptima's membership files combine ethnicities "Asian and Pacific Islander"
  - 1997 OMB Ethnicity Classification modified to include combined ethnicities

As of August 2020

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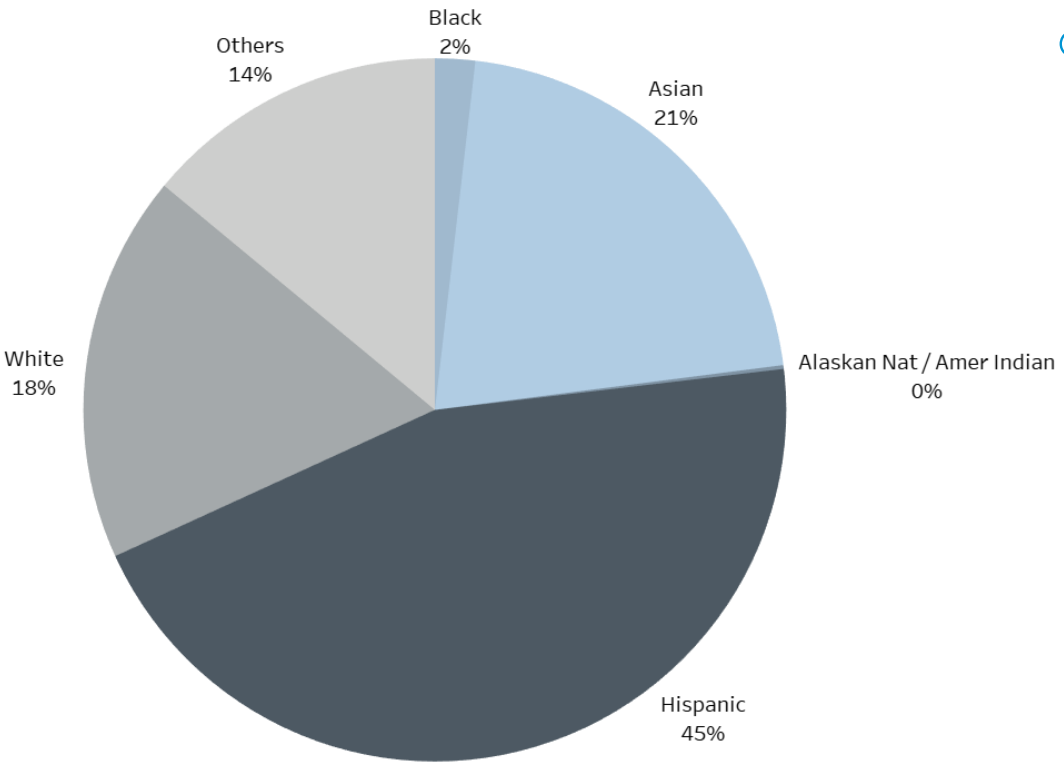
Race and Ethnicity Profiles



- Black population is 2% of CalOptima's overall membership
  - Second smallest ethnic group
  - Native American is the smallest ethnic group at less than 1%.

As of August 2020

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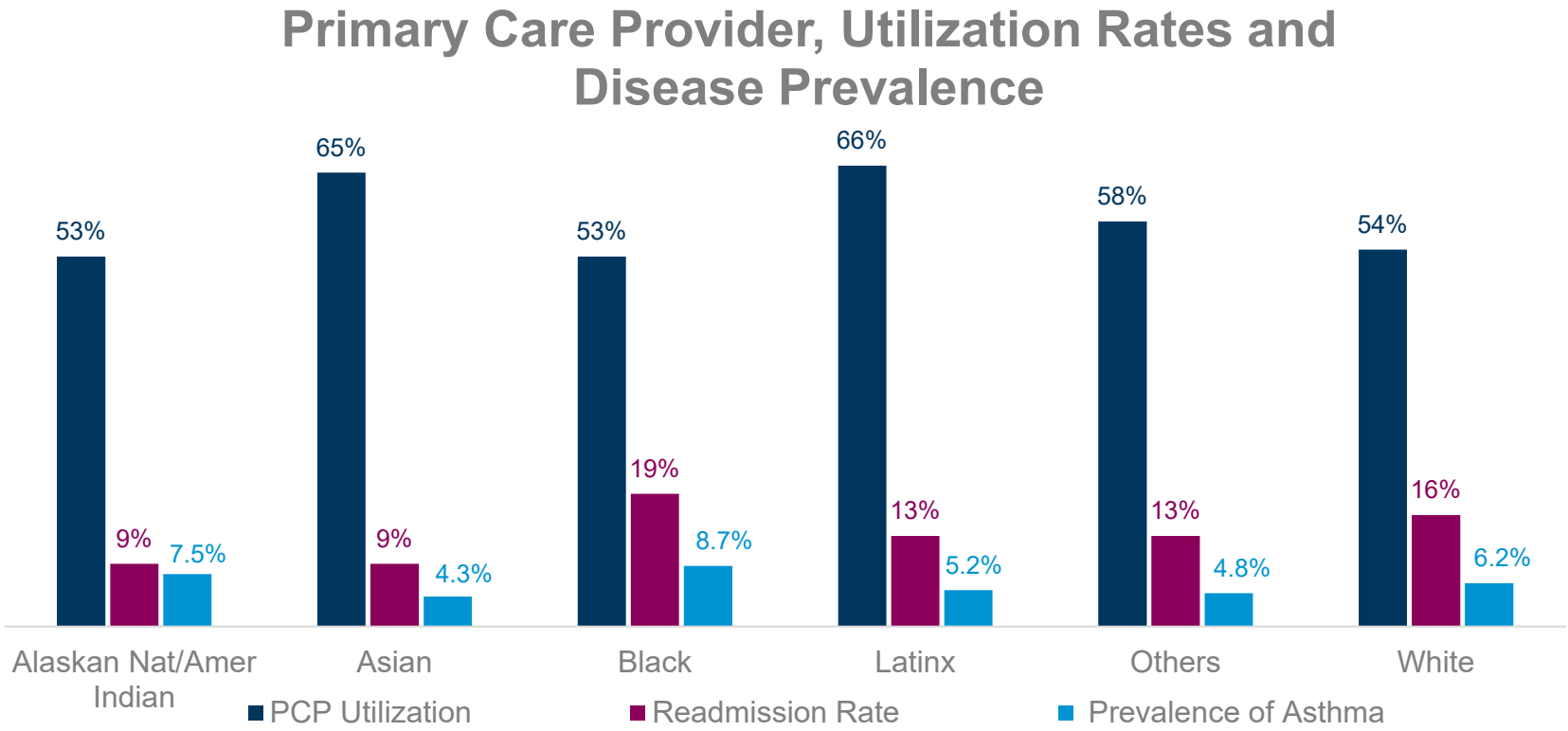
Health Disparities Across Ethnic Groups

- Lowest primary care provider utilization, highest hospital readmission rate and highest prevalence of asthma for black members



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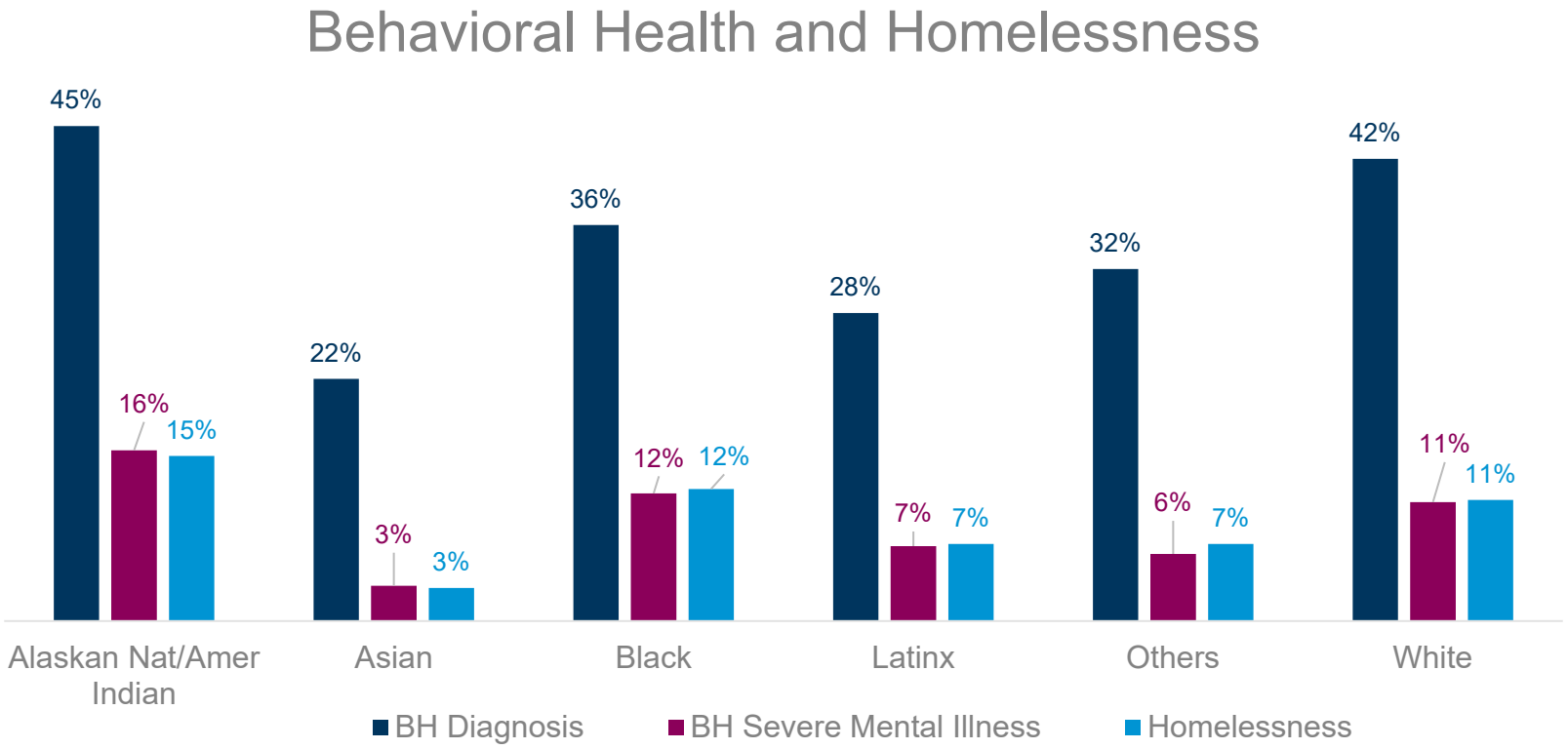
Health Disparities Across Ethnic Groups (cont.)

- 3rd highest prevalence of behavioral health disease, 2nd highest prevalence of severe mental illness and homelessness for black members



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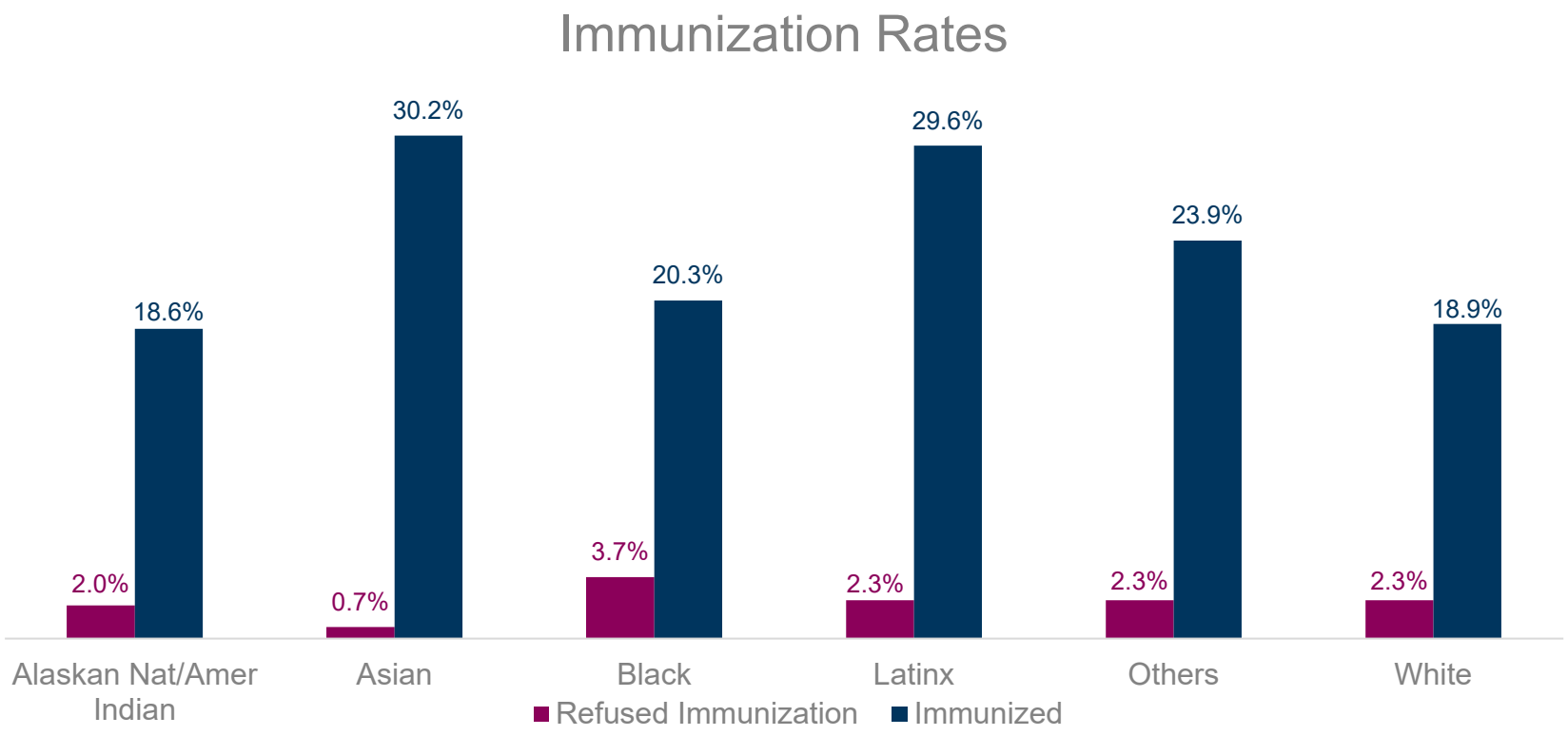
Health Disparities Across Ethnic Groups (cont.)

- 3rd lowest rate of immunization and highest immunization refusal rate for black members



Refused Immunization: Provider used ICD 10 to code immunization not carried out due to patient or caregiver reason/refusal. Excludes coding for under-immunization and no immunization due to contraindications/allergies

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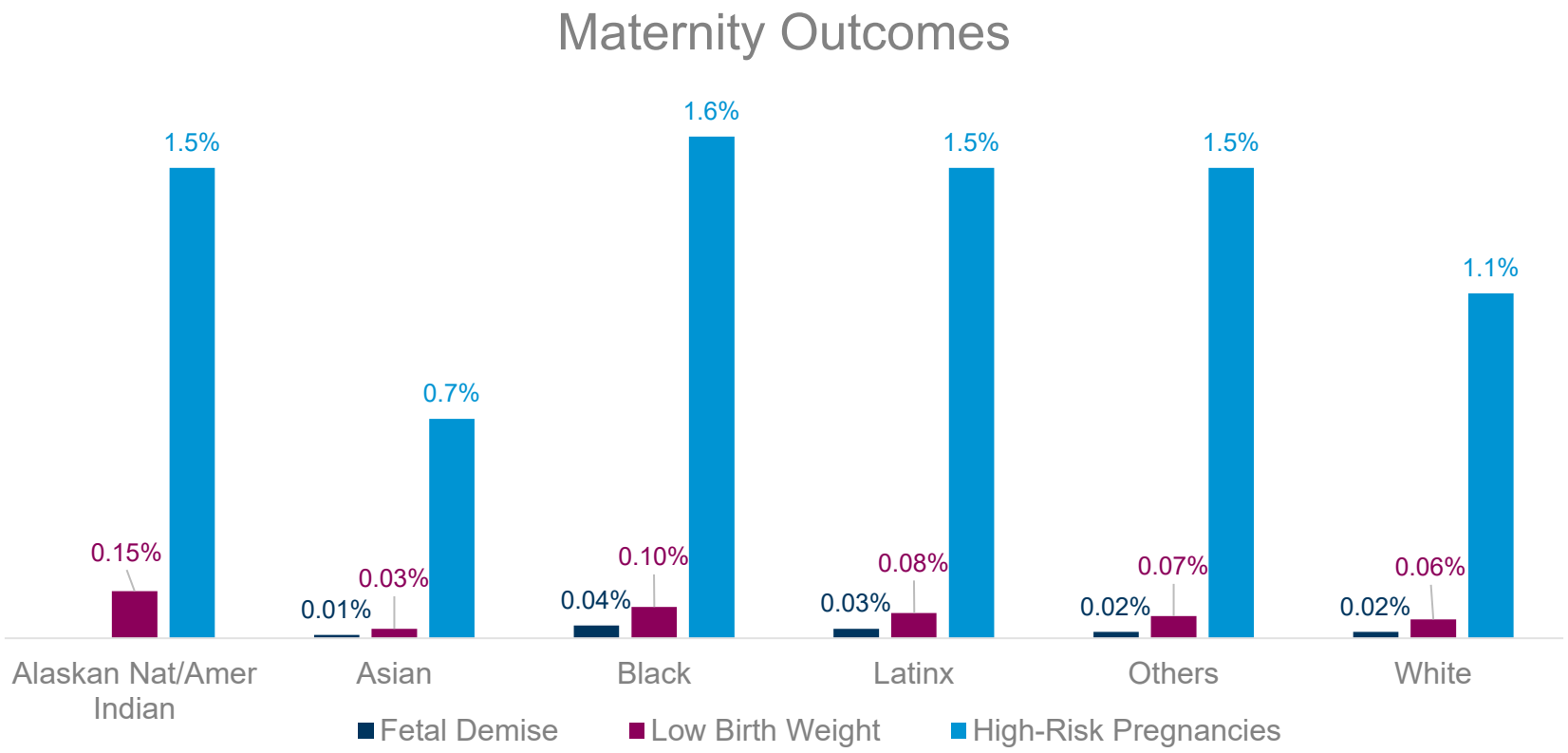
Health Disparities Across Ethnic Groups (cont.)

