



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

**WEDNESDAY, SEPTEMBER 21, 2016
5:30 P.M.**

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

Board of Directors' Quality Assurance Committee

Paul Yost, M.D., Chair
Ria Berger
Dr. Nikan Khatibi
Alexander Nguyen, M.D.

CHIEF EXECUTIVE OFFICER
Michael Schrader

CHIEF COUNSEL
Gary Crockett

CLERK OF THE BOARD
Suzanne Turf

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 under the 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 least 72 hours prior to the meeting at (714) 246-8806

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

CALL TO ORDER

Pledge of Allegiance
Establish Quorum

PUBLIC COMMENTS

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

CONSENT CALENDAR

1. Approve Minutes of the May 18, 2016 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS

2. Consider Recommending Board of Directors' Approval of Amendment to the Measurement Year 2016 Pay for Value Program Payment Methodology for Medi-Cal
3. Consider Recommending Board of Directors' Authorization to Expend Intergovernmental Transfer (IGT) 1 Funds to Expand the Child and Adolescent Components of the Shape Your Life Weight Management Program for CalOptima Medi-Cal Members and Contracts with Vendor(s) to Provide Weight Management Program Interventions
4. Consider Recommending Board of Directors' Approval to Distribute Provider Payments that Support Initiatives to Reduce 30-Day All Cause (Non Maternity Related) Avoidable Hospital Readmissions for Medi-Cal
5. Consider Recommending Board of Directors Approval of Amendment to the 2016 Quality Improvement Program Description Regarding Culturally Competent Access and Delivery of Services
6. Consider Recommending Revision to the FY 2016-17 Board of Directors' Quality Assurance Committee Meeting Schedule

INFORMATION ITEMS

7. Program of All-Inclusive Care for the Elderly (PACE) Member Advisory Committee Update
8. Intergovernmental Transfer (IGT) Update
9. PACE Year Three Preliminary Audit Results
10. Quarterly Reports to the Quality Assurance Committee
 - a. Quality Improvement Report
 - b. Member Trend Report

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS’
QUALITY ASSURANCE COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 18, 2016

CALL TO ORDER

Chair Viet Van Dang, M.D., called the meeting to order at 5:33 p.m., and led the Pledge of Allegiance.

Members Present: Viet Van Dang, M.D., Chair; Ellen Ahn; Tricia Nguyen

Members Absent: Theresa Boyd; Samara Cardenas, M.D.

Others Present: Michael Schrader, Chief Executive Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Suzanne Turf, Clerk of the Board

MINUTES

1. Approve the Minutes of the March 23, 2016 Special Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: On motion of Director Ahn, seconded and carried, the Committee approved the Minutes of the March 23, 2016 Special Meeting of the CalOptima Board of Directors’ Quality Assurance Committee as presented. (Motion carried 3-0-0; Directors Boyd and Cardenas absent)

PUBLIC COMMENTS

There were no requests for public comment.

REPORTS

2. Recommend Board of Directors’ Approval of Proposed Technical Changes to Policy GG. 1643: Minimum Physician Standards

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend Board of Directors’ approval of the proposed technical changes to Policy GG. 1643: Minimum Physician Standards. Certain technical language issues requiring modification or clarification were identified subsequent to Board approval of Policy GG.1643 in April 2016. The following proposed technical changes to the policy were presented for review: the deletion of the definition of Healthcare Delivery Organizations; replace the date placeholder with the intended policy effective date of July 1, 2016;

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remove references related to the inclusion of physician assistants; and clarify that Health Networks must ensure that physicians providing services to CalOptima members meet the Minimum Physician Standards. It was noted that the manner in which the Health Networks incorporate verification of the Minimum Physician Standards in their processes is left to their discretion.

Action: On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the proposed technical changes to Policy GG. 1643; Minimum Physician Standards as presented. (Motion carried 3-0-0; Directors Boyd and Cardenas absent)

INFORMATION ITEMS

3. PACE Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported that the PMAC met on April 25, 2016 and received a report from the PACE Director on the following topics: Secure Transportation will be adding another van to the PACE fleet due to the growth in PACE census; PACE is working with community providers to expand the network; and team education on patient-centered care. PMAC participant members discussed increasing physician hours at the center, and extended their thanks to PACE staff for the care received.

4. Behavioral Health Request for Proposal Update

Edwin Poon, PhD., Behavioral Health Services Director, presented an overview of Behavioral Health Services at CalOptima and the use of Managed Behavioral Health Organizations to provide expertise and specialization in the management of behavioral health benefits.

Terri Stanley, Executive Director of Clinical Operations, provided an update on the Behavioral Health RFP opportunities, including the potential to contract with one vendor for all services for better coordination among lines of business, operational efficiencies, administrative simplicity for providers and CalOptima, update contracts to align with current standards and requirements, and innovation and best practices. Key RFP evaluation metrics were reviewed with the Committee, including experience working with Medi-Cal and managed Medicare, NCQA accreditation, demonstrated success, operational efficiency and flexibility, and the ability to manage all lines of business and products. It is anticipated that the RFP will be issued in June 2016.

5. Quality Improvement Committee Update

Caryn Ireland, Executive Director, Quality and Analytics, presented an overview of Quality Improvement Committee activities for the first quarter, including cultural and linguistic services, disease management, case management, credentialing, and highlights of potential quality issues.

6. Member Experience Update

Kelly Rex-Kimmet, Quality and Analytics Director, presented an update on member experience scores in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. An enterprise-wide Member Experience Work Group was formed to identify the focus areas and implement strategies related to member satisfaction scores. Areas of focus are Rating of Health Plan, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service. A supplemental survey was developed and administered by CalOptima to approximately 26,000 members. Preliminary findings indicate that the supplemental survey results were higher than CAHPS

on the Rating of Health Plan, Rating of Doctor, and Rating of Health Plan; Getting Needed Care, Getting Care Quickly, and How Doctors Communicate were in line with CAHPS survey results. Further analysis is in progress regarding provider specific results and other qualitative analysis.

COMMITTEE MEMBER COMMENTS

Chief Executive Officer Michael Schrader extended his appreciation to Committee members for their dedication and service to the Board of Directors' Quality Assurance Committee.

ADJOURNMENT

Hearing no further business, Chair Dang adjourned the meeting at 6:43 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: September 21, 2016

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken September 21, 2016 **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

Report Item

2. Consider Recommending Board of Directors' Approval of Amendment to the Measurement Year 2016 Pay for Value Program Payment Methodology for Medi-Cal

Contact

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

Recommended Action

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

Background

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

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

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

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

Discussion

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

- Address the need to consider the complexity or member acuity (SPD compared to Non-SPD members) and the subsequent higher consumption of physician/health network resources to care for SPD members;
- Reward both performance and improvement;
- Improvement funding will be contingent upon CalOptima's overall improvement (New);

- Include both Adult and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and increase the value of these measures in the program, thereby expanding our focus on the member experience.

Population Included:	
	Total # of Children in Health Network
Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)	
Payment	
50% based on Performance score and 50% based on Improvement score Improvement score will be weighted by CalOptima's overall improvement	
	CAHPS Measures = 40% of the Total
Proposed Scoring for Measure Performance:	
<ul style="list-style-type: none"> • A relative point system by measure, based on: <ul style="list-style-type: none"> • NCQA National HEDIS Percentiles (clinical measures) • NCQA National CAHPS Percentiles (satisfaction measures) • Final score is the sum of points for each measure • Improvement score based on improvement from previous year (receiving 1 point for increasing each percentile level and negative 1 point for decreasing) 	

P4V Scoring - NEW	
Performance Points	
HEDIS	CAHPS
1 point: $\geq 50^{\text{th}}$ percentile 2 points: $\geq 75^{\text{th}}$ percentile 3 points: $\geq 90^{\text{th}}$ percentile No points $< 50^{\text{th}}$ percentile	1 point: $\geq 10^{\text{th}}$ percentile 50 th percentile 2 points: $\geq 33^{\text{rd}}$ percentile 75 th percentile 3 points: $\geq 66^{\text{th}}$ percentile 90 th percentile 4 points: $\geq 90^{\text{th}}$ percentile No points: $< 10^{\text{th}}$ percentile $< 50^{\text{th}}$ percentile
Improvement points for HEDIS & CAHPS	
<u>1 point for increasing 1 percentile level</u> (e.g. 1 point for 25 th percentile to 50 th percentile; 2 points for 50 th percentile to 90 th percentile, etc.) <u>Negative one (-1) point for decreasing 1 percentile level</u> (e.g. -1 point for 75 th percentile to 50 th percentile; -2 points for 50 th percentile to 10 th percentile, etc.)	<u>1 point for increasing 1 percentile level</u> (ex. 1 point for 10 th percentile to 33 rd percentile; 2 points for 10 th percentile to 66 th percentile, etc.) <u>Negative one (-1) point for decreasing 1 percentile level</u> (ex. -1 point for 66 th percentile to 33 rd percentile; -2 points for 66 th percentile to 10 th percentile, etc.)

Rev.
9/21/16

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

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

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

Distribution of Incentive Dollars

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

/s/ Michael Schrader
Authorized Signature

09/16/2016
Date



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Pay-for-Value 2016

**Board of Directors' Quality Assurance Committee Meeting
September 21, 2016**

Richard Helmer, M.D., Chief Medical Officer

Pay for *Value* - 2016

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

Medi-Cal P4V Clinical Measures

2016 Measurement Year Measures

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

MediCal P4V CAHPS Measures

2016 Measurement Year Measures

Child & Adult Measures

Getting Appointment with a Specialist

Timely Care & Service

Rating of PCP

Rating of all HealthCare

Introduced Display Measures

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

Payment Methodology

Population Included:

Total # of Adults in Health Network

Total # of Children in Health Network

Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)

Payment

50% based on Performance score and 50% based on Improvement score

Improvement score will be weighted by CalOptima's overall improvement

Clinical Measures = 60% of the Total

CAHPS Measures = 40% of the Total

Proposed Scoring for Measure Performance:

- A relative point system by measure, based on:
 - NCQA National HEDIS Percentiles (clinical measures)
 - NCQA National CAHPS Percentiles (satisfaction measures)
 - Final score is the sum of points for each measure
- Improvement score based on improvement from previous year (receiving 1 point for increasing each percentile level and negative 1 point for decreasing)

Recommended Scoring

P4V Scoring - NEW

Performance Points

HEDIS

1 point: $\geq 50^{\text{th}}$ percentile
 2 points: $\geq 75^{\text{th}}$ percentile
 3 points: $\geq 90^{\text{th}}$ percentile
 No points $< 50^{\text{th}}$ percentile

CAHPS

1 point: $\geq 40^{\text{th}}$ 50th percentile
 2 points: $\geq 33^{\text{rd}}$ 75th percentile
 3 points: $\geq 66^{\text{th}}$ 90th percentile
 4 points: $\geq 90^{\text{th}}$ percentile
 No points: $< 40^{\text{th}}$ 50th percentile

HEDIS & CAHPS Improvement points

1 point for increasing 1 percentile level
 (e.g. 1 point for 25th percentile to 50th percentile;
 2 points for 50th percentile to 90th percentile, etc.)

Negative one (-1) point for decreasing 1 percentile level
 (e.g. -1 point for 75th percentile to 50th percentile; -
 2 points for 50th percentile to 10th percentile, etc.)

1 point for increasing 1 percentile level
 (ex. 1 point for 10th percentile to 33rd percentile; 2
 points for 10th percentile to 66th percentile, etc.)

Negative one (-1) point for decreasing 1 percentile level
 (ex. -1 point for 66th percentile to 33rd percentile; -2
 points for 66th percentile to 10th percentile, etc.)

2016 MY OneCare P4P Clinical Measures

(Retire Program for MY2016)

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

OneCare Connect P4V Clinical Measures

2016 Measurement Year Measures – OneCare Connect

1. Plan All Cause Readmissions
2. Behavioral Health:
 - Antidepressant Medication Management
3. Blood Pressure Control
4. Part D Medication Adherence for Diabetes

Where Do We Go From Here?

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contact

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

Recommended Action

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

Background

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

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

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

Discussion

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

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

Medi-Cal Changes:

- All health networks will have performance measures for both adult and child care. This addresses the unique needs of children in all networks.
- Introduction of an “acuity” calculation to address the unique health needs in the populations.
- Addition of access to care measures:
 - Adults Access to Preventative/Ambulatory Care Services
 - Children’s Access to Primary Care Physicians
- Retirement of the “provider satisfaction with the health network and UM process” measure.
- The weighting of each domain in the Medi-Cal Pay for Performance program has been adjusted accordingly. Increased weighting has been allocated to member experience. This aligns with CalOptima’s increased focus on improving member experience.

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

OneCare:

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

OneCare Connect:

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

Windstone:

- Reinstate pay for value measures for Windstone Behavioral Health.

Distribution of Incentive Dollars

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

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

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

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

Attachments

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

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date

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

Adult Measures	2016 Measurement Year HEDIS 2017 Specifications Anticipated Payment Date: Q4 2017	Measurement Assessment Methodology
<p>Clinical Domain- HEDIS</p> <p>Weight: 60.00%</p> <p>SPD Weight 4.0</p> <p>TANF Weight 1.0</p>	<p>Prevention</p> <ul style="list-style-type: none"> Breast Cancer Screening (BCS) Cervical Cancer Screening (CCS) <p>Diabetes</p> <ul style="list-style-type: none"> HbA1c Testing Retinal Eye Exams <p>Access to Care:</p> <ul style="list-style-type: none"> Adults Access to Preventive/Ambulatory Care <p>Adult & Child Measure:</p> <ul style="list-style-type: none"> Medication Management for People with Asthma 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> NCQA National HEDIS Percentiles Percent improvement
<p>Patient Experience Domain- CAHPS</p> <p>Weight: 40%</p>	<p>Adult Satisfaction Survey</p> <ol style="list-style-type: none"> Getting Appointment with a Specialist Timely Care and Service Rating of PCP Rating of All Healthcare 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> NCQA National CAHPS Percentiles Percent improvement

Pediatric Measures	2016 Measurement Year HEDIS 2017 Specifications Anticipated Payment Date: Q4 2017	Measurement Assessment Methodology
Clinical Domain HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	Respiratory <ul style="list-style-type: none"> Medication Management for People with Asthma Appropriate Testing for Children with Pharyngitis (CWP) Appropriate Treatment for Children with Upper Respiratory Infection (URI) Prevention <ul style="list-style-type: none"> Childhood Immunization Status Hepatitis Combo 10 (CIS) Well-Care Visits in the 3-6 Years of Life (W34) Adolescent Well-Care Visits (AWC) Access to Care <ul style="list-style-type: none"> Children's Access to Primary Care Physicians 	A relative point system by measure based on: <ul style="list-style-type: none"> NCQA National HEDIS Percentiles Percent improvement
Patient Experience Domain-CAHPS Weight: 40%	Child Satisfaction Survey (Child CAHPS) <ol style="list-style-type: none"> Getting Appointment with a Specialist Timely Care and Service Rating of PCP Rating of All Healthcare 	A relative point system by measure based on: <ul style="list-style-type: none"> NCQA National CAHPS Percentiles Percent improvement

Windstone Behavioral Health

Calculations for these measures will be the responsibility of CalOptima.