- Higher rates of fetal demise, low birth weight infants and high-risk pregnancies for black members



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Short-Term: Targeted Population Outreach and Intervention

- Continue to gather member feedback to identify appropriate peer support.
- Continue to integrate race and ethnicity as part of the Population Health Management risk algorithm.
  - Bright Steps
  - Chronic Care Program
    - Asthma
    - Diabetes
    - Hypertension
  - Individualized person-to-person outreach, care planning and care coordination
  - Wraparound trauma-informed care navigation support

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Recommendation: Adapt Institute for Healthcare Improvement Health Equity Framework

- Make health equity a strategic priority.
- Develop structure and processes to support health equity work.
- Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact.
- Develop partnerships with community organizations to improve health and equity.

Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

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Trauma-Informed Care and ACEs Aware Update

Special Quality Assurance Committee

December 10, 2020

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

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Agenda

- Background
- ACEs Aware Grantees and Community Partners
- What is CalOptima Doing?
- Trauma-Informed Care Framework
- ACEs Aware Provider Toolkit, Workflows and Algorithms for Pediatrics and Adults
- Q&A

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Adverse Childhood Experiences (ACEs)

Dr. Nadine Burke Harris
California Surgeon General

2019:

"ACEs and toxic stress represent a public health crisis."

2020:

"…We cannot just attack the (COVID-19) pandemic and not attack the other endemic disease of American society, which is racism."

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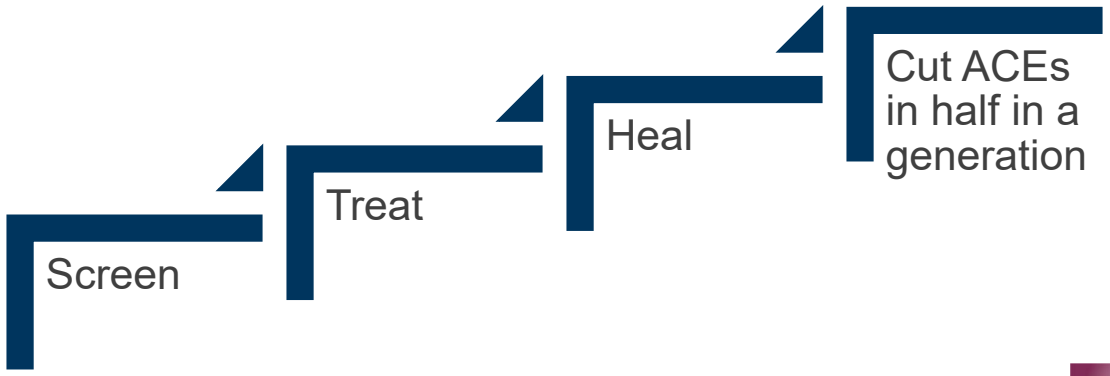
ACEs Aware Initiative

- Initiative led by the Office of the California Surgeon General and the Department of Health Care Services (DHCS)
  - Partner with health care systems and communities to ensure providers have the training, tools and resources to incorporate ACE screening into patient care.
  - Fund organizations to help expand the reach and impact of the ACEs Aware Initiative to Medi-Cal providers and organizations serving Medi-Cal beneficiaries.



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ACEs Aware Grant

- ACEs Aware awarded $14.3 million in grants to 100 organizations across California on June 16, 2020.
- Grants will fund activities
  - Informing and educating Medi-Cal providers about the importance of screening for ACEs
  - Responding to trauma-informed care
- Total of 150 individual grants awarded across the three areas of focus/categories:
  - Provider Training
  - Provider Engagement
  - Communications

ACEs Aware Grant Categories

- Provider Training — 31 grants
  - Help educate Medi-Cal providers about the importance of incorporating ACE screening, how to administer and provide trauma-informed care.
- Provider Engagement — 83 grants
  - Help organizations offer additional opportunities for providers to share lessons learned and best practices.
    - Tailored to specific geographic areas, patient populations, providers and practice settings
- Communications — 36 grants
  - Inform organizations and key audiences about provider training and engagement opportunities.
  - Increase awareness about the overall initiative.

ACEs Aware Grantees

	Organization	Grant Category	Proposed Activity	Target Audience
1)	American Academy of Pediatrics – Orange County ($150,000)	Provider Engagement (Peer-to-Peer Learning)	• Monthly online peer-to-peer learning sessions coupled by two webinar learning sessions	• 75–100 Orange County Medi-Cal providers
2)	Children's Hospital of Orange County (CHOC Children's) ($180,000)	Provider Training (Supplemental)	Virtual trainings focusing on: • How toxic stress can lead to negative health outcomes • Actions to support children and families who have experienced trauma • Impact of race, ethnicity, other diversity elements on trauma experiences	• 280 Medi-Cal providers and team members • 280 non-physician providers (mental health and school personnel)
3)	Orange County Department of Education ($100,000)	Communications	• Disseminate news and information about ACEs, toxic stress and the ACEs Aware initiative	• 1,000 unique Medi-Cal pediatricians

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ACEs Aware Grantees (cont.)

Organization	Grant Category	Proposed Activity	Target Audience
4) Early Childhood Orange County ($120,000)	Provider Engagement	• Community provider conversations on implementing an ACEs approach.	• Early childhood medical and mental health community providers and community-based providers who specialize in specific ethnic populations
	Provider Engagement (White Paper)	• Address stigmatization, bias, re-traumatization at an individual and community level in implementing an ACEs screening and treatment approach.	
5) The Raise Foundation ($60,000)	Provider Engagement (Network of Care)	• Network of Care established through 12 monthly online trainings through July	• Up to 1,000 social workers, nurses, doctors, therapists, counselors, eligibility technicians, community health workers and benefit enrollers

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ACEs Aware Grantees (cont.)

Organization	Grant Category	Proposed Activities	Target Audience
6) Western Youth Services ($250,000)	Communications	• Expand upon existing communications around ACEs and training programs	• Medi-Cal providers and aligned providers/ organizations
	Provider Engagement (Network of Care)	• Engagement activities focused on shared learning on trauma-informed care and the impact of ACEs	• Medi-Cal providers and aligned providers/ organizations
	Provider Engagement (Peer-to-Peer Learning)	• Sessions for network of care targeted toward shared learning on trauma-informed care and the impact, utilizing a cohort model to drive collaborative change	• Providers in the community invested in championing the work of ACEs awareness
	Provider Engagement (White Paper)	• Exploring how a collaborative system of care can work to reverse the negative impacts of ACEs	

Source: www.acesaware.org

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ACEs Aware Community Partners and Grantees Meeting

- Community partners and grantees connected on August 24, 2020
- Community Partners
  - Aurrera Health (formerly Harbage Consulting)
  - OC Health Care Agency
  - First 5 Orange County
  - CalOptima
  - ACEs Connection
- Next Steps
  - Continue making connections with state-level funded grants and follow up on potential collaborations

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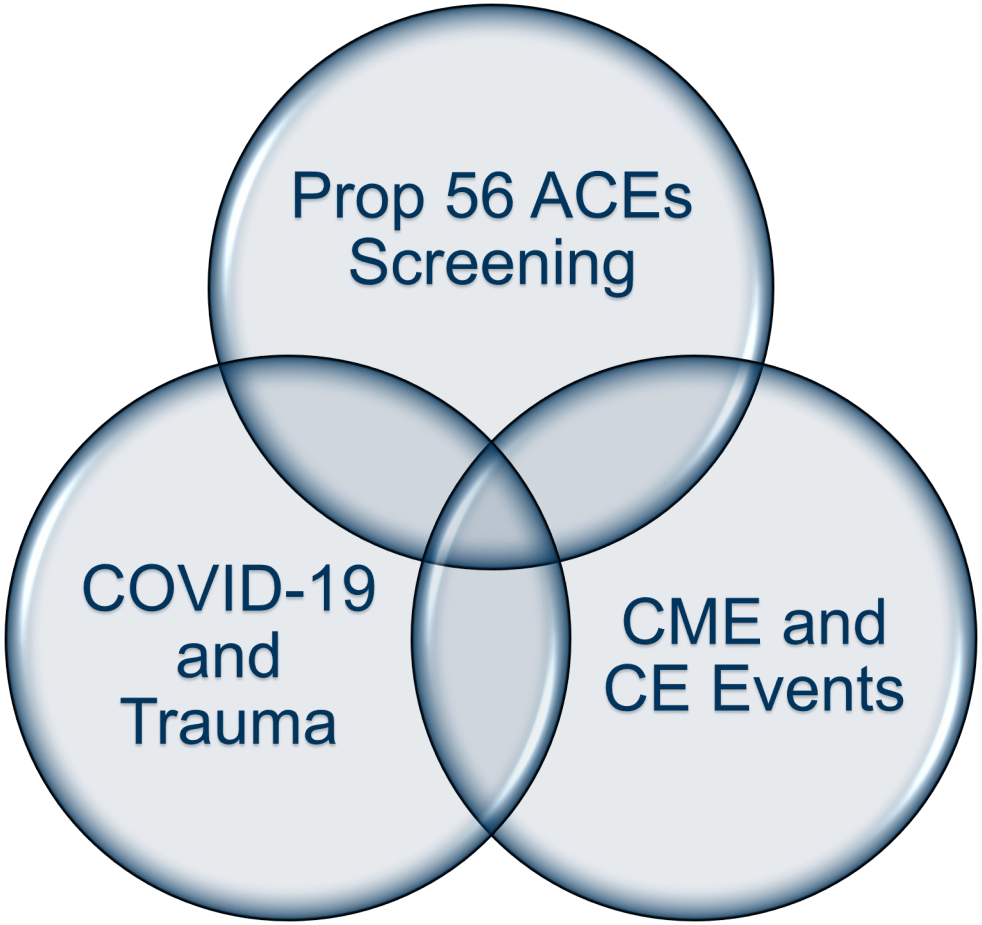
What Is CalOptima Doing?



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Proposition 56 ACEs Screening

- Funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, to support:
  - Provider training for trauma screenings
  - Clinically appropriate trauma screenings for Medi-Cal children and adults
- DHCS requires Managed Care Plans (MCPs) to comply with minimum fee schedule of $29 for each qualifying ACEs screening service.
  - Starting January 1, 2020, CalOptima began reimbursing providers $29 for any ACEs screening.
  - As of July 1, 2020, CalOptima requires providers to complete a certified trauma-informed care training and self-attest before being reimbursed.

Source: www.dhcs.ca.gov

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Proposition 56 ACEs Screening (cont.)

- As of November 3, 2020

Total number of providers completed ACEs training in OC	1,316
Total number of providers submitted ACEs screening claims	222
Number of members screened	23,197
Number of health network members	18,989
Number of CCN members	4,208
ACEs screening total claims paid	$691,619.40

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CalOptima CME and CE Events

- Date: October 2–3, 2020
  - Title: Mental Health Live Webinar: Compassion Fatigue/Vicarious Trauma for the Provider
  - Host: CHOC Children's
- Date: October 29, 2020
  - Title: What's Past is Prologue: Fundamentals of Adverse Childhood Experiences (ACEs)
  - Speaker: Dr. Brent Sugimoto
- Date: March 3, 2021
  - Title: Mindfulness; A Core Resilience Skill for Provider Wellbeing
  - Speaker: Dr. Reena Kocheta

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COVID-19 and Trauma

- Well-being of parents and children during COVID-19
  - 1 in 7 parents reported worsening behavioral problems in their children due to loss of school, childcare, jobs and food insecurity.
  - More than 25% of parents say their mental health has worsened since the pandemic.
- CalOptima Behavioral Health (BH) has seen a 156% increase in therapy referral compared to same period last year.

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COVID-19 and Trauma (cont.)

- DHCS AI-Plan Letter (APL 20-008): Mitigating Health Impacts of Secondary Stress Due to COVID-19 Emergency
  - Expansion of telehealth for BH
  - Identify providers with specialties in treating childhood trauma.
  - Educate health networks, providers and internal staff on how to support members with mental health concerns due to COVID-19.
  - Weekly mindful moment with internal staff
  - Population health equity analysis to address health disparity

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Solution: Trauma-Informed Care Framework

Understanding	• The prevalence and impact of trauma and adversity on health and behavior
Recognizing	• The effects of trauma and adversity on health and behavior
Responding	• Incorporating trauma-informed principles throughout clinical practices and community support systems
Integrating	• Knowledge about trauma and adversity into policies, procedures, practices and treatment planning
Resisting	• Re-traumatizing, including staff

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ACEs Aware Provider Tool Kit

- Provides information on the ACEs Aware Initiative
- How to screen for and respond to ACEs
- How Medi-Cal providers can get trained and receive payment for conducting ACE screenings
- ACEs fact sheets

Source: ACEs Aware Initiative: Overview • ACEsAware.org
https://www.acesaware.org/heal/provider-toolkit/

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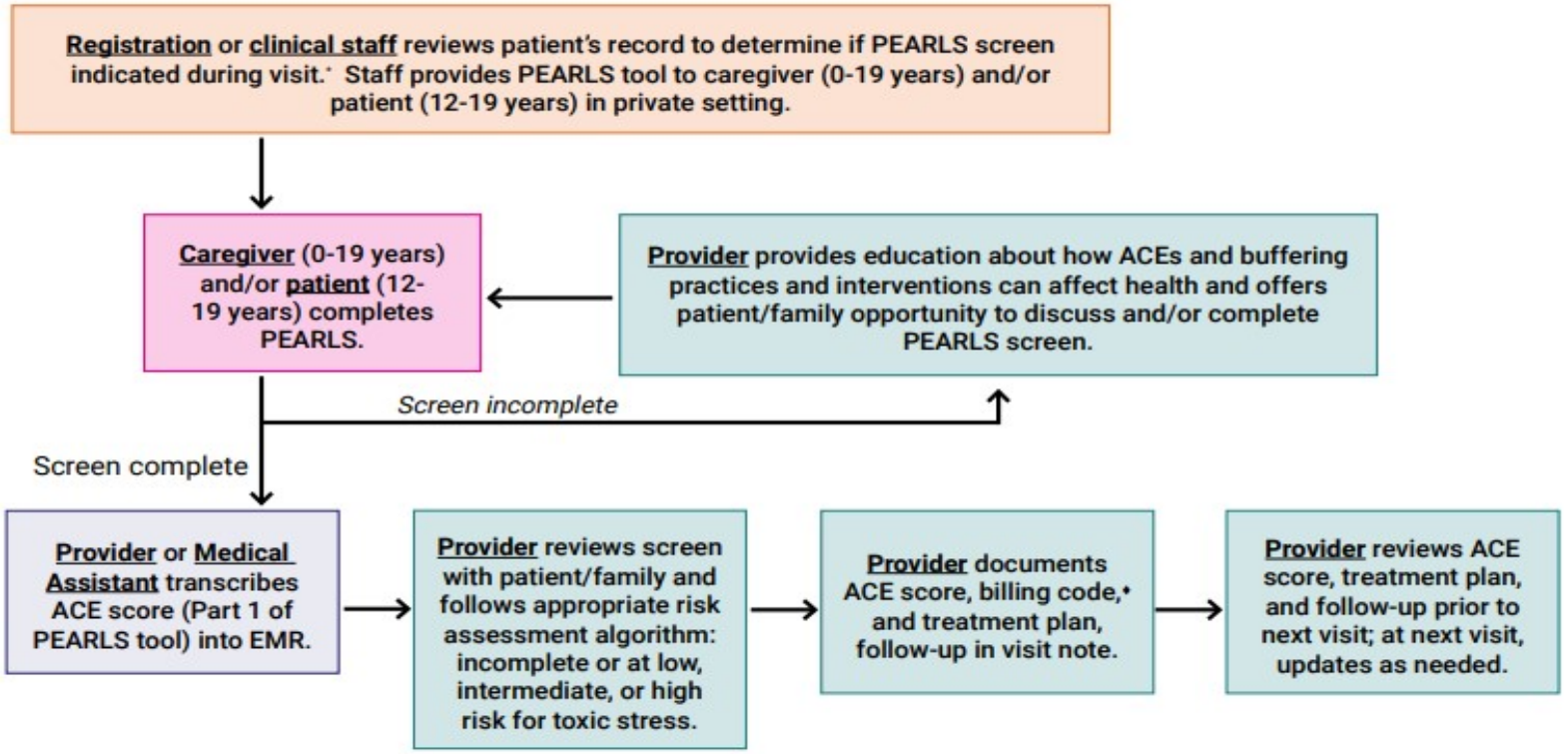
ACE Screening Clinical Workflow: Pediatrics



*PEARLS is recommended to be completed once per year.