Measures	Allocation CY 2016	Data Source	Anticipated Payment Date	Benchmark
Quality of Care				
1. Follow-up After Hospitalization for Mental Illness <ul style="list-style-type: none"> Follow-up Visit after 7 days Follow-up Visit after 30 days 	\$15,000 <ul style="list-style-type: none"> 50% at 50th percentile- 100% if score is at or above 75th percentile \$15,000 <ul style="list-style-type: none"> 50% at 50th percentile 	HEDIS 2017	October 2017	Most current NCQA Quality Compass Medicare Percentiles
2. Reduction in ED use for Seriously Mentally Ill and Substance Use Disorders	\$30,000	CA State Defined Measure	October 2017	Significant improvement based on CMS methodology.

OneCare Connect	2016 Measurement Year Anticipated Payment Date: (Q4)	Measurement Assessment Methodology
<p>Clinical Domain Weight:100%</p> <p>Each measure weighted equally</p>	<p>Measures:</p> <ul style="list-style-type: none"> • Plan All Cause Readmissions • Antidepressant Medication Management Outcome Measures: • Blood Pressure Control • Part D Medication Adherence for Diabetes 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA National HEDIS Percentiles • Percent improvement <p>For the Part D Medication Adherence Measure:</p> <p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • CMS Star Rating Percentiles • Percent improvement

Participation in Quality Improvement Initiatives

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

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

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

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

MEASUREMENT DETAILS:

I. Clinical Domain (HEDIS measures)

Program Specific Measurement Sets

Performance measures were selected as appropriate per program based on the following criteria:

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

Criteria

The following criteria were considered in selecting these indicators:

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

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

Incentive Measure Definition

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

II. Customer Satisfaction

Member Satisfaction

Background

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

Survey Methodology

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

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

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



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2016 Pay For Value Programs

Board of Directors Meeting

April 7, 2016

Richard Bock, M.D.

Deputy Chief Medical Officer

Pay for Performance - Current

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

Pay for *Value* - 2016

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

Medi-Cal P4V Clinical Measures

2016 Measurement Year Measures

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

MediCal P4V CAHPS Measures

2016 Measurement Year Measures

Child and Adult Measures

Getting Appointment with a Specialist

Timely Care & Service

Rating of PCP

Rating of all HealthCare

Introducing Display Measures

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

Payment Methodology

Population Included:

Total # of Adults in Health Network

Total # of Children in Health Network

Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)

Proposed Scoring for Measure Performance:

A relative point system by measure, based on:

- NCQA National HEDIS Percentiles (clinical measures)
- NCQA National CAHPS Percentiles (satisfaction measures)
 - Percent Improvement year over year

Final score for each measure is determined by weight and acuity

Clinical Measures = 60% of the Total

CAHPS Measures = 40% of the Total

2016 MY OneCare P4P Clinical Measures

(Retire Program for MY2016)

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

OneCare Connect P4V Clinical Measures

2016 Measurement Year Measures – OneCare Connect

1. Plan All Cause Readmissions
2. Behavioral Health:
 - Antidepressant Medication Management
3. Blood Pressure Control
4. Part D Medication Adherence for Diabetes

OneCare Connect P4V: Windstone Behavioral Health

2016 Measurement Year Measures – Windstone

1. Follow-up After Hospitalization for Mental Illness:
 - Follow-up Visit after 7 days
 - Follow-up Visit after 30 days
2. Reduction in Emergency Department use for Seriously Mentally Ill and Substance Use Disorders (per CMS-defined standards)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken September 21, 2016 **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

Report Item

3. Consider Recommending Board of Directors' Authorization to Expend Intergovernmental Transfer (IGT) 1 Funds to Expand the Child and Adolescent Components of the Shape Your Life Weight Management Program for CalOptima Medi-Cal Members and Contracts with Vendor(s) to Provide Weight Management Program Interventions

Contact

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

Recommended Actions

Recommend that the Board of Directors authorize:

1. The expenditure of \$500,000 in Intergovernmental Transfer (IGT) 1 funds to expand the child and adolescent component of the Shape Your Life weight management program for CalOptima Medi-Cal members; and
2. The CEO to contract with the vendor(s) selected through an RFP process to provide group-based child and adolescent Shape Your Life program interventions.

Background

Childhood obesity is a growing national epidemic that has more than doubled in children and quadrupled in adolescents in the past 30 years. Overweight and obesity in childhood are known to have significant impact on both physical and psychosocial health. In 2014, an average of 33% of Orange County students in 5th, 7th, and 9th grades were overweight or obese, compared to 38% statewide. In 2011-2012, 32% of Orange County adults were overweight, in addition to 23% identified as obese. Weight status has worsened in Orange County, decreasing from 50% of adults with a healthy weight in 2001 to only 43% in 2011-2012.