♦Healthcare Common Procedure System (HCPCS) billing codes for ACE scores:
G9919: ACE score ≥ 4, high risk for toxic stress
G9920: ACE score of 0 – 3, lower risk for toxic stress. For purposes of coding, scores of 1-3 with ACE-Associated Health Conditions should be coded as G9920, even though patient falls into the high-risk category of the clinical algorithm.
***PEARLS to be completed once per year, and no less often than every 3 years

Source: ACEs Aware Initiative: Overview • ACEsAware.org
https://www.acesaware.org/heal/provider-toolkit/

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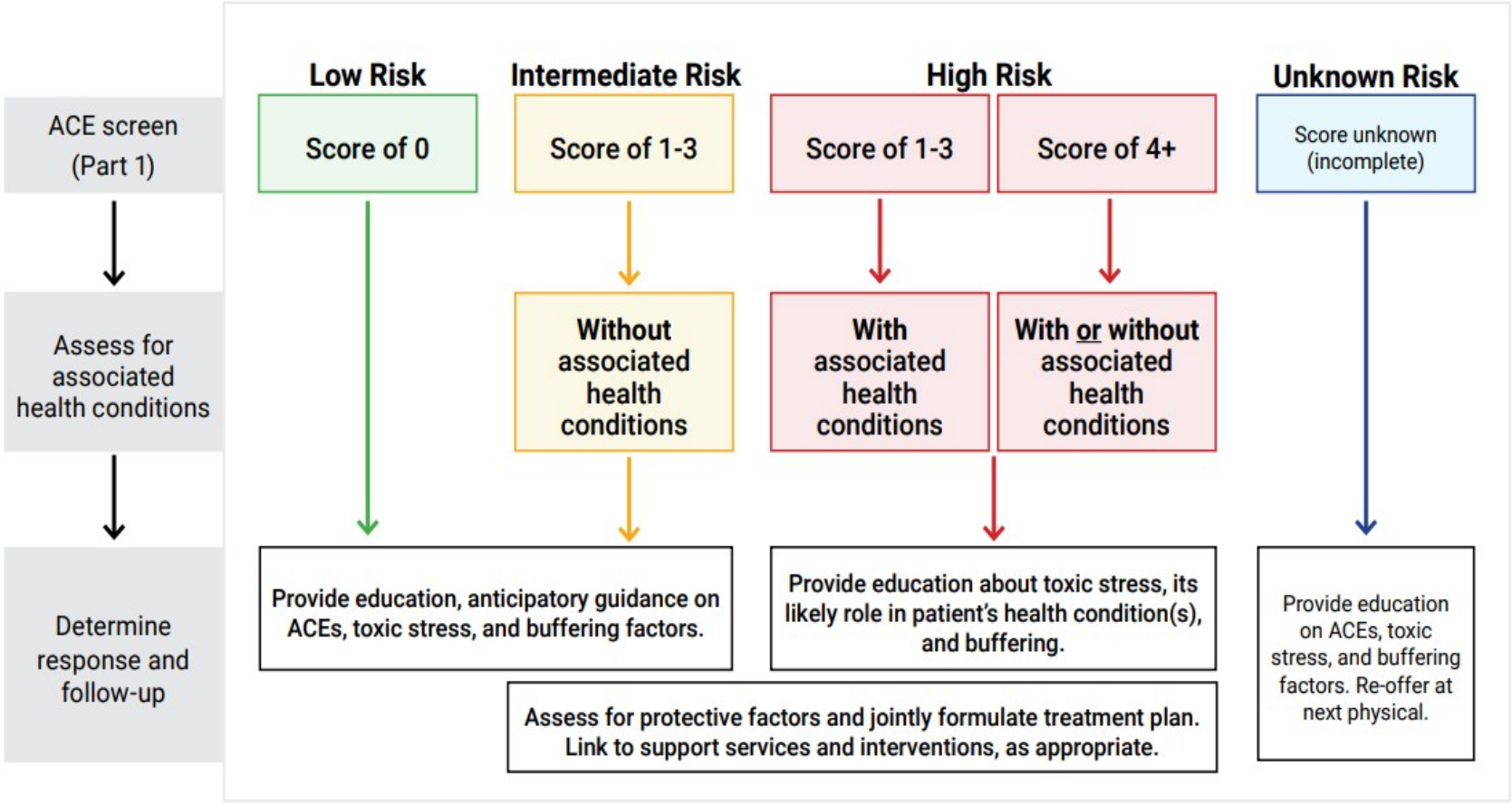
ACEs Screening Score Algorithm and Interventions: Pediatrics



Source: ACEs Aware Initiative: Overview • ACEsAware.org
https://www.acesaware.org/heal/provider-toolkit/

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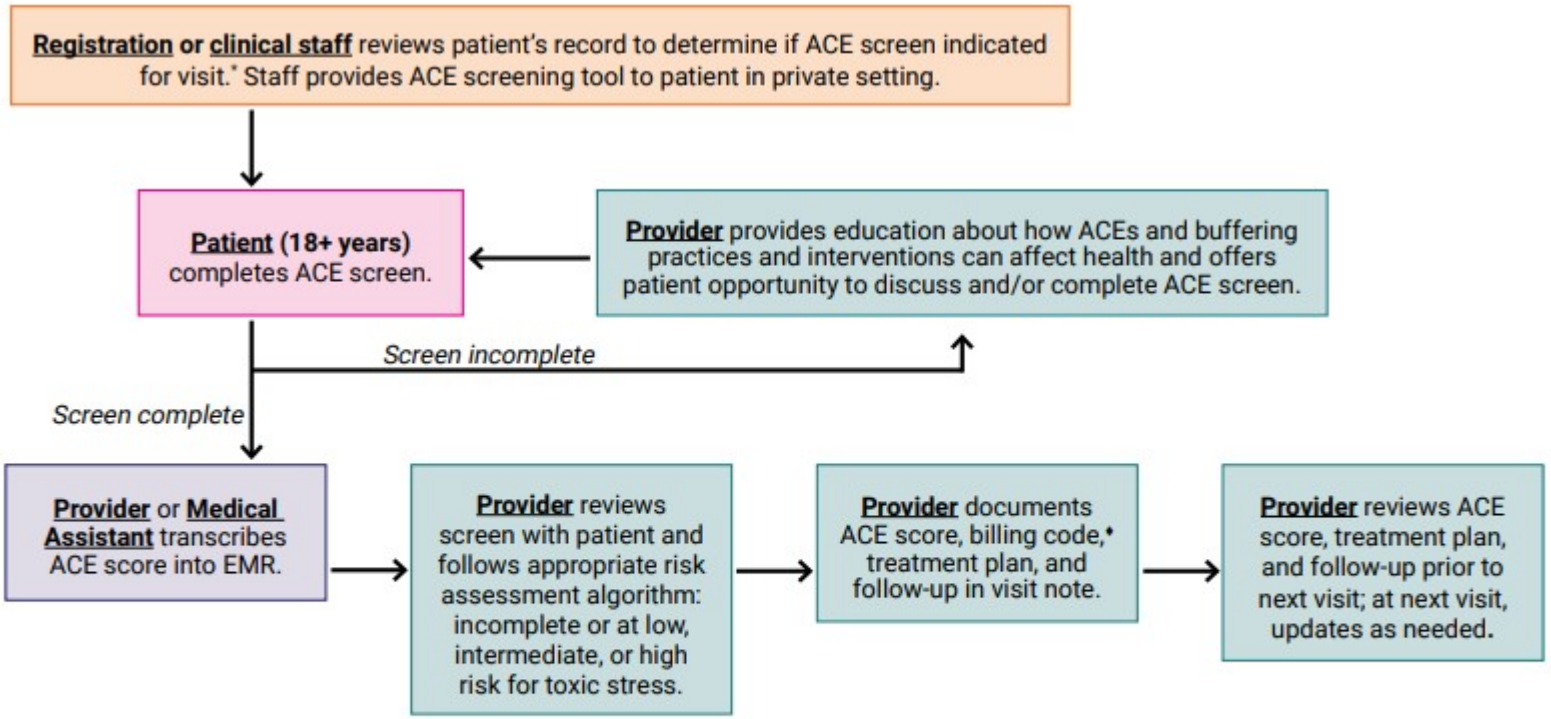
ACE Screening Clinical Workflow: Adult



*ACE tool is recommended to be completed once per adult, per lifetime.
•Healthcare Common Procedure System (HCPCS) billing codes for ACE scores:
G9919: ACE score ≥ 4, at high risk for toxic stress.
G9920: ACE score of 0 – 3, at lower risk for toxic stress (on algorithm, at either low or intermediate risk).

Source: ACEs Aware Initiative: Overview • ACEsAware.org
https://www.acesaware.org/heal/provider-toolkit/

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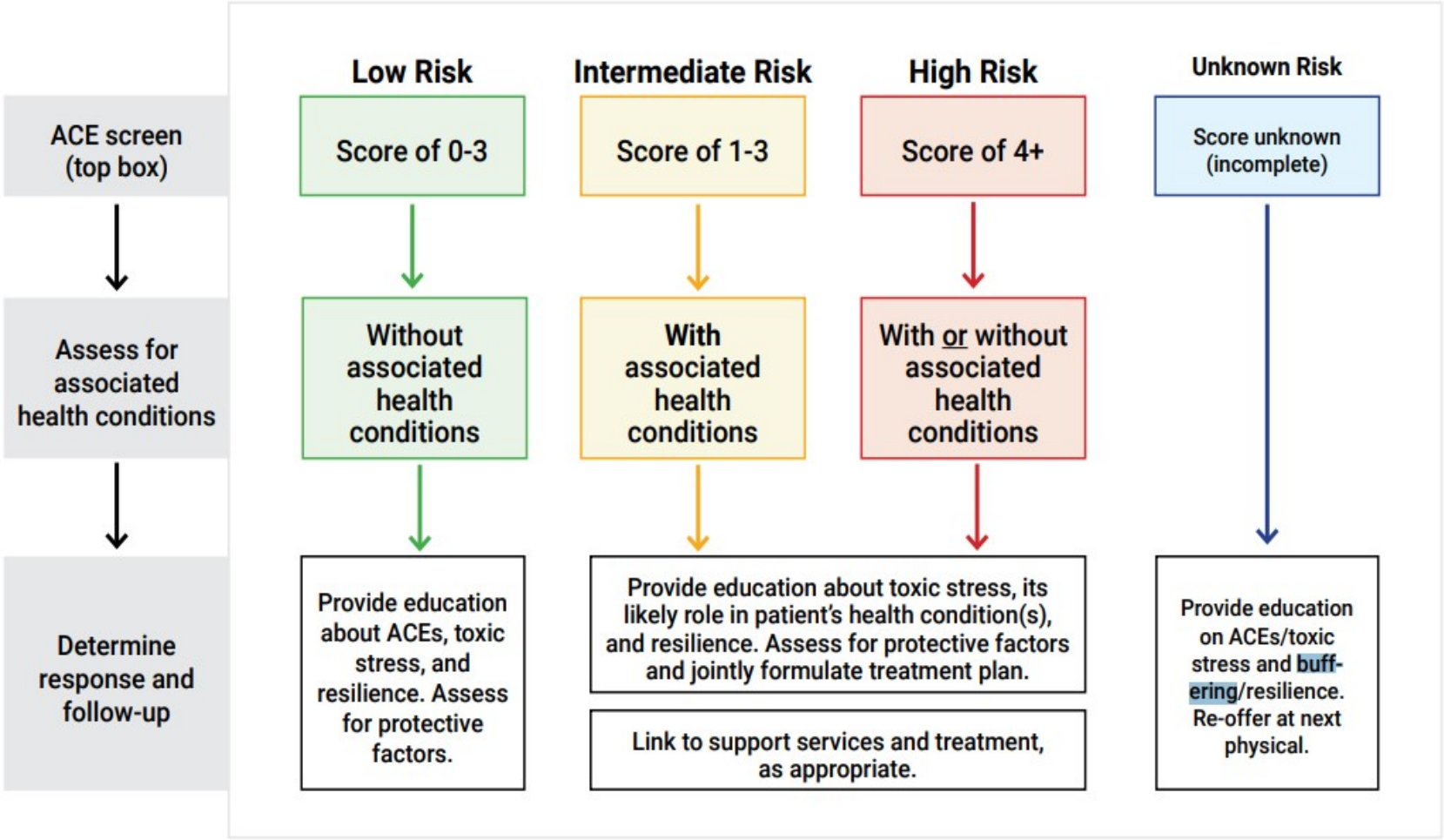
ACEs Screening Score Algorithm and Interventions: Adult



Source: ACEs Aware Initiative: Overview • ACEsAware.org
https://www.acesaware.org/heal/provider-toolkit/

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Questions?

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NCQA Accreditation Preparedness Update

Special Quality Assurance Committee

December 10, 2020

Esther Okajima, Director, Quality Improvement

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NCQA Timeline and Milestones

File Review Look-Back:
UM/CCM/Appeals: May 2020–May 2021
Credentialing: May 2018–May 2021

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How Will Plans Earn Accreditation?

- Before the 2020 standards year, 50% of the points organizations earned toward Accreditation were based on standards (processes, policies and procedures), and 50% were based on measures (HEDIS®/ CAHPS® reporting). Plans will still be evaluated based on standards and HEDIS/CAHPS reporting. Starting in 2020:
  - To earn Accreditation, plans must:
    - Meet at least 80% of applicable points in **each** standards category.
    - Submit HEDIS/CAHPS reporting during the reporting period after their first full year of Accreditation.
      - Submit HEDIS/CAHPS annually thereafter.

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COVID-19 Impact on Accreditation

- Extending the grace period two months to allow 16 months for annual requirements such as analysis, member communications and delegation oversight.
- Extending practitioner and provider recredentialing cycle by two months to 38 months.
- Potential to remove files from the March–December 2020 time frame (CalOptima impact May–December 2020) from Credentialing, UM denial/appeal and Complex Case Management files from the universe, as documented in disaster management plans.

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Year 1 Accomplishments

- Documents for year one look-back period May 2019–May 2020 almost complete (see Dashboard).
- Consultant webinar trainings w/staff and health networks
  - **CCM Standards** (June 10, 2020)
  - **UM Denials** (June 11, 2020)
  - **CR** (June 8, 2020)
- File review mock sessions held with consultants
  - **UM Medical Denials, Appeals CCN** (April 13, 2020)
  - **Credentialing CCN** (April 15, 2020)
  - **UM Medical Denials** w/AMVI/Prospect, Monarch, AltaMed (June 22, 2020)
  - **Credentialing** w/ AltaMed, AMVI/Prospect, UCMG, Monarch (June 25, 2020)
  - **CCM (PHM)** w/Prospect, CHOC, Arta (June 29, 2020)

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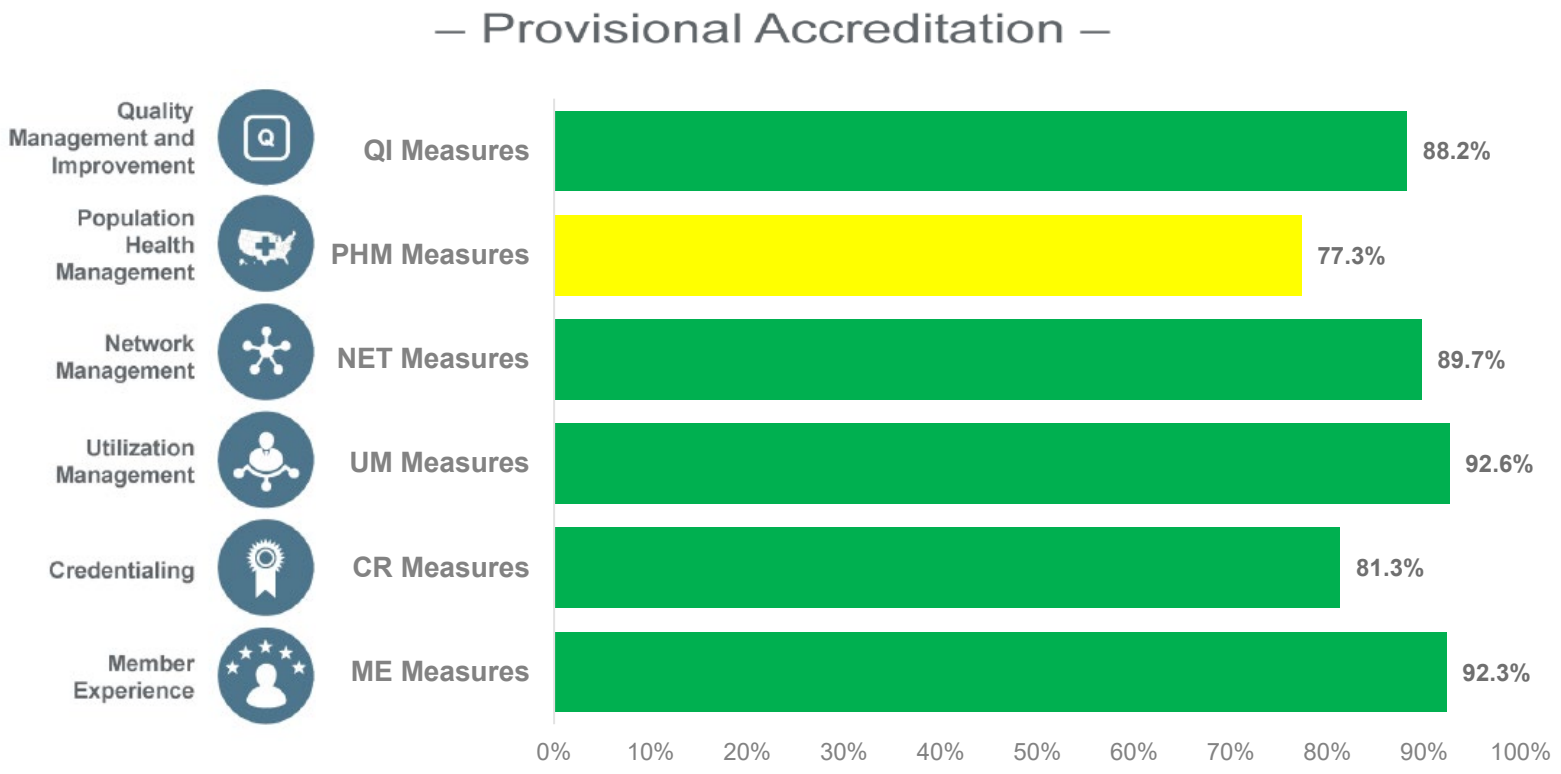
NCQA Dashboard

CalOptima's Estimated Scoring (Year 1)

Earning Provisional Status



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Year 2 Progress

- Assess impact and create disaster management plan to remove files for CR, UM, CCM, Appeals — March–December 2020
- Submit application and check to NCQA — September 2020
- Repeat all of year one reports plus any specific reports due once in lookback — all drafts are due by March 1, 2021.
- Final off-site or on-site mock audits with consultants in April 2021
- Policies updated prior to submission
- 2020 Delegation Agreements signed by all delegates and subdelegates

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Questions or Comments?