Discussion

CalOptima's takes a population management approach towards addressing obesity. Clinical practice guidelines serve as the foundation of the program. These guidelines provide direction for medically-based prevention and treatment protocols within the program. The child and adolescent component of the Shape Your Life program has adopted the clinical practice guidelines entitled "Prevention, Assessment and Treatment of Childhood Obesity: Recommendations from the AMA Expert Committee on Childhood Obesity, June 2007". The main tenet of these guidelines is that a staged approach should be used in the treatment of childhood obesity. This incremental approach begins with health education and moves to structured weight management programs.

Staff has completed a comprehensive evaluation of CalOptima's program and identified many opportunities for improvement, including revising the program's structured weight management interventions for children due to the interventions' high costs, low member penetration and limited geographical access. As a result, staff has redesigned the child and adolescent evidenced-based core

curriculum for our community, group-based weight management interventions, refined our risk stratification and rebranded our entire obesity program "Shape Your Life." The program currently provides health education materials to all its members and has outreached to all CalOptima primary care physicians (PCPs) to share the evidenced-based treatment recommendations, as well as tools to aid in the office-based treatment of childhood and adult obesity.

The Board allocated \$500,000 of IGT 1 funds for high risk children programs at its March 6, 2014, meeting. Of these allocated funds, none have been expended to date. Staff believes these funds are best used to expand the child and adolescent components of the redesigned Shape Your Life program.

Staff proposes to use \$150,000 on the group-based weight management childhood obesity interventions, \$100,000 for member and provider incentives and up to \$250,000 over two years to hire new staff to manage this expansion.

Child and Adolescent Group-Based Interventions: \$150,000

For the proposed child and adolescent group-based weight management interventions, staff plans to use the RFP process to find and contract with vendors who can provide these services countywide to our child and adolescent Medi-Cal members. The proposed intervention will be 6-8 group-based visits with nutritional, exercise and healthy habit components.

Incentives: \$100,000

A proposed distribution approach for the member and provider incentives are presented below. However, actual payment and methodology will be finalized based on funds available, DHCS approval of member incentive plan and participant engagement. Member incentive goals will be established by CalOptima. The goals will be based on completing 6-8 group-based visits, completing a pre and post-program PCP assessment and behavior modification achievements as measured by a validated questionnaire. Provider incentives will be established by CalOptima and will be based on program referrals, pre-intervention program assessments and post-intervention assessments.

Member

- \$50 for achievement of program process and outcome goals.
- \$25 for post-program office visit.

Provider

- \$25 for program referral and member assessment.
- \$50 for post-program office visit and reassessment.

Staffing: \$250,000

Staff proposes the use of up to \$250,000 over two years to hire one new project manager that will help in the expansion of the child and adolescent components of the Shape Your Life program. As proposed, the staff duties will include:

1. Evaluating the vendors who respond to the RFP
2. Developing rates for the community, group-based child and adolescent weight management interventions

3. Providing technical assistance to vendors across the county as needed
4. Developing, managing and evaluating the child and adolescent "Shape Your Life" member and provider incentives
5. Continuously evaluate the vendors, interventions and the incentive programs

At the conclusion of the two years, staff will transition the remaining ongoing duties of the project manager to budgeted staff positions.

Fiscal Impact

The recommended action to authorize use of \$500,000 in currently available IGT 1 funds to expand CalOptima's Shape Your Life program is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Childhood obesity is a growing epidemic that affects more than 48,000 children enrolled in CalOptima's Medi-Cal program. Although health plans are not the only stakeholder in this national epidemic, CalOptima recognizes that it plays a critical role in combating this important issue.

Early intervention can assist children in achieving and maintaining appropriate BMI levels. These interventions may prevent complications such as hyperlipidemia, hypertension, diabetes, and other chronic conditions associated with obesity. The IGT funds will be used to expand the newly redesigned child and adolescent components of the CalOptima Shape Your Life program with a focus on evidence-based interventions and outcomes.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Power Point Presentation – "Shape Your Life" Expansion
2. Board Action dated March 6, 2014, Approve Final Expenditure Plan for Use of FY 2010-11 IGT Funds; Approve Expenditure Plan for Use of FY 2011-12 IGT Funds; Authorize the CEO to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