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2020 Quality Improvement Program Preliminary Evaluation

Special Quality Assurance Committee

December 10, 2020

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

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Overview

- QI Program Development and Evaluation Annual Cycle
- Measurement Year (MY) 2019–2020 Priority Quality Improvement Workplan Initiatives
  - DHCS Managed Care Accountability Set (MCAS)
  - Star Measures
- Member and Provider Incentive Program Evaluation
  - MY 2018–2019 Findings
  - 2020 Preliminary Findings
- 2021 Priority Quality Improvement Workplan Recommendations

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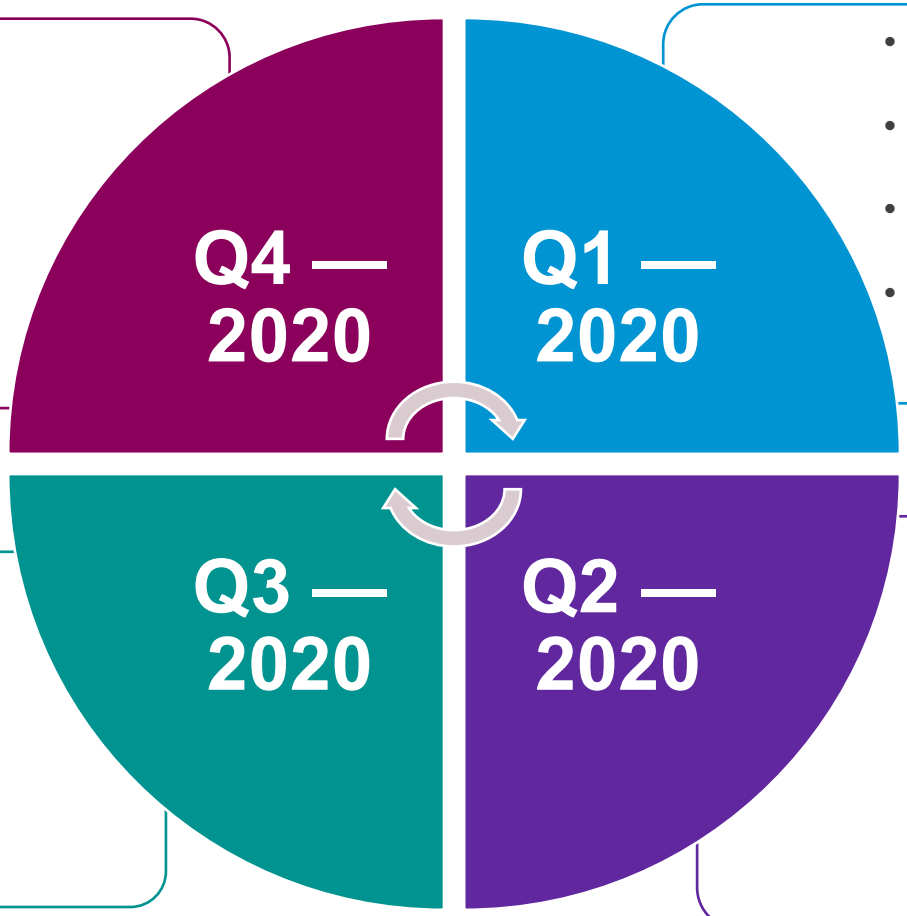
QI Program Development and Evaluation Cycle



- 2020 Preliminary Evaluation to QAC
- Begin Drafts for 2021 QIP and WP
- Kickoff HEDIS 2021
- Q3 QI WP Reported to QIC

- 2020 QIP and WP Approved by QAC
- 2020 Quality Initiatives In Process
- 2019 QI WP Complete and presented to QIC
- HEDIS 2021 MY Begins

- Q2 QI WP Reported to QIC
- 2020 Health Plan Ratings Released*

- Results for HEDIS 2020 (Measurement Year 2019) are Released and Finalized
- Q1 QI WP Reported to QIC

*NCQA Health Plan Ratings were not released for MY 2019 due to COVID-19.

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2020 QIP Priority Goals

- Improve Member Experience CAHPS performance from 25th percentile to 50th percentile focusing on Getting Needed Care and Getting Care Quickly.
- Improve member ability to access primary and specialty care timely, for urgent and routine appointments, from 2019 baseline to goal of 80%.
- Improve NCQA 4.0 overall rating to 4.5 rating by 2021.

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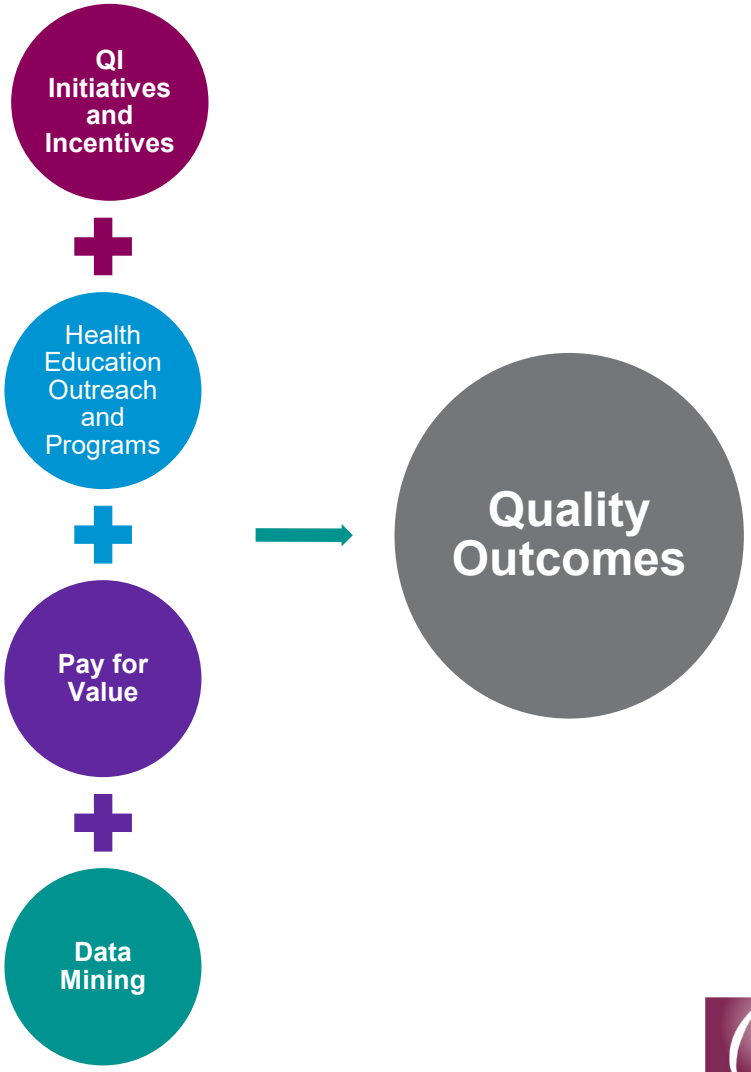
Drivers for Quality Outcomes



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Priority Quality Initiatives Measurement Years 2019–2020

- DHCS MCAS Priority Medi-Cal Measures
  - Well-Care visits
    - Adolescent Well-Care (AWC)*
    - Well-Care Visits in first 15 months of life (W15)*
  - Cancer Screenings
    - Breast Cancer Screening (BCS)*
    - Cervical Cancer Screening (CCS)*
  - Prenatal and Postpartum Care
  - Immunizations
    - Childhood Combo 10
    - Adolescents Combo 2

*NCQA Accreditation Measure

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Priority Quality Initiatives Measurement Years 2019–2020 (cont.)

- Priority Medi-Cal HEDIS Measures
  - Adults' Access to Preventive/Ambulatory Health Services (AAP)
  - Children and Adolescents' Access to Primary Care Practitioners (CAP)
  - Colorectal Cancer Screening (COL)
  - Comprehensive Diabetes Care (CDC)
    - HbA1c Testing (A1C)
    - HbA1c Good Control*
    - HbA1c Eye Exam
  - Statin Use for People with Diabetes (SPD)*
- Priority Medicare Star Measures
  - Colorectal Cancer Screening (COL)

*NCQA Accreditation Measure

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Quality Initiatives Activities 2019–2020

- Member and Provider Incentives
  - Member Incentives = $324,637
    - Cancer Screenings $25,685
    - Colorectal Cancer Screening (Stars Measure) $600
    - Comprehensive Diabetes Care $17,800
    - Postpartum Checkup $20,650
    - Well Care Visits (AWC and W15) $253,352
    - Shape Your Life Childhood Obesity Program $6,550
  - Provider Incentives = $84,575
    - Shape Your Life Childhood Obesity Program $9,825
    - Well Care Visits (W15) $74,750
  - Broader multimedia promotion and marketing

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Quality Initiatives Activities 2019–2020 (cont.)

- Direct Member Mailings
  - Incentive Mailings
  - Health Guides, Health Coach Packets
  - SPD Quarterly Statin Mailings
  - Significant Health Network Collaboration and Information Sharing
  - Events
    - CalOptima Days* 2018–2020
      - Member Incentives — $40,425
      - Provider Incentives — $75,200
    - Targeted Cluster Events — Mobile Mammography

*Series of health and wellness events co-hosted by CalOptima, health network partner and clinic/provider office to offer immunizations and well care visits to Medi-Cal members between the ages of 0-21. Members and providers are incentivized to participate.

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Quality Initiatives Activities 2019–2020 (cont.)

- W15
  - Scope and design document to find well visits billed for infants when the well-care visit was billed under the mom's CIN.
  - Pursuit medical record for **every** visit through 15 months of life.
  - Convene health network collaboration meetings and offer technical assistance.
- A1c
  - Implementation of point of care lab data with three health networks

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Lessons Learned

- **Interventions MY 2018–MY 2019**
  - Low sustained impact, temporary lift in response rates when one-time **only** direct mailing
- **Preliminary MY 2020 Observations**
  - Multi-faceted initiatives impacted prospective rates despite COVID-19.
    - Surge in member incentive submissions despite COVID-19 Impact
    - Positive member and provider experience
  - Year-round health network collaboration and provider engagement yield improved data capture opportunities.
  - Anticipated impact on HEDIS RY 2021 favorable but pending year-end evaluation and COVID19 impact to preventive care.

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Lessons Learned (cont.)

- **Data Gaps**
  - Likely biggest impact is bridging data gaps
  - Office Ally is expected to bridge EMR data gap

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2021 Quality Initiative Recommendations

- **Continue 2021 Health Rewards**
  - Retain most preventive health rewards — due to anticipated COVID-19 preventive services decline
  - Sunset of AWC incentive
- **Intensify Member Outreach By Leveraging Resource Efficient Modalities**
  - Implement mobile texting adhering to the Telephone Consumer Protection Act (TCPA) health care regulations.
  - Provide alternative health reward portals or use vendor service.

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2021 Quality Initiative Recommendations (cont.)

- **Prioritize Data Bridge Efforts**
  - Important with key HEDIS measures becoming Administrative **ONLY** instead of hybrid — no more medical record review
    - **Lab Data —** quality check to match files with data discrepancies that would not otherwise be counted
    - **Encounter Data** — early well-care visits
  - Integrating more data elements from Guiding Care and Office Ally EMR

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Board of Directors'
Special Quality Assurance Committee Meeting
December 10, 2020

Program of All-Inclusive Care for the Elderly (PACE)
Member Advisory Committee (PMAC) Update

Committee Overview
The PACE Member Advisory Committee (PMAC) meets quarterly to share information and engage PACE participants in a discussion on recommendations to inform CalOptima PACE leadership on the PACE care delivery system. The committee is primarily comprised of PACE participants. The September 30, 2020, meeting was accomplished via virtual meeting, with PACE participants joining from their private residences, senior apartments and residential care facilities throughout Orange County.

PMAC Meeting September 30, 2020

Updates from the Director
Director Elizabeth Lee thanked PMAC participants for joining the first virtual committee meeting. Participants expressed appreciation for being able to see each other on the screen and hear familiar voices. Participants were provided an overview of the CalOptima PACE response to COVID-19, including coordination with regulatory authorities, operational changes, infection control training and the expansion of telehealth. Participants were briefed on long-term telehealth options, including Vsee Clinic, a virtual clinic application, as well as smart phone devices for participants without access to a device or data plan to engage in telehealth encounters.

PMAC Member Forum

- One participant asked if there is an expected date that participants will be able to come back to the PACE Center. Director Lee shared there is currently no date selected. The PACE Center is steadily increasing services, such as physical and occupational therapy visits, showers, and clinic visits.
- A participant suggested for the next PMAC meeting to occur on the PACE Center outdoor patio area so that everyone can meet one another and have better interaction. She also thanked the staff for holding the PMAC meeting.
- A participant expressed that he is thankful that staff members are working so hard. He also commented that he is glad that we have technology resources to allow us to continue our work and meet for PMAC.

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Board of Directors'
Special Quality Assurance Committee Meeting
December 10, 2020

Quality Improvement Committee Third Quarter 2020 -- Update

Summary

- Quality Improvement Committee (QIC) met on July 14, 2020, August 11, 2020, and September 8, 2020.
- The following subcommittees reported to QIC in Quarter 3 (Q3):
  - Whole-Child Model Clinical Advisory Committee (WCM CAC)
  - Utilization Management Committee (UMC)
  - Credentialing and Peer Review Committee (CPRC)
  - Member Experience Committee (MEMX)
  - Grievance & Appeals Resolution Services Committee (GARS)
  - Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PACE QIC)
- Accepted and filed minutes from the following committees and subcommittees:
  - WCM CAC meeting minutes: May 19, 2020
  - UMC meeting minutes: May 28, 2020
  - MEMX meeting minutes: June 17, 2020, and August 19, 2020
  - GARS meeting minutes: May 21, 2020
  - PACE QIC meeting minutes: May 12, 2020, and June 9, 2020
  - 2020 Quality Improvement (QI) Work Plan Q2

QIC Highlights

- **Quality Program Highlights**
  - HEDIS 2020
    - There have been changes to HEDIS and regulatory reporting due to COVID-19. This is the first year DHCS established the Managed Care Accountability Set (MCAS) new measure set. Plans are required to achieve a new minimum performance level (MPL) which increased from national Medicaid 25th percentile to 50th percentile. CMS and MMP rates and patient level data are not required this year for OC/OCC due to COVID-19. CalOptima continued to report results for all three lines of business, however, they were not publicly reported to NCQA. CMS 2021 Star Rating will be using HEDIS 2019 results. CalOptima expects to receive Commendable status once again this year. NCQA Health Plan ratings were not released for 2020–2021 due to COVID-19.

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- CalOptima met all DHCS Minimum Performance Levels (MPLs), and 18 out of 49 measures demonstrated significant improvement. Full presentation of HEDIS results were presented at Q2 QAC.

➢ 2020 Member Experience (CAHPS)
- Of 1,350 sample sizes, response rate for adult members was at 19.6%. Similarly, of 1,650 sample size for child members, the response rate was 20%. Overall good response considering the pandemic. Pain points continue to be Getting Needed Care and Getting Care Quickly, which is the focus for the Member Experience staff and subcommittee. Results will be shared with CalOptima stakeholder groups and committees. Also, results by health networks will be calculated for Pay-for-Value score and payments.

➢ Quality Incentives
- Promotion of incentives were consolidated for members and providers to help providers promote during office visits with members. Staff created two posters, one adult focused, and one child focused, in English and Spanish.

➢ NCQA Renewal Survey Update
- CalOptima is on track to renew the Health Plan Accreditation in May 2021. We are currently in year two of a two-year lookback, and on track with completing programs, policies, reports and materials for submission. Conducted file review training with CalOptima and its health networks in preparation for the start of the file review look-back period, and file review sessions with NCQA in July 2021. 2020 Delegation Agreements still need to be signed and completed as soon as possible in order to meet the look-back period requirements. Due to COVID-19, NCQA has made time frame adjustments for reports, materials and files that will have favorable impact for our submission.

➢ Pay-4-Value Program for Behavioral Health Integration Applied Behavioral Analysis
- BHI presented a proposal for a new Pay-4-Value program related to Applied Behavioral Analysis providers. This proposal was presented to QAC on September 16, 2020 and will be presented at CalOptima's Board of Directors for approval.

➢ Population Health Management (PHM) Updates
- Director of PHM presented an update on the Preventative Care Outreach Campaign, which was paused at the direction of DHCS related to the Telephone Consumer Protection Act. This act requires CalOptima to ensure a process is in place to ask members' permission to perform robocalls and text communication to members. CalOptima is exploring other options while staying in compliance with laws and regulations.
- PHM strategy updates were also presented. The strategy was presented and approved in May of 2019. The four PHM areas of focus have not changed, however, some of initiatives related to the focus areas have been updated. Specifically, the PHM strategy for patient safety will sunset the Opioid Misuse Reduction measure and retain Multi-Drug Resistant Organism Reduction in Long-Term Care Facilities, as well as Promoting Statin Therapy for Patients with Diabetes. Also, for Managing

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Members with Chronic Conditions focus, Clinical Field Team and Homeless Clinical Access Programs were removed from the PHM strategy, and the Whole-Child Model and Care Coordination measures were retained.

- The annual Population Assessment for 2019 was presented. This assessment analyzes quality performance trends, member experience survey and utilization data to assess the characteristics and needs of the population in the community we serve. The analysis identified the increased need to focus on health disparities within sub-populations. The findings will contribute to the 2021 QI Work Plan.
- Additional updates to QIC include Homeless Health Initiative Update, Clinical Field Team Updates, Telehealth Services, Shape Your Life Program Update, as well as updates to the MC, OC and OCC Health Improvement Projects.
- Trauma-Informed Care and Adverse Childhood Experience (ACE) Aware update was presented by Betsy Chang Ha, RN. ACEs Aware initiative aims to cut ACEs in half. Six organizations in Orange County were awarded grants; 31 grants were for provider training, 83 grants for provider engagement and 36 grants for communication. Children are the focus for all grantees. CalOptima met with grantees and community partners to explore collaboration. CalOptima will focus on providers and target adult community and post ACE trainings and resources for youths and adults utilizing ACEs connection social network. Since July 1, 2020, reimbursements have been made to 1,229 unique NPIs with attestation to ACEs training and 1,459 ACEs screenings paid in COD/CCN.

- **UMC**
  - Utilization metrics were presented at QIC. Overall, there were no outliers in operational performance, presented for Medical, Behavioral Health and Pharmacy.
  - Over/under utilization is being monitored by a workgroup who reviewed data from Q1 2020. The metrics include UM, GARS, HEDIS, Pharmacy, BHI, Referral pattern analysis and Fraud, Waste and Abuse. As the data matures and trends emerge, the workgroup will present findings and opportunities to improve.
  - AMR Board Certified Specialists lists that are used to review authorizations, appeals and quality cases were presented, reviewed and approved by QIC.

- **GARS**
  - Medi-Cal complaints for second quarter 2020 remain similar to previous reports. The top grievance issues are Access: Appointment availability (55); Specialty Care (35); Quality of Service: Delay in Service (351); Transportation (137); Quality of Care: Question Treatment (116); and Delay in Treatment (44). There was a 40% decrease in transportation grievances from 239 in Q1 to 143 in Q2. The significant decrease can be attributed to cancelled and unscheduled appointments in April and May due to COVID-19.
    - There was a 25% decrease in Behavioral Health (BH) grievances. The decrease was apparent in all categories except billing, which saw a 225% increase due to reimbursement requests from non-contracted providers.

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- OCC and OC grievances decreased by 40%. The overall decrease in grievances can be attributed to less member service activity due to COVID-19 during Q2.
- COVID-19 related grievances continue to be analyzed by an ad hoc workgroup and presented to the committee. COVID-19 related grievances appear to have leveled off and remain low and steady. Providers are beginning to reopen their offices or provide telehealth visits, and members are being scheduled for care and services. CalOptima continues to monitor the availability of providers to ensure adequate access to care during the pandemic.

- **Whole-Child Model — Clinical Advisory Committee (WCM CAC)**
  - Provided updates from the May 19, 2020, meeting, which included a presentation of Whole-Child Model measures from Q3 and Q4 2019. The committee discussed the committee's charter as well Continuity of Care (CoC) transitions, which affected members after January 1, 2020. Grievance data did not reveal many issues received as a result of CoC ending. Member Experience Subcommittee will continue with general member experience and will not have a separate WCM CAC member experience workgroup as previously considered. Pharmacy update on California Children's Services utilization reflected an increase in pharmacy usage. Medi-Cal pharmacy benefit carve-out information was shared and is still planned for January 1, 2021.

- **Member Experience Subcommittee (MEMX)**
  - 2019 Health Network CAHPS were presented at Member Experience. CalOptima planned to issue Quality Improvement Plans (QIPs) to health networks (HNs) who had Health Network Ratings of 2.5 or below, however, the QIPs were halted due to the pandemic. We received responses to previous years' QIPs where health networks identified several barriers to lower CAHP ratings such as: not enough specialists, overbooking patients in the same time slot, physician offices not practicing open access (walk-in or same day appointments), and specialists limiting panels to new Medi-Cal members. As a result of barriers identified, several HNs implemented interventions that include: customer service training in patient experience concepts and provider coaching, overcapacity letters issued, geographic population needs assessment, sharing of best practices, encouraging providers to outreach to non-compliant members within quality measures, and provider office site support for patient experience. In addition, HNs planned interventions in 2020 such as medical assistant skills training, provider task turnaround time tracking, provider physician and office site engagement, provider recognition, increase payment rates and/or incentivize hard to access PCPs/specialists including after-hours services, and expanding urgent care centers. Next steps, Member Experience Subcommittee will meet to review and discuss HN activities on improving member experience and will share best practices with HNs.

- **Credentialing and Peer Review Committee (CPRC)**
  - CPRC continues to review credentialing files during the pandemic. Turnaround times for recredentialing has been extended from 36 to 38 months by NCQA. This extension has

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improved the recredentialing turnaround time to <.5%. Ongoing monitoring for the plan continues, and appropriate action taken, as identified.

- Potential Quality Issues and Analysis are presented through CPRC, with 93% of the cases leveled as Quality of Service in both Q1 and Q2. Member expectations related to their care/need was identified as a primary reason why the cases were leveled as Quality of Service. DHCS 2020 audit findings for GARS and PQI found that CalOptima did not correctly identify and process Quality of Care grievances. Also, CalOptima did not immediately submit all Quality of Care grievances to a medical director for review. CalOptima responded to the Corrective Action Plan (CAP)s and a proposed process was shared with the committee.
- Effective April 24, 2020, per All-Plan Letter 20-011, in-person site reviews were temporarily suspended. In addition, the implementation of the new facility site review (FSR) tool from DHCS is on hold due to COVID-19 until further notice. The FSR team started conducting on-site visits for initial FSR at the end of Q2 to enable initial credentialing to proceed. In addition, the team started conducting in-person, on-site visits for periodic FSRs starting in August. The team has adjusted the method for conducting FSRs to minimize time spent in the provider offices due to COVID-19.

Attachment

2020 Quality Improvement Work Plan Q2

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2020 QI Work Plan Element Description	Goals	Planned Activities	**Staff Responsible**	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.*)	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT						
2020 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2020 QI Program and Workplan by March 2020	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Betsy Ha	Approved: QIC 1/14/20; QAC 2/19/20; BOD 3/5/20		
2019 QI Program Evaluation	Complete Evaluation 2019 QI Program by January 2020	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Betsy Ha	Approved: QIC 1/14/20; QAC 2/19/20; BOD 3/5/20		
2020 UM Program	Obtain Board Approval of 2020 UM Program by June 2020	UM Program will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Mike Shook	2020 UM Program approved: QIC 4/21/20		
2019 UM Program Evaluation	Complete Evaluation of 2019 UM Program by March 2020	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Mike Shook	2019 UM Evaluation approved: QIC 4/21/20		
Population Health Management Strategy	Review and implement strategy in 2020	Review and adopt on an annual basis	Pshyra Jones	Population Health Management Strategy was written in May of 2019, and presented at QIC in August of 2019. The annual review of the strategy is in progress, and will be presented at QIC 8/11/2020.	Strategy will be presented at QIC in Q2 (8/11/20).	
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee, as well as Nursing Facility and CBAS quality oversight annual results.	Miles Masastugu, MD/ Esther Okajima	CPRC update on Q1 activity presented to QIC 6/9/20. Upate on Initial/Recred, FSR, PARS, MRRCredentialing Met 100% Timeliness for Recredentialing files. No medical-disciplinary action taken. All CAPs were corrected and there are no closed panels for this quarter. In Q1 97% were determined no quality of care issue or service-related issue. CPRC is concerned of COVID-19 impact on credentialing, FSR, and PQI processes. QI staff will modify FSR approach to minimize time spent in office sites (i.e. doing pre-review prior to office, going when members not present, assigned to single person).	Credentialing staff usually presents credentialing for CCN, however in future quarters they would like to bring a more complete picture of the CalOptima network to QIC. Staff is looking at options to perform virtual visits. The new FSR tools that is in development has been temporarily placed on hold and may not resume until next year. QI staff will modify FSR approach to minimize time spent in office sites (i.e. doing pre-review prior to office, going when members not present, assigned to single person).	

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Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Mike Shook	UMC presented 2019 4th quarter and annual trends update to QIC on 4/21/20. QIC accepted and filed UMC 2/27/20 meeting minutes. 2019 UM Evaluation approved by QIC. 2020 UM Program Description approved by QIC. Update to QIC included: Member Summary for Nov 2019, 3Q Operational Performace, 3Q 2019 Utilization Outcomes, WCM Update, Over/Under Utlization, Annual review of Criteria, BMSC Update.	UMC is scheduled to present to QIC on 7/14/20.	
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Kelly Rex-Kimmet/Marsha Choo	MEMX Sub-Committee presented Q1, 2020 report on 6/9/20. QIC accepted and filed their 4/15/20 meeting minutes.	Area of focus for the workgroup is on Urgent and specialty care appointments (e.g. neurology, pulmonology, endocrinology, gastroenterology) and provider data quality. **Next steps are to present results to committees and share results with the Health Networks. The 2020 Timely Access Survey is on hold until the Fall due to COVID-19**. **PCP Overcapacity Monitoring is also on hold:** Closing panels due to COVID-19 however staff will continue to monitor panels and will open for PCPs meeting capacity for 3 consecutive months.	
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	T.T. Nguyen, MD	WCM CAC presented to Q1 2020 update to QIC on 5/12/20. QIC accepted and filed their 2/18/20 meeting minutes. The WCM CAC Charter was presented and discussion on voting members and quorum was held. The Charter will be brough back to review at the next meeting.	After July 1, 2020, requests for extension of continuing of care with out-of-network providers will be evaluated on a case by case basis. Medi-Cal pharmacy benefit carve out: DHCS effort is ongoing.	
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Ana Aranda	GARS presented to QIC on 4/21/20 their report of Q4 2019 Member and Provider Complaints.Medical/OCC BH Appeal/Grievances. QIC accepted and filed GARS 11/21/19 Meeting Minutes.	CalOptima continues to review all grievances and appeals for: Trends, Improvements, Corrective Actions	

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PACE QIC - Quarterly review and update of PACE QIC activities		The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC, and summarized quarterly at QIC	Miles Masatsugu, MD	PACE QIC and PACE Center update was presented to QIC on 5/12/20. QIC accepted and filed PQIC 1/24/20 adHoc; PQIC 2/25/20 meeting minutes. The PACE Clinic office was closed to patients due to COVID-19 and is conducting telehealth visits when available.	PACE is looking at next stage of PACE center operations and how to move forward with socializing members in the next 12-18 months taking into consideration that PACE is not able to perform all services via telehealth. Also are coordinating plans to slowly be able bring members into the center while following CDC guidelines and recommendations. PACE is also looking at alternatives accommodations to bring patients back to the center for visits prior to the expected second wave of increase of COVID-19 cases in the winter.	
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2020	Monitor and report to QIC	Kelly Rex-Kimmet/ Sandeep Mital	100% of Quality Withhold Dollars are expected to be received. For CY2018, CalOptima passed 7 of 8 measures in the OneCare Connect Quality Withhold program for a final passing score of 87% which qualifies us to receive 100% of the quality withhold dollars back.	Await payment from CMS. Distribute payment to HN's upon receipt of payment	
Quality Program updates (Health Network Quality Rating, MCAS, P4V)	Achieve 50th percentile on all MCAS measures in 2020	**Varies per measure**. Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Kelly Rex-Kimmet/ Paul Jiang	Based on 2019 performance (HEDIS 2020), CalOptima achieved the MPL for all measures. YTD performance in calendar year 2020 reported as of May (with claims processed through April) shows only 3 measures have achieved the MPL. However, results are lagging due to COVID-19 as well as several measures MPL will be calculated with medical record data which will be added when final rates are calculated.	Continue to monitor and await guidance from DHCS regarding any changes in MPL measures and benchmarks for MY2020	
Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIP:** Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in OC; Improving well-care visits for children int he 15 months of life (W15) **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% **OCC QIP:** Improving Status Use (SPD) **OCC PIP:** Member with ICP with documented discussions of care goals **PPME (OC):** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC):** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents	Helen Syn/ Mimi Cheung/Sloane Petrillo/ Cathy Osborn	Medi-Cal PIPs: Closed as of June 30, 2020 due to COVID and DHCS is in the RFP process for a new EQRO. 1) **MC PIP**: Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County. 2) **MC HE PIP:** Improving well-care visits for children int he 15 months of life (W15) 3) **OC and OCC CCIP**: Improving CDC measure, HbA1C good control <8% OCC QIP: Improving Status Use (SPD) 4) **OCC PIP**: Member with ICP with documented discussions of care goals. PIP was closed and completed. 5) **PPME (OC)**: HRA outreach meeting goals, ICP/ICT bundles reflect high level of compliance over 90% for the quarter 6) **QIPE (OCC)** : HRA outreach meeting goals, ICP High/Low Risk, ICP Completed within 90 days is trending upward, HN MOC Oversight-bundles reflect high level of compliance with average over 90%	DHCS closed out all PIPs for the 2019-2021 cycle due to COVID-19 pandemic impacting the interventions. DHCS is in the RFP process and will be selecting a new EQRO. They anticipate keeping the same PIP topic areas (Child/adolescent Health and Healthy Equity) for the next cycle of PIPs. More information to come at the end of summer 2020. OCC ICP PIP: Completed the 3-year cycle in June, 2020. Closed out PIP. QIPs and CCIPs: Continue to track and monitor progress. Annual attestation due at the end of the year. PPME/QIPE: Continue to track and monitor progress.	

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II. QUALITY OF CLINICAL CARE						
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 44.82%; OC 58.82%; OCC 50.39%	Educate providers and members on importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. Track number of educational events on depression screening and treatment.	Edwin Poon	PR HEDIS Rates Q2: MC 38.78%; OC 46.15%; OCC 52.94% No educational events occurred due to COVID-19. Continues to maintain above 50% without an active intervention.	1) Reissue educational article to members on depression and treatment compliance.	
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS 2020 Goal:** 30-Days: OC: NA; OCC: 56% 7-Days: OC: NA; OCC: 18.20%	1) Visit top 3 hospitals in the first quarter. 2) Outreach to members post discharge to coordinate follow-up appointments. 3) Track the number of members that have a follow up appointment at discharge.	Edwin Poon	PR HEDIS Rates Q2: OCC 30 day: 32.73%; OCC 7 day: 7.27% Weekly BHI clinical rounds meeting with MD, MCM's and PCC to discuss concurrent reviews and internal coordination interventions. BHI Transition of Care Management (TCM) team building and maintaining relationships with hospitals; Guiding Care scripts capturing follow-up appointment outreach. CalOptima working with OC HCA to credential providers to ensure that County claims are being processed to capture all data.	1) Develop report to pull Guiding Care script data. 2) Establish tracking method to identify members that did not attend follow-up appointment within 7 days of discharge.	
Statin Therapy for People with Cardiovascular Disease (SPC) and Statin Therapy for People with Diabetes (SPD)	**HEDIS 2020 Goal:** SPC - Therapy MC 77.57%; OC 79%; OCC 79% SPD - Therapy MC 70.19%; OC 74.13%; OCC 74.13%	1) Quarterly faxes to Provider offices with lists of members missing an appropriate statin (SPD: any potency statin; SPC: moderate to high potency statin) or members who fall below adherence thresholds (PDC< 80%). (Rx) 2) SPD targeted mailings to members based on list provided from Pharmacy Provider outreach. (PHM) 3) Conduct IVR outreach calls to targeted members. (PHM) 4) Track the number of new members starting appropriate statins medications from targeted outreach list. 5) Track the number of members who were adherent to appropriate statins using calculated PDC rates.	Nicki Ghazanfarpour/ Helen Syn	**Pharmacy Management:** 1. Provider fax interventions completed by Pharmacy Dept for SPD: 553; Successful: 527; Failed: 26 (faxes); 6,780 (members) Total Mbr Count: MCAL: 5,989; OCC: 722; OC: 69 2. Provider fax interventions completed by Pharmacy Dept for SPC: 182; Successful: 176; Failed: 6 (faxes); 330 (members) Total Mbr Count: MCAL: 278; OCC: 50; OC: 2 **PHM:** **1. SPD Member mailing :** **MC**: English 521; Spanish 514; Vietnamese 224 **OC:** English 6; Spanish 3; Vietnamese 1 **OCC**: English 62; Spanish 79; Vietnamese 12 **2) 2020 May Prospective Rate (PR):** **SPC:** **MC:** Adherence Total: 0.58% Therapy Total: 77.68% L **OC:** Adherence Total: 0.00% Therapy Total: 71.79% B **OCC:** Adherence Total: 0.75%% Therapy Total: 80.12% B **SPD:** **MC:** Adherence Total: 0.18% Therapy Total: 67.59% B **OC:** Adherence Total: 0% Therapy Total: 73.58% B **OCC:** Adherence Total: 0.65% Therapy Total: 74.96% B	Continue to implement interventions and monitor. Adherence rate are lower because it too early in the year to assess it. The rates will be more reflective in Q4. Therapy rates are doing better when compared to same time last year.	
Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	**HEDIS 2020 Goal:** MC 77.93%; OC N/A; OCC N/A	1) Quarterly faxes to Provider offices for members missing persistent beta blocker use for a total of 6 months post-ASCVD date. 2) Track the number of members who are persistently using beta blockers 6 months post-ASCVD date.	Nicki Ghazanfarpour	Provider fax interventions completed by Pharmacy Dept for PBH: 244; Successful: 220; Failed: 24 (faxes); 418 (members) Total Mbr Count: MCAL: 418; OCC: 63; OC: 3	Continue quarterly faxes and tracking.	