/s/ Michael Schrader
Authorized Signature

09/16/2016
Date



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“Shape Your Life” Expansion

**Board of Directors’ Quality Assurance Committee Meeting
September 21, 2016**

Dr. Miles Masatsugu, Medical Director

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

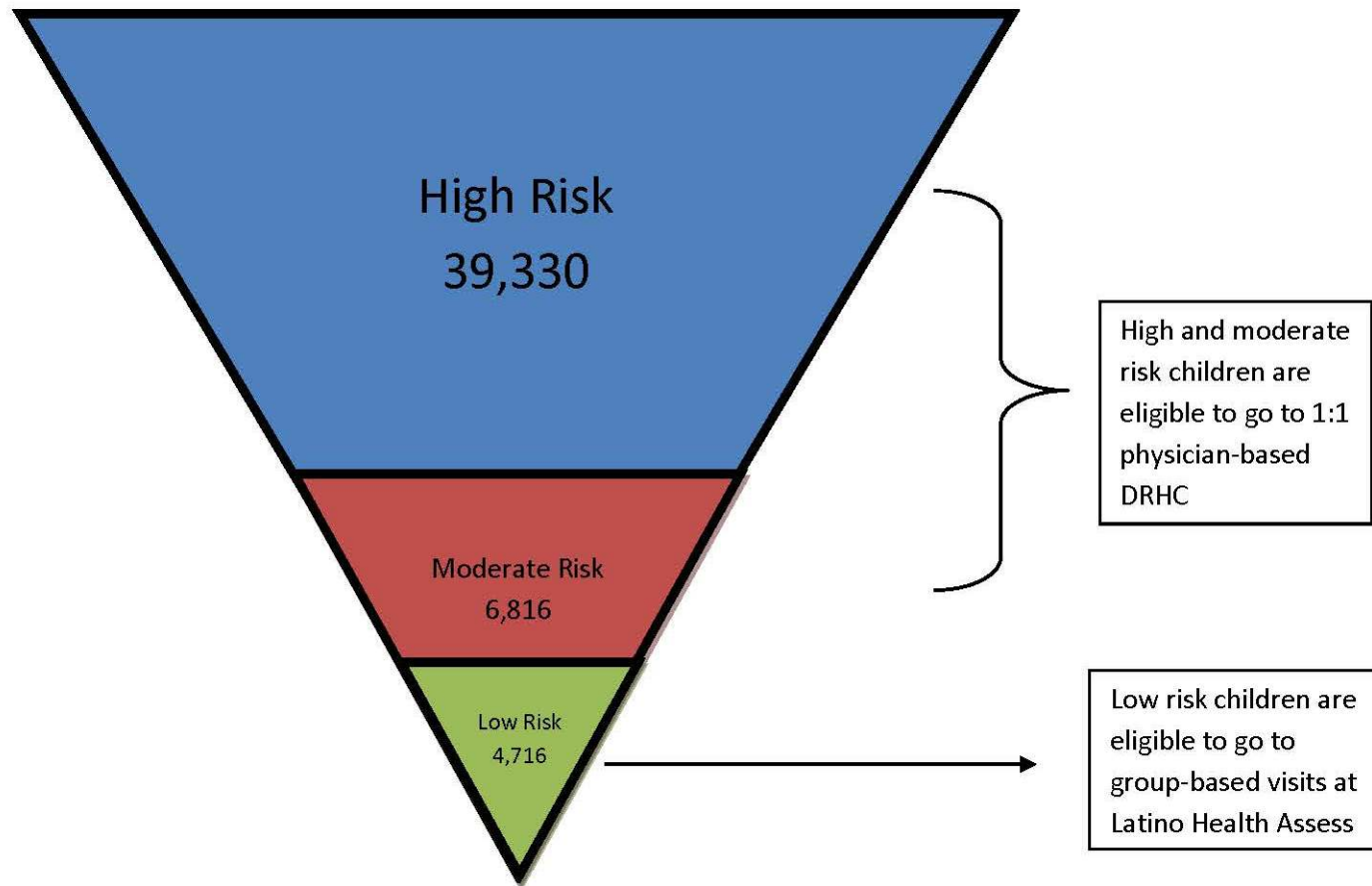
Roadmap

- Completed a comprehensive assessment of our obesity programs
- Redesigned our entire obesity program
 - Rebranded the program “Shape Your Life”
 - Refined our obesity risk stratification
 - Developed an evidenced-based core curriculum for our obesity interventions
 - Refined our evidence-based outcome metrics for our obesity interventions
- Expansion
- Evaluation and further refinement

Assessment Findings

- Evidence **is not yet conclusive** on the long term benefits of intensive short term interventions.
- However, evidence-based recommendations on the prevention and treatment of childhood obesity have been made and endorsed by the CDC, AAP and AMA
- Limited provider understanding of evidence-based recommendations
- Providers and members alike would like to know what resources exist in the community and what is offered through CalOptima
- **Access is an issue** for our members due to limited intervention sites and lack of knowledge of the interventions offered by CalOptima by both its providers and members.

Assessment Findings: Risk Stratification Data Upside Down



Assessment Findings:

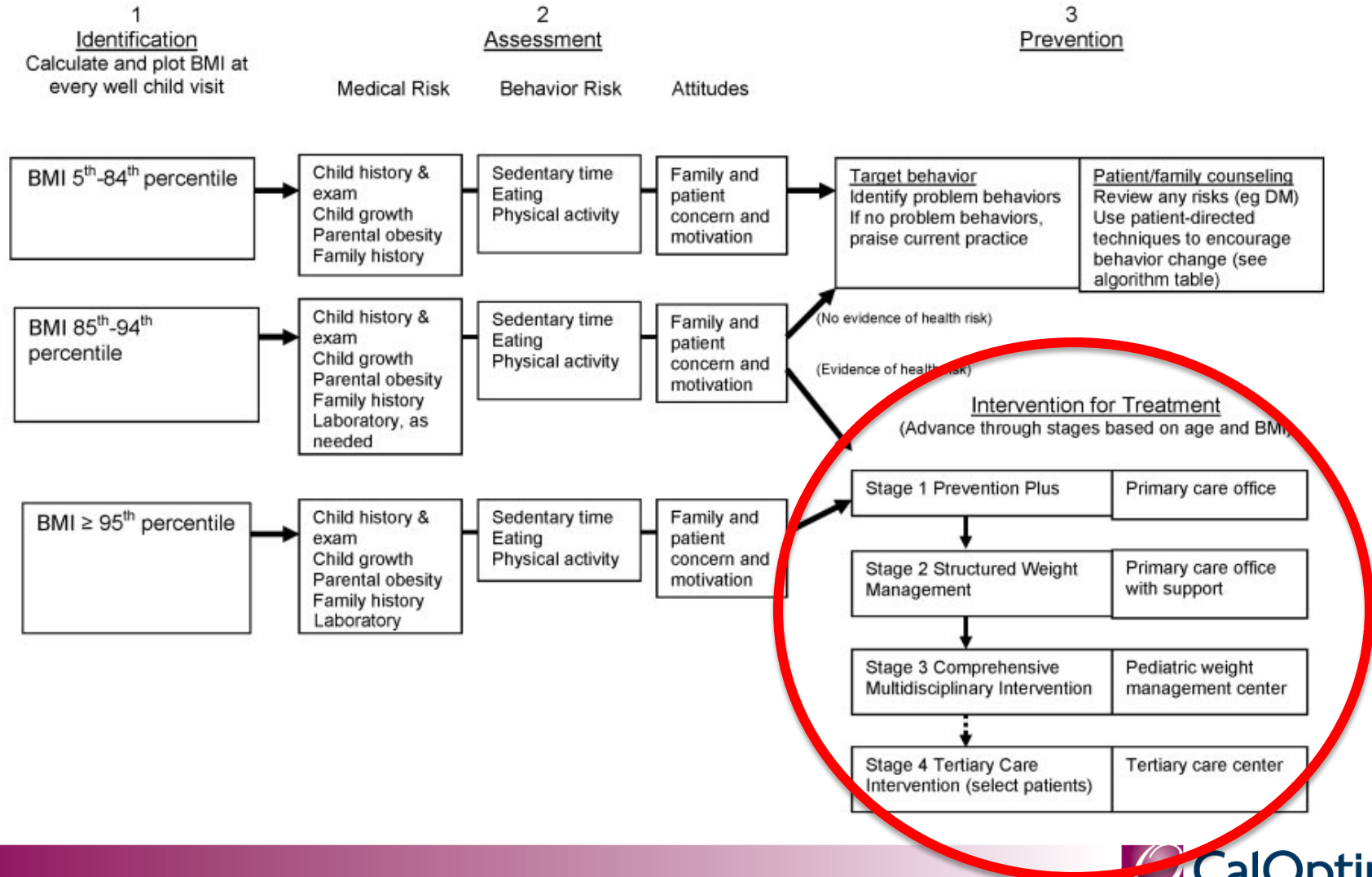
Penetration Low and Costs High

		2012-2013	2013-2014	% Increase Year Over Year
Dr. Riba's Health Club	Members	361	666	84%
Medium and High Risk	Visits	1,165	2,325	99.6%
Members	Costs	\$130,020	\$263,200	102.4%
	Cost per Member	\$364.20	\$395.13	7.8%
		2012-2013	2013-2014	% Increase
Latino Health Access	Members	100	115	15%
Low Risk	Visits	764	843	10.3%
Members	Costs	\$76,472	\$85,788	12.1%
	Costs per Member	\$764.72	\$745.98	-2.5%