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Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	**HEDIS 2020 Goal:** MC 76.07%; OC 95.66%; OCC 93.70%	1) Continue Homeless Clinical Access Program (HCAP) program. This program started in late 2019 and will be available for members in 2020 2) Support health networks and provider offices with targeted outreach (i.e. CalOptima Day activities) 3) Implement the Health Equity PIP to improve access to acute/preventive care services for homeless members. 4) Track the number of homeless members accessing preventive care services at Homeless clinic events, and help transition members back to PCP	Pshyra Jones/ Jasmine Awadallah/ Helen Syn/ Mimi Cheung	HCAP program continued with barriers due to the COVID-19 pandemic. Counts were adjusted to include telehealth visits instated during the COVID-19 pandemic. **2020 May Prospective Rate (PR):** MC: 48.40% OC: 75.62% OCC: 74.46% Measure is performing lower than same time last year for all LOBs (MC, OC, OCC)	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations.	
Cervical Cancer Screening (CCS)	**HEDIS 2020 Goal:** MC 63.99%	1) Implement $25 member incentive program for completing a CCS. 2) Targeted outreach campaigns to promote cervical cancer screenings 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach (IVR, call campaigns, etc.)	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Targeted mailing to CCS population was delayed due to COVID-19 pandemic and competing priorities. **2) # of CCS 2020 member incentives processed as of 6/30/20: 70** 3**) 2020 May Prospective Rate (PR):** MC: 50.48% Measure is performing lower than same time last year.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations. Targeted Mailings: (July/Aug 2020)	
Colorectal Cancer Screening (COL)	**HEDIS 2020 Goal:** OC 73%; OCC 73%	1) Implement new member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy)	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Colorectal incentive article dropped in the April OCC Newsletter. **2) # of COL 2020 member incentives processed as of 6/30/20: 3** **3) 2020 May Prospective Rate (PR):** OC: 43.09% OCC: 43.30% Measure is performing lower than same time last year for both OC/OCC.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations. Colorectal screening article to go out in the Fall OCC Newsletter Targeted Mailings: (Sept 2020)	
Breast Cancer Screening (BCS)	**HEDIS 2020 Goal:** MC 63.98%; OC 76%; OCC 66%	1) Implement $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted outreach campaigns to promote breast cancer screenings. Track the number of calls listened to from targeted outreach campaigns (i.e. IVR or direct phone outreach) 5) Track the number of mammograms scheduled through targeted call campaigns.	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Targeted mailing to BCS population was delayed due to COVID-19 pandemic and competing priorities. **2) # of BCS Medi-Cal 2020 member incentives processed as of 6/30/20: 37** 3**) 2020 May Prospective Rate (PR):** MC: 51.57% L OC: 57.58% B OCC: 54.42% L Measure is performing better than same time last year for OC and lower for MC/OCC.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations. Targeted Mailings: (July/Aug 2020)	

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Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 55.50%	1) Develop CORE report and track the numbers of members that filled Rx and their providers. 2) Coordination for members and providers through outreach and assistance with appointment setting and reminders. 2)Track the number of members that have a follow up appointment scheduled.	Edwin Poon	PR HEDIS Rates Q2: Initiation Phase: 30.63%; Continuation and Maintenance Phase: 41.77% Pharmacy intervention (30-day limit on initial Rx fill for members to attend a follow-up appointment with provider) impacted by COVID-19; members allowed 90-day supply. Pharmacy intervention only effective through end of the year due to pharmacy benefit changes. Unable to conduct member outreach as a result of limited resources.	1) Create report to identify providers at risk of noncompliance to track/trend. 2) Identify which providers serve most members and conduct outreach.	
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS 2020 Goal:** **MC: NA**	1) Develop way to load PHQ scores from Guiding Care to HEDIS software. Develop way to capture information (i.e., PHQ scores and scheduled f/u appts) from provider offices. 2) Educate providers on depression screening tools and importance of screening. 3) Educate providers and members on importance of follow up appointments via newsletters/ outreach. 4) Track depression screening scores completed by internal staff in GC. 5) Track number of educational events for depression screening and treatment, and increase # compared to last year.	Edwin Poon	PR HEDIS Rates Q2: N/A CORE report developed to capture HNA PHQ2 scores from Guiding Care for CM and WCM. Data loaded into HEDIS software. Met with QA team and learned data is supplemental requires auditor approval; will not take place until supplemental data is loaded in 2021. Overall, data collection continues to be a challenge because of the lack of mechanisms for capturing provider data. Meetings will continue to address data barriers and develop alternate solutions (e.g., development and implementation of Electronic Health Records (EHR)).	1) Collaborate with other health plans on data collection. 2) Develop a HEDIS reporting tip sheet to educate providers on depression screening tools and importance of screening. 3) Explore ways on how to incorporate tools into CalOptima's internal system to gather data from providers.	
Well-Care Visits in first 15 months of life (W15)	**HEDIS 2020 Goal:** MC 65.83%	1) Implement CalOptima Days targeting the W15 population only and track the number of members who engaged in W15 CalOptima Day events. 2) Implement **Member** incentive program for completing 1-3 and 4-6 well-child visits in the first 15 months of life and Track the number of W15 incentives paid out to members 3) Implement **Provider** incentive program for the W15 measures; members must complete 1-3 and 4-6 visits. Track the number of W15 incentives paid out to providers.	Pshyra Jones/ Helen Syn/ Mimi Cheung	**1) # of W15 1-3 and 4-6 visit 2020 member incentives processed as of 6/30/20: 799** **2) 2020 May Prospective Rate (PR):** (W15 all 6 visits) MC 18.06% Measure is performing lower than same time last year. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going into their PCP's office timely.	Due to the COVID-19 pandemic, the quality measures are negatively impacted as members are not accessing timely health care services. W15 incentives will continue through 2020 but with RCA analysis on impact of W15 rate and incentive impact. Analysis of additional data sources and retrieval on W15 rate. The W15 measure will be retired likely for a combined measure W30.	
Adolescent Well-Care Visits (AWC)	**HEDIS 2020 Goal:** MC 60.34%	1) Implement $25 member incentive program for adolescents 12-17 years old and Track the number of AWC incentives paid out to members. 2) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents and Track the number of participants for targeted adolescent "back-to-school" events.	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Health Guides with AWC incentive were mailed during Q2 of 2020. A large number of AWC incentives are coming in through member submissions and Health Network submissions. **2) # of AWC 2020 member incentives processed as of 6/30/20: 2131** 3**) AWC 2020 May Prospective Rate (PR):** **MC:12.66%** Measure is performing lower than same time last year.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust accordioning to CDC recommendations.	

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Children and Adolescents' Access to Primary Care Practitioners (CAP)	**HEDIS 2020 Goal:** **MC:** 12-24 Months 95.62% 25 months-6 years: 87.87% 7-11 years: 92.33% 12-19 years: 90.21%	1) Targeted outreach campaigns (IVR, call campaigns, etc.) 2) Also see other measure activities: [W15, AWC, IMA, CIS activities] 3) Track number of members who have an office visit after targeted outreach campaigns (i.e. IVR/Text messaging) 4) CAP measures is impacted by the following measures: W15, AWC, IMA, CIS and it's activities.	Pshyra Jones/ Helen Syn/ Mimi Cheung	**Child Access to Primary Care (CAP)** **2020 May Prospective Rate (PR) Medi-Cal:** 1. Age 12 - 24 months: 82.51% B 2. Age 25 months - 6 years: 54.82% L 3. Age 7- 11 years: 85.12% B 4. Age 12 - 19 years: 82.05% B Measure is performing better than same time last year for all submeasures except 7-11 years.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. However, CAPs appears to be OK for now. Continue to monitor measure and adjust according to CDC recommendations.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing	**HEDIS 2020 Goal:** MC: HbA1c Testing: 89.78% OC: HbA1c Testing: 93% OCC: HbA1c Testing: 93%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Targeted mailing to Diabetes population was delayed due to COVID-19 pandemic and competing priorities. 2) IVR message campaign promoting Diabetic Eye Exams was launched on June 28th to 2,884 members, With some HN concern at subjecting members to risk in this COVID-19 climate, the campaign was paused and has yet to go out to a remaining 20, 300 diabetic members. Other HNs voiced concern that risks and complications may rise without proper ongoing testing. **CDC A1c:** **3) # of A1c Testing - 2020 member incentives processed as of 6/30/20: 9** **4) 2020 May Prospective Rate (PR):** MC: 52.64% L OC: 54.20% L OCC: 55.46% L Measure is performing lower than same time last year for all measures	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations. Diabetes mailing with diabetes medication and DM services flier scheduled with A1C incentive form for July/August due to delays in needing to add COVID-19 precautionary language. To reassess continuing the diabetes IVR campaign urging testing and exams due to potential risks of unchecked diabetes.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Good Control (<8.0%)	**HEDIS 2020 Goal:** MC: HbA1c Control (<8.0%): 60.77% OC: HbA1c Control (<8.0%): 71.97% OCC: HbA1c Control (<8.0%): 71.97%	1) Targeted outreach to members in "emerging risk" category (8.0-9.0) 2) Track the number of completed calls to emerging risk members identified	Pshyra Jones/ Helen Syn/ Mimi Cheung	Health coaches continue outreach to members who moved recently from <8% to >8% based on recent lab data to identify the cause for the increase and support efforts to reduce it with behavior modification and/or better medication adherence. **2020 May Prospective Rate (A1c >8; Adequate Control - (PR):** MC: 15.27% B OC: 20.63% L OCC: 21.05% B Measure is performing better than same time last year for MC and OCC but lower for OC	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations. Continue health coach outreach to those showing emerging risk with recently identified A1C values >8%	

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Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS 2020 Goal:** MC: Eye Exam: 64.72% OC: Eye Exam: 78% OCC: Eye Exam: 78%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Targeted mailing to Diabetes population was delayed due to COVID-19 pandemic and competing priorities. 2) IVR message campaign promoting Diabetic Eye Exams was launched on June 28th to 2,884 members, With some HN concern at subjecting members to risk in this COVID-19 climate, the campaign was paused and has yet to go out to a remaining 20, 300 diabetic members. Other HNs voiced concern that risks and complications may rise without proper ongoing testing. 3) Provider communications made to encourage exchange of results from diabetic eye exam providers back to primary care providers. **CDC Eye Exam:** **4) # of Eye Exam - 2020 member incentives processed by 6/30/20: 6** **5) 2020 May Prospective Rate (PR):** MC: 36.98% L OC: 49.30% B OCC: 46.67% L Measure is performing lower than same time last year for MC and OCC and better for OC.	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations. Diabetes mailing with diabetes medication and DM services flier scheduled with Eye Exam incentive form for July/August due to delays in needing to add COVID-19 precautionary language. To reassess continuing the diabetes IVR campaign urging testing and exams due to potential risks of unchecked diabetes.	
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	**HEDIS 2020 Goal:** Prenatal MC 86.37% Postpartum MC 68.36%	1) Implement $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments	Ann Mino	Highlights for Quarter 2 2020 **1) # of Postpartum Care Incentives processed by 6/30/20: 156** **2) 2020 May Prospective Rate (PR): PPC** **MC: 59.39%** **Measure performing higher than same time last year for MC** 3) Bright Steps total participants = 1382. Out of those 331 member were contacted to complete the postpartum assessment. 4) CORE report updated to provide addition information regarding high risk pregnancies to each Health Network for all pregnant members. The report is uploaded automatically to each HN's FTP site weekly.	Continue to incorporate the PP incentive and encourage member to attend the PP visit during Bright Steps trimester calls. Continue to work with providers and community organization to increase member participating in Bright Steps and to adhere to prenatal and postpartum guidelines.	

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III. QUALITY OF SERVICE						
Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Needed Care	Improve Member Experience for **Getting Needed Care** from 25th to 50th percentile AND Improve Member Experience for **Getting Care Quickly** from 25th to 50th percentile	1) Continue Provider Data Initiative 2) Update the CalOptima Website (Provider Directory) so that providers and services are easily accessible to members 3) To have HN meet Time and Distance Standards 4) To have HN have at least 1 urgent care enter int he provider directory. 5)Provider Coaching and Workshops, report on # of Physician Shadow Coaching and Customer Service Improvement Workshops	Marsha Choo	All of the project listed are being monitored and reviewed by the Member Experience Sub-Commmitee. 1) As DHCS reviews CalOptima's 274 file and provides quarterly feedback, CalOptima works to clean and update FACETs and the 274 file. In this quarter, CalOptima re-configured the business report of the 274 file to accurately reflect provider telehealth services, physician extender affiliations, and appropriate HN affiliations, 2) CalOptima website was updated so that members can easily find member information, particulary information on COVID-19 and how to access services. Website was updated so that topics are listed on the left hand side and members can click on the topic rather than need to scroll to find the topic. 3) CalOptima re-submitted the Annual Network Certification (ANC) to DHCS using the DHCS approved percent of census data analysis methdology. CalOptima did not meet time and distance for one (1) zip code in San Clemente for adult and pediatric ENT and Orthopedic Surgery. For these zip code/provider type combination, CalOptima outreached to the 2 closest in-network providers for contracting and requested an alternate access standard (AAS). CalOptima continue to work on developing accessibility reports for time and distance for the HNs. 4) CalOptima reached out to the HNs to confirm their contracted urgent care centers and the provider directory was updated to accurately reflect their network of urgent care centers. An additional 7 MC, 4 OC and 3 OCC urgent care centers were added to the directory in the last quarter. 5) No provider coaching nor workshops were conducted in this quarter. A couple of provider offices were committed to conduct a workgroups. However, due to COVID-19, the workshops were placed on hold until further notice.	1) Provider relations, Qualiyt Analytics and IS continue to meet regularly to validate data in the 274 file and business report folder and will continue to validate the following provider data elements: HIV flags, PCP indicator, telehealth indicator, HN affilitation, and hospital affiliation. 2) Continue to review the website and make updates as needed. 3) CalOptima awaiting DHCS response on the plan level network certification submission. CalOptima to posted approved alternate access standard on the CalOptima website. Time and distance analysis to be run for each HN and data to be shared with the HN and upper managment. CalOptima to work with HNs to validate their provider data. 4) Continue to review and monitor data 5) On hold until further notice.	
Review of Timely Access - Increase appointment availability	Improve Timely Access for **Compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists** from current rate to 80%	1) Increase payment rates for hard to access specialists 2) Contract with Telehealth vendor and initiate telehealth services for identified specialties. 3) Incentive for hard to access PCPs/Specialists to open their panels 4) PCP Overcapacity Monitoring and closing of panels 5) Offer After Hours Incentive	Marsha Choo	All of the project listed are being monitored and reviewed by the Member Experience Sub-Commmitee. 1) No longer moving forward with initiative 2) CalOptima has executed a contract and completed on-boarding with Bright Heart Health, a BH provider group specialized in telehealth. 3) No longer moving forward with initiative 4) While CalOptima continues to monitor PCP capacity, CalOptima has placed a hold on closing provider panels if the are overcapacity due to COVID-19. CalOptima will continue to open PCP panels if they meet capacity for 3 consecutive months. 5) $2 million was approved by the Board of Directors in April to initiate the Extended Office Hours Pilot Program. As part of this pilot program, providers would be incentived for provider extended offices hours. CalOptima identified the top ten high volume clinics/provider groups for outreach to determine interest in the incentive and staff worked to identify different payment structures.	1) No longer moving forward with initiative 2) Continue to identify potential BH telehealth provider groups. 3) No longer moving forward with initiative 4) Continue to monitor and open panels. Closed panels on hold until further notice. 5) In light of COVID-19 and that members may be choosing to not go in for office visits, staff has decided to reallocate the IGT-9 fund from the Extended Office Hours Pilot Program to Urgent Telehealth. COBAR to be presented at the next Board meeting.	
Plan All-Cause Readmissions (PCR)	**HEDIS 2020 Goal:** OC 8%; OCC 8%	1) Complete RFP and select vendor to collect ER data, and reinstate ER discharge program 2) Track # of Members receiving health coaching 3) Track # of member with a hospital admission versus unplanned readmission	Sloane Petrillo Helen Syn/ Jocelyn Johnson	**2020 May Prospective Rate (PR):** MC: 9.86% L OC: 9.52% B OCC: 11.39% L Measure is performing better than same time last year for OC and lower for MC and OCC. **OCC CHF Transition of Care Q2 2020:** 5 referrals were received though the automated system: 3 referrals were for same member who was discharged to a Long-Term Care facility each time she left the hospital 1 Member was UTC 1 Member was released on Hospice Care	Two vendors have been selected and contracting is underway. Planning and implementation group has met and is preparing for implementation once contracting is complete.	

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IV. SAFETY OF CLINICAL CARE						
Opioids Utilization	Optimal utilization of opioid analgesics.	Interventions: a. Quantity limits b. Duration limits c. Prior Authorization criteria d. Prescriber Report Cards e. Pharmacy Home f. Prescriber Restriction	Kris Gericke	Goal: Average Morphine Milligram Equivalent (MME)/Member <15.5 1Q19: 13.9 1Q20: 12.0 2Q20: 11.4	Goal met. Continue interventions and monitoring.	
Post-Acute Infection Prevention Quality Incentive (PIPQI), aka as SHIELD OC	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	Cathy Osborn	QIC Update on 8/5/2020 PIPQI goals met 1. Twenty-five nursing facilities participating; 2. Due to COVID-19 on-site visits are suspended; CalOptima nurses are doing phone outreach instead to monitor and offer support to participating facilities. Nursing facilities are overwhelmed during COVID due to short staffing, chronic staff turnover, staff illness and an increase in reporting requirements, making it very difficult to get the necessary documentation for PIPQI. 3. Facilities report continued and regular use of CHG and nasal swabs. 4. Six PIPQI facilities continue to be COVID free.	Continue to Monitor. PIPQI nurses do monthly phone outreach to offer support to PIPQI facilities; infection control strategy videos were distributed to PIPQI nursing facilities (i.e. hand washing, preventing the spread of infection in the breakroom, etc.); additonal CHG and nasal swab training videos are being reviewed with PIPQI facilities by the PIPQI nurses	

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Board of Directors'
Special Quality Assurance Committee Meeting
December 10, 2020

Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
Third Quarter 2020 Meeting Summaries

July 21, 2020: PACE Quality Improvement Committee (PQIC) Meeting and PACE Infection Control Subcommittee Summary

- Christine Sisil (absent). All other PQIC members present.
- Infection Control Subcommittee:
    - Dr. Miles Masatsugu provided an Orange County COVID-19 update including county positivity rates, rates of hospitalization and hospital capacity.
    - Dr. Masatsugu discussed a delay ranging from 7–14 days in receiving COVID-19 test results, which poses a challenge in terms of exposure and quarantine. We will continue to monitor closely.
    - Dr. Masatsugu discussed the new Centers for Disease Control and Prevention (CDC) guidelines regarding isolation of individuals testing positive for COVID-19, Personal Protective Equipment (PPE) use and the provision of critical and non-critical services for patients.
    - PACE plans to purchase additional PPE in bulk in preparation for winter. The strategy is to have adequate amounts of PPE through April 2021.
    - PACE's response to COVID-19:
        - In June, placed 4,161 daily wellness calls to participants.
        - Implemented "PACE without Walls" which, per DHCS, allows PACE organizations greater flexibility in delivering participant care by optimizing a home-based model.
        - Trained 20 PACE staff members in the provision of in-home services
        - Continued transportation services for specialty appointments, delivery of durable medical equipment and assistance with grocery shopping
        - Implemented internal contact tracing for community-acquired COVID-19 positive participants
        - Finalized contract with virtual telehealth platform vendor VSee.
- Membership: Three new enrollees are expected in August. Enrollment is trending slightly lower due to COVID-19 restrictions. We anticipate a change in the landscape of PACE organizations within the county starting in January 2021 with the entrance of a new PACE organization. CalOptima PACE will retain its own identity and focus on building the best program.

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- Immunizations: Through our "drive-through" immunization clinic, 333 vaccines were administered to PACE participants. We anticipate delivery of the 2020/2021 influenza vaccine in August and will offer it to participants using the "drive-through" model. We will administer other needed vaccines concurrently with the flu vaccine as appropriate.
- Falls without Injury: Since participants are home-bound, most falls are occurring in the participant's bathroom/bedroom area. It was also noted that participants tend not to use their assistive devices in their home. We will continue to monitor any trends.
- Appeals and Grievances: No appeals were reported, and there is a decrease in the number of grievances. We will continue to monitor.
- Medication Errors: No errors were reported.
- Unusual Incidents: There were six falls with injury reported for the quarter. Most falls are occurring in the participant's home. There was one reported incident of a burn and two reported pressure ulcers. Root Cause Analyses are conducted for each unusual incident.
- Quality Initiatives:
    - Advance Health Care Directive: Data generated identified 210 participants who have the capacity to engage in completing an Advance Health Care Directive. As of July 20, 33 were completed.
    - Immunizations: An immunization dashboard was presented. There will be an emphasis on administering both the Prevnar 13 and Pneumovax 23 pneumonia vaccines. We are also tracking tetanus vaccination rates, which now show that 85% of the participants are up to date with that vaccine.

August 25, 2020: PQIC Meeting and PACE Infection Control Subcommittee Summary

- All PQIC members present.
- Infection Control Subcommittee:
    - Dr. Masatsugu provided an Orange County update, indicating that county cases have fallen below the county threshold which may soon move us to Tier 2.
    - The PACE Quality Improvement Team is tracking PACE participant positivity rates and those rates are falling as well.
    - PACE Director Elizabeth Lee shared a letter from a PACE participant who wished to express his thanks for all that PACE has done.
    - PACE Quality Improvement Manager Eva Elser presented actions taken by PACE in response to COVID-19:
        - We continue to submit COVID-19 data to Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS) and the National PACE Association (NPA).

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- We continue to provide drive-through COVID-19 testing for PACE participants who are symptomatic. Approximately 55 participants received testing through drive-through services.
- The response time for COVID-19 test results are now averaging 48 hours.
- We continue to contact trace PACE participants who have acquired the virus through community spread.
- Weekly COVID-19 updates are provided during weekly leadership meetings as well as during monthly all-staff meetings.
- Infection control training has been provided to all staff members.
- Continuation of weekly wellness calls to participants with 5,232 wellness calls placed between July 1, 2020, through August 13, 2020.
- Continued implementation of short-term telehealth solutions using FaceTime and Google Duo. There were 2,271 member interactions either though telephone or telephone with video from July 1, 2020, through August 13, 2020.
- Formation of a Telehealth Implementation Group that meets weekly.
- Finalizing a long-term telehealth solution by finalizing a contract with VSee, a telehealth platform
- Reviewing device options for participants who do not have a device or the bandwidth to engage in telehealth.
- Planning for guidance and education for participants on using devices and installing VSee.

- Improve the Quality of Care for Participants:
  - Membership: We anticipate an increase of enrollments for the month of September.
  - Immunizations: Due to a 2-week drive-through immunization campaign, our pneumococcal vaccination rate rose to 93%. We anticipate the arrival of the influenza vaccine shortly and have planned several drive-through influenza vaccination dates.
  - Infection Control: There has been a significant decline in the respiratory infection rate, and we remain below the national benchmark.
  - Physician Orders for Life-Sustaining Treatment (POLST): 95% of the participants have completed a POLST.
  - Functional Assessments: 99.7% have been completed with one participant being out of the service area.
  - Comprehensive Diabetes Care:
    - Blood Pressure Control: We fell below our goal for this indicator. Approximately 140 blood pressure monitors have been delivered to participants at home which will enable us to closely monitor it.

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        - Eye Exams: We are above goal with a rate of 97% and are sending participants to the optometrist office for services.
    - Nephropathy Monitoring: We are at 100% and continue to monitor it.
    - Medication Reconciliation Post-Discharge: 100% compliance and we will continue to monitor.
- Ensure Safety of Clinical Care:
    - Use of Opioids at High Dosages: Two participants are included in this group. There was some discussion about whether the data was correct. The PACE clinical director and the Quality Improvement department will review the data and bring back for discussion at the next meeting.
    - Drug Disease Interactions in the Elderly: There was also discussion about this data. The PACE clinical director and the Quality Improvement department will review the specific data and bring back for discussion at the next meeting.
    - Day Center Falls: No day center falls were reported since it is closed. We will continue, however, to monitor falls in the home.
- Ensure Appropriate Use of Resources:
    - Access to Specialty Care: We are at goal at 91% and we will continue to monitor.
    - Hospital/ER/Readmissions Utilization.
        - 30-day Readmission: We are below our benchmark at 5% and trending down and we will continue to monitor.
        - Acute Hospital Stays: Yearly and quarterly rates were presented. For quarter 2, the rate of bed days was trending down.
        - Emergency Room Utilization: Yearly and quarterly rates were presented. Our quarter 2 rate has decreased. Participants have been resistant to going to the ER due to the COVID-19 outbreak. Instead, more participants are using the urgent care after-hours service. Wellness calls are being made to every participant at least once a week to ensure that they are not delaying urgently needed care.
- Long-Term Care: 2% of the participants are in long-term care. We will continue to closely monitor participants who transitioned from custodial care to home care due to the COVID-19 health crisis.
- Improve Participant Experience:
    - Disenrollments: We had 23 disenrollments in Q2. We are developing a Plan Do Study Act (PDSA) that better describes controllable vs. non-controllable disenrollments.
- Transportation: On-time performance is 100%. Transportation expenses have decreased by one-third since April 2020. Transportation services have been used during the health emergency to deliver Wellness Kits, Advance Health Care Directives, enrollment packages and forms, and DME deliveries, as well as assisting participants with grocery shopping.

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Member Trend Report: 2nd Quarter 2020

Special Quality Assurance Committee
December 10, 2020

Ana Aranda, Director, Grievance and Appeals Resolution Services

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Overview

- Complaints by category
- Appeals and Grievance trends
  - Per 1,000 member months for Medi-Cal program
  - Per 1,000 members for OneCare and OneCare Connect programs
- Interventions based on trends

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Definitions

- Appeal: A request by the member for review of any decision to deny, modify or discontinue a covered service
- Grievance: An oral or written expression indicating dissatisfaction with any aspect of a CalOptima program
- Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction
- Quality of Care (QOC): Concerns regarding care the member received or feels should have been received

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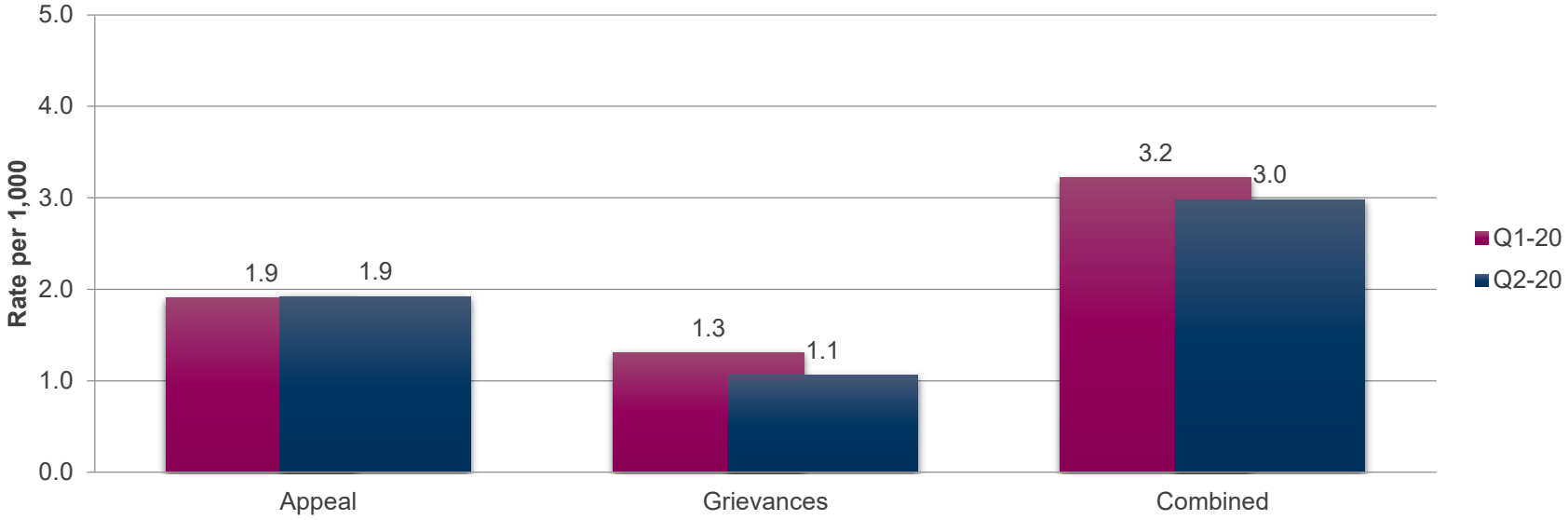
Medi-Cal Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2020	3,090	334	2,756	701,662
Q2-2020	2,653	348	2,305	725,939

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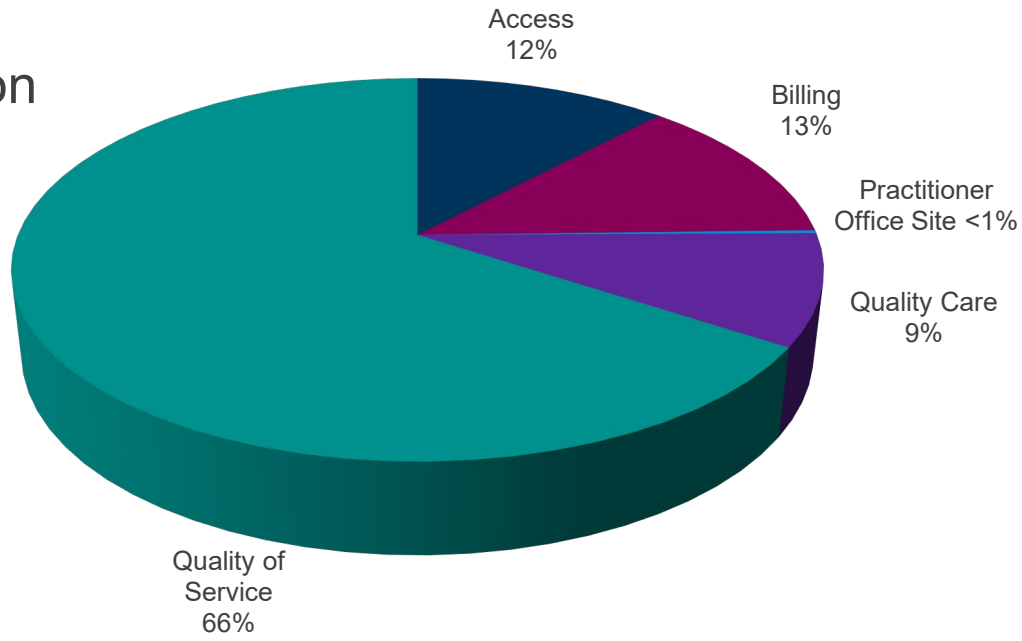
Medi-Cal Grievances by Category

- Top grievance types
  - Delays in service
  - Question treatment
  - Member billing
  - Non-medical transportation
  - Primary Care Provider



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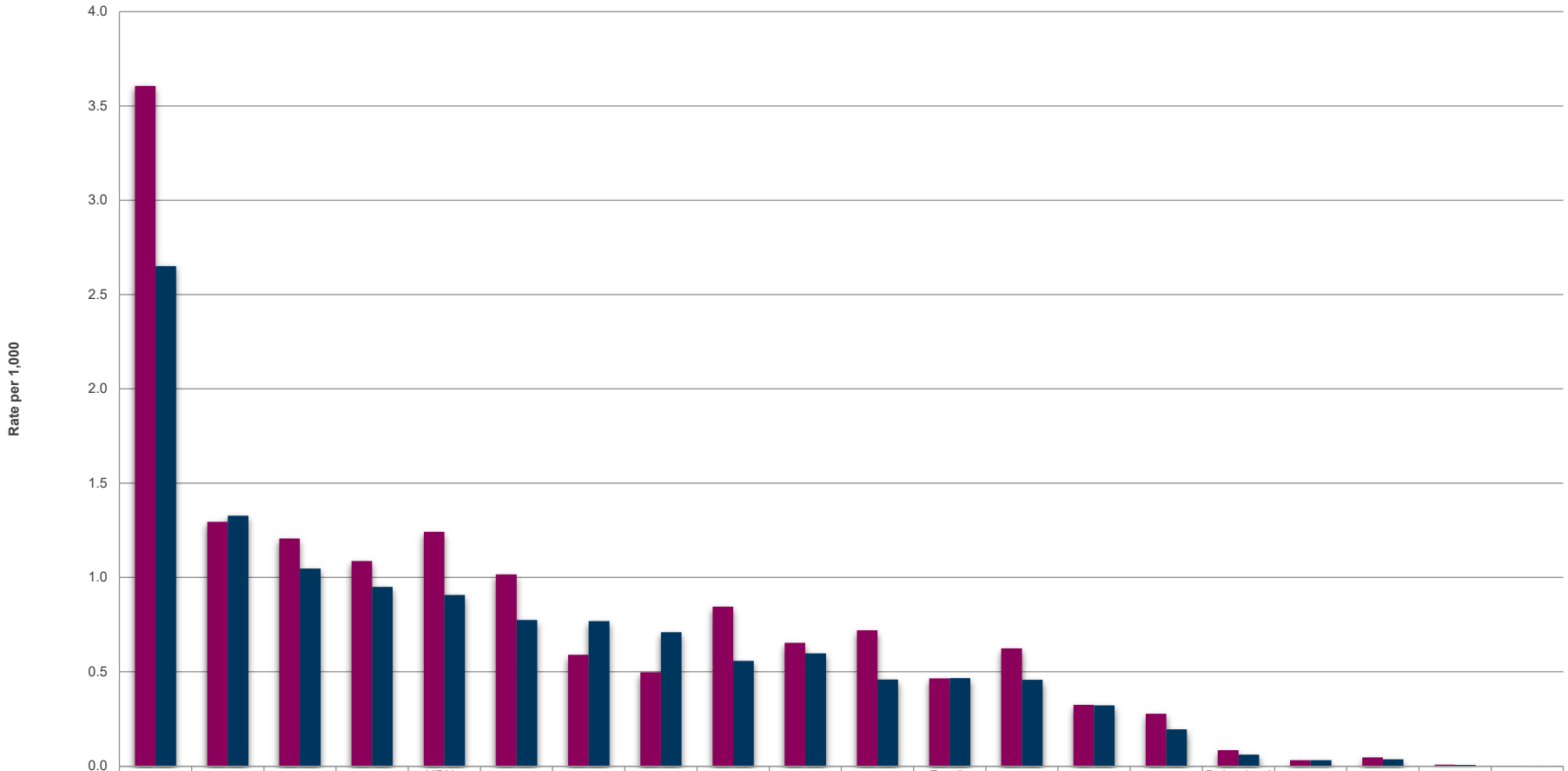
Medi-Cal Member Grievances Quarterly Rate/1,000



	CCN (81,879)	Kaiser (44,201)	Monarch (78,218)	Talbert (23,499)	HPN - Regal (6,977)	Prospect (34,396)	COD (97,149)	Noble (19,257)	Arta (60,293)	Veyo, LLC (79,781)	AltaMed (37,783)	Family Choice (43,602)	UCMG (33,494)	AMVI (21,756)	CHA (143,435)	Behavioral Health (725,939)	CO Prog (725,939)	CO Pharm (681,738)	VSP (681,738)	MLTSS (681,738)
Q1-20 (2756)	3.6	1.3	1.2	1.1	1.2	1.0	0.6	0.5	0.8	0.7	0.7	0.5	0.6	0.3	0.3	0.1	0.03	0.05	0.01	0.00
Q2-20 (2305)	2.7	1.3	1.0	1.0	0.9	0.8	0.8	0.7	0.6	0.6	0.5	0.5	0.5	0.3	0.2	0.1	0.03	0.04	0.01	0.0

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Medi-Cal Summary

- Grievances decreased by 16% from Q1 2020 to Q2 2020.
  - Quality of care grievances decreased by 34%.
  - Quality of service grievances decreased by 19%.
  - Billing grievances decreased by <1%.
- Non-medical transportation grievances decreased by 40%.
  - Utilization of rides decreased by 35%.
- Access related grievances increased by 4%, which was attributed to office closures during the COVID-19 emergency.

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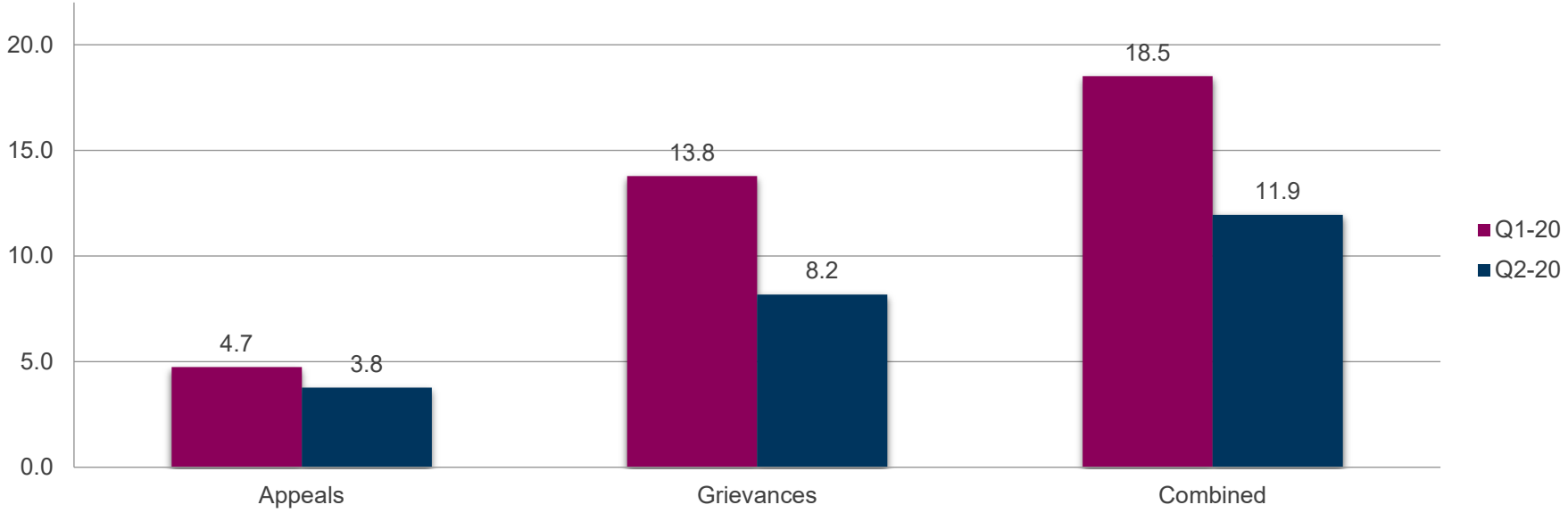
OneCare Connect Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2020	262	67	195	14,148
Q2-2020	171	54	117	14,318

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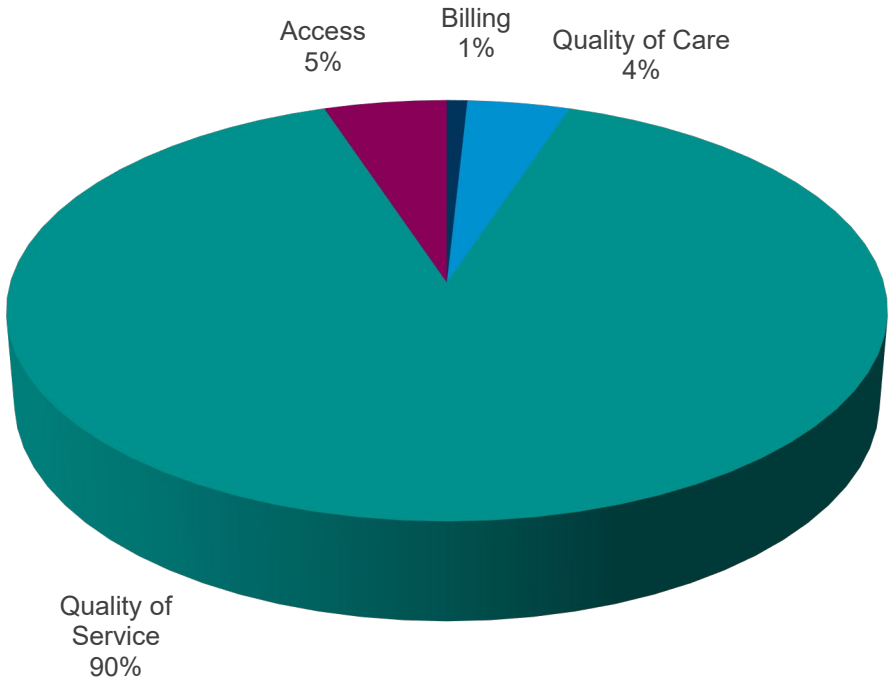
OneCare Connect Grievances by Category

- Top grievance types
  - Non-medical transportation (NMT) services
  - Primary care provider
  - Provider services



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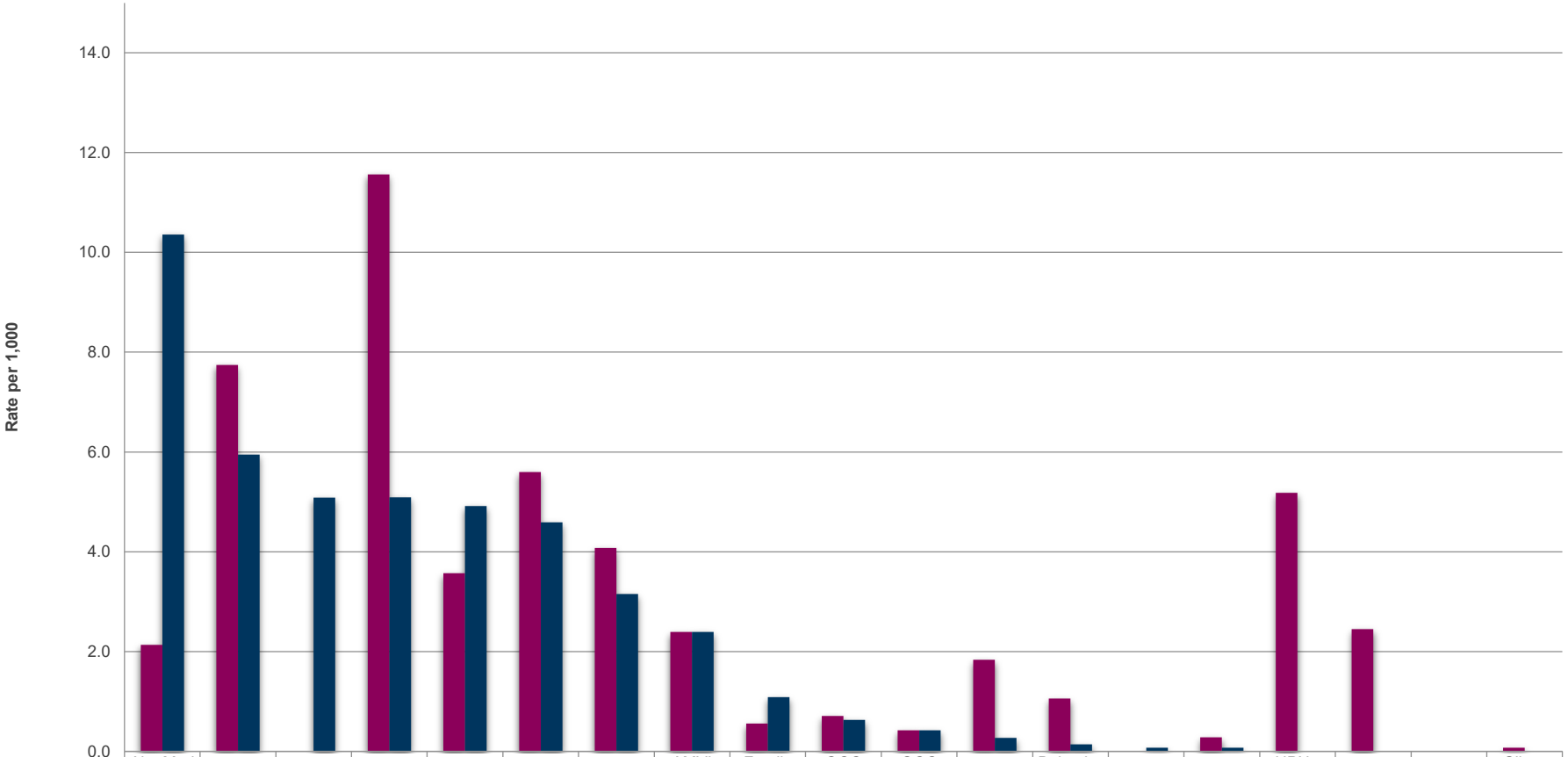
OneCare Connect Member Grievances Quarterly Rate/1,000



	Alta Med Health (483)	Monarch (4,538)	Arta (590)	CCN (1,963)	Prospect (2,239)	Talbert (1,090)	Veyo (10,469)	AMVI Care (418)	Family Choice (1,838)	OCC Ops (14,318)	OCC Pharm (14,318)	UCMG (3,709)	Behavioral Health (14,318)	Convey (14,318)	VSP (14,318)	HPN - Regal (190)	Noble (394)	MLTSS (14,318)	Silver and Fit (14,318)
Q1-20 (195)	2.1	7.7	0.0	11.6	3.6	5.6	4.1	2.4	0.6	0.7	0.4	1.8	1.1	0.0	0.3	5.2	2.5	0.0	0.1
Q2-20 (117)	10.4	5.9	5.1	5.1	4.9	4.6	3.2	2.4	1.1	0.6	0.4	0.3	0.1	0.1	0.1	0.0	0.0	0.0	0.0

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OneCare Connect Summary

- Grievances decreased by 40% from Q1 2020 to Q2 2020.
  - Billing grievances decreased by 67%.
  - Access grievances decreased by 60%.
  - Quality of service grievances decreased by 39%.
- Non-medical transportation grievances decreased by 60%.
  - Utilization of rides decreased by 40%.

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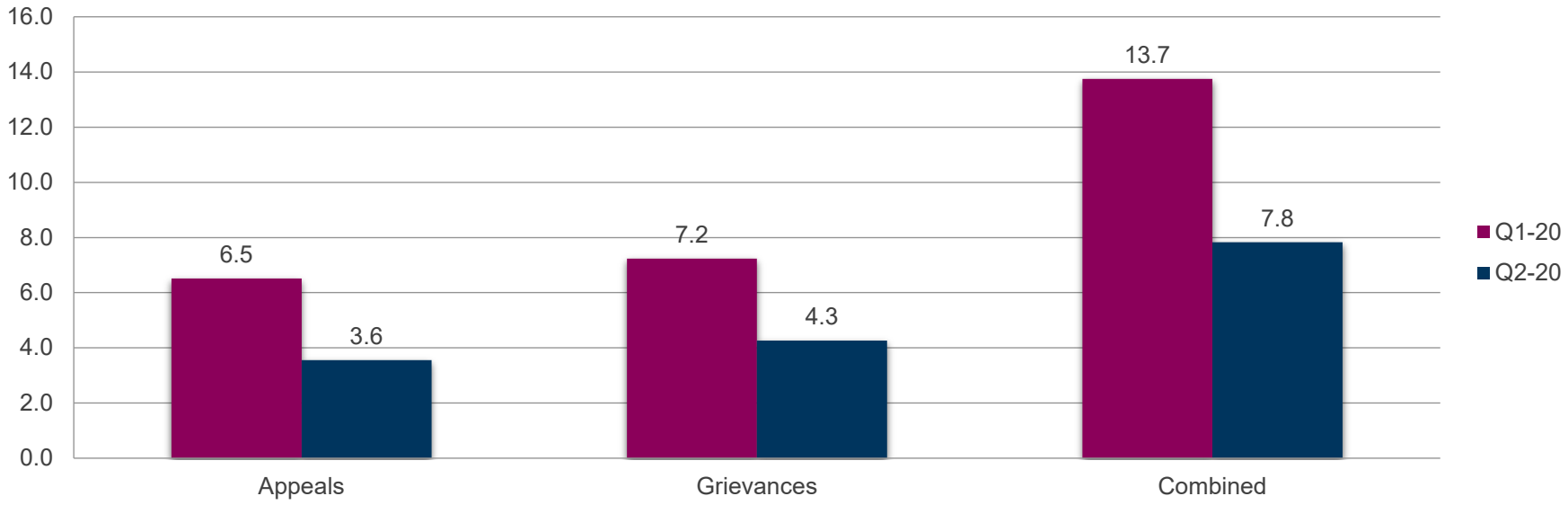
OneCare Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2020	19	9	10	1,382
Q2-2020	11	5	6	1,406

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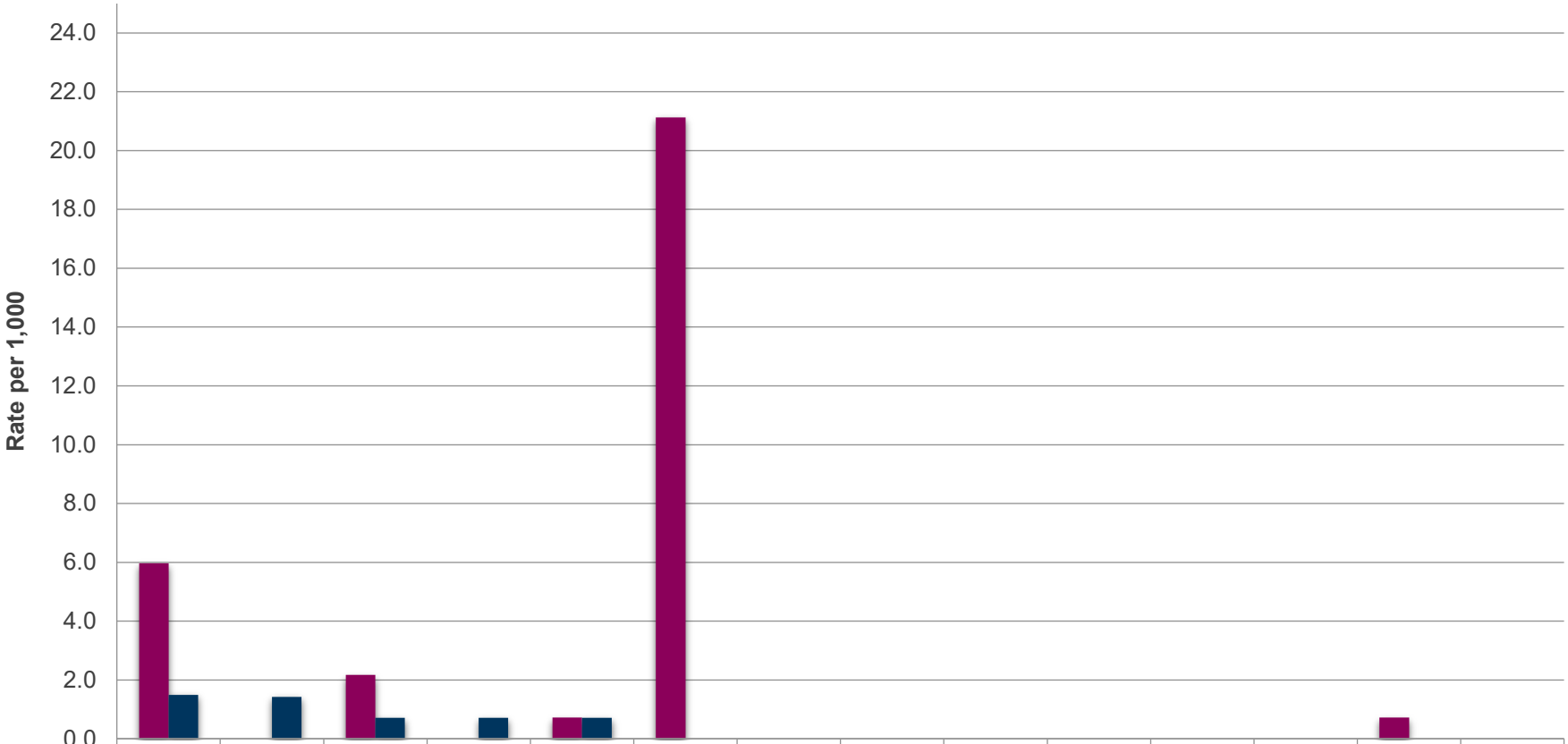
OneCare Member Grievances Quarterly Rate/1,000



	Monarch (672)	OC Operations (1,406)	OC Pharm (1,406)	Convey Health (1,406)	VSP (1,406)	Alta Med Health (58)	AMVI/ Prospect (256)	Arta Western (108)	Family Choice (86)	Noble (28)	Talbert (142)	UCMG (56)	Behavioral Health (1,406)	Veyo (194)
Q1-20 (10)	6.0	0.0	2.2	0.0	0.7	21.1	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.0
Q2-20 (6)	1.5	1.4	0.7	0.7	0.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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OneCare Summary

- Grievances remain relatively low
  - There was a 40% decrease (from 10 to 6) from Q1 2020 to Q2 2020.
- Grievances noted the following:
  - Pharmacy services/vendor
  - CalOptima staff/services
  - Provider demeanor
  - Billing

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Overall Interventions

- CalOptima continues to monitor the availability of providers to ensure adequate access to care.
- Members continue to be educated on how to contact CalOptima and get care.
- Grievance trends continue to be reviewed with the Quality Improvement department and shared with Provider Relations leadership for further action.
- Provider Relations staff continue outreach to providers with high grievance counts to provide awareness and education.

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Our Mission

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

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