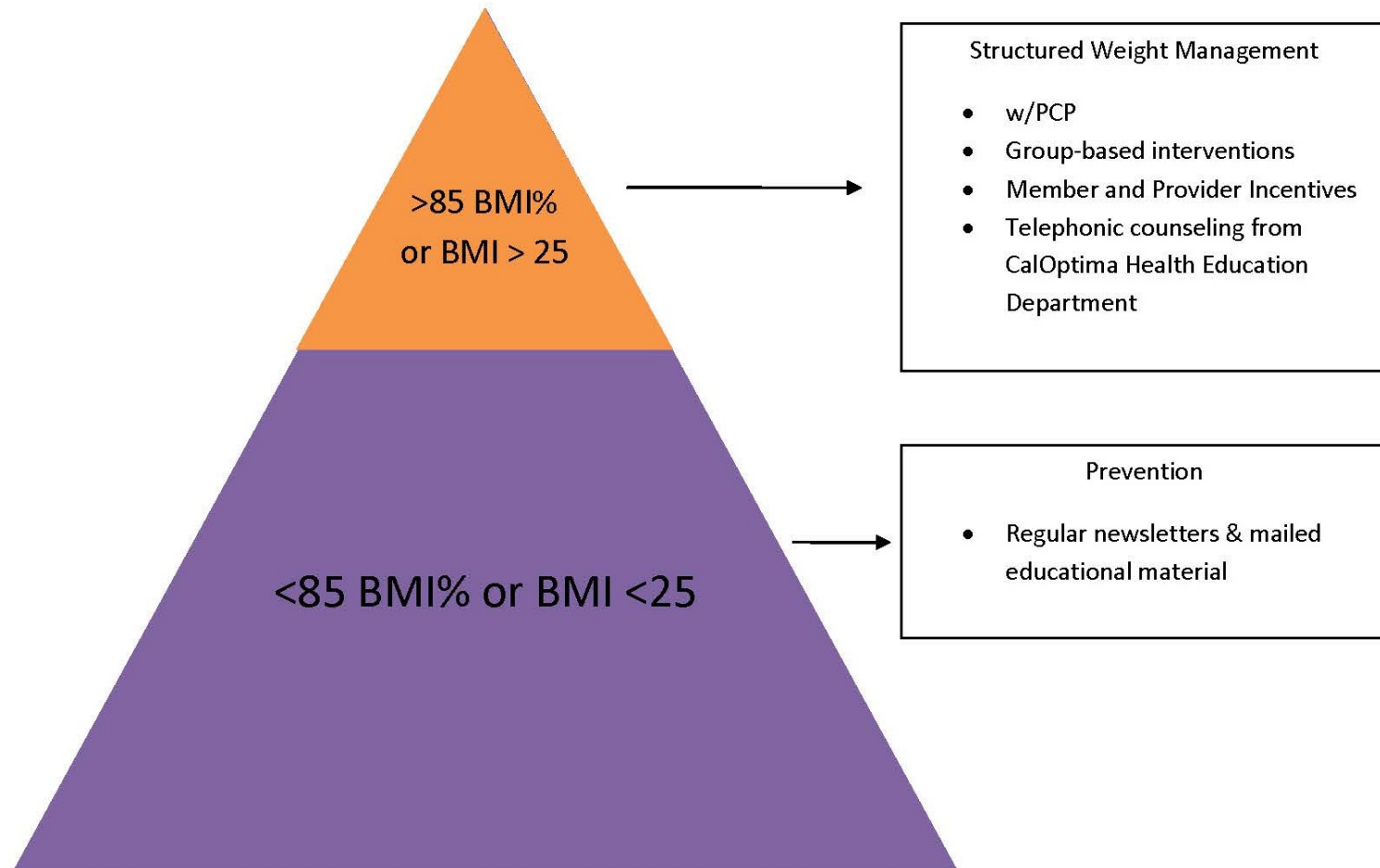
Rebranded Obesity Program



Adopted the Expert Committee Recommendations for the Assessment, Prevention, and Treatment of Childhood Obesity by Childhood Obesity Action Network (COAN) Evidenced-Based Recommendations



Refined New Risk Stratification



Redesigned Interventions (Implemented)

- Entire Population
 - Healthy Alert
 - Quarterly newsletter w/healthy recipes, tips for parents, teens and children, informed about other services for eligible members
- Group-Based Interventions
 - Assessing member readiness for behavior modification prior to authorization
 - Streamlined referral process
 - Supportive tools and local resources mailed to members to support group-based education intervention model
 - Evaluated existing vendor contracts

Redesigned Interventions (Not Implemented)

- Member incentives to improve children's participation in group-based interventions and reaching outcome goals
- Provider incentives to improve the assessments, referrals and post-program reassessments of overweight and obese children
- Expand the group-based educational intervention for children countywide

Proposed Next Steps

- Request Board authorization to expend the \$500,000 in allocated IGT funds
- Request for Proposal (RFP) to find vendors who can provide the group-based intervention
- Hire project manager
- Develop Member and Provider Incentives
- Contract with vendors and expand intervention countywide
- Ongoing evaluation of interventions and incentive programs

Project Manager Duties

- Evaluate the vendors who respond to the RFP
- Provide technical assistance to vendors as needed
- Develop, manage and evaluate the child and adolescent “Shape Your Life” member and provider incentives
- Develop, manage and evaluate the child and adolescent “Shape Your Life” group-based interventions

Proposed Member and Provider Incentives

Member

- \$50 for achievement of program process and outcome goals*
- \$25 for post-program office visit*

Provider

- \$25 for program referral and member assessment*
- \$50 for post-program office visit and reassessment*

*Actual payment and methodology will be finalized based on funds available, DHCS approval of member incentive plan and participation engagement

Proposed IGT Expenditures to Expand “Shape Your Life”

- Use up to \$250,000 to add a new staff member for up to two years to implement and manage the program expansion
- \$100,000 to support member & provider incentives
- \$150,000 to pay new vendors for group-based intervention services

Recommended Board Action

- Recommend Board of Directors' authorize the expenditure of \$500,000 in Intergovernmental Transfer (IGT) 1 funds to expand the child and adolescent component of the Shape Your Life program for CalOptima Medi-Cal members.
- Recommend authorizing the CEO to contract with the vendors selected through the RFP process to provide the group-based child and adolescent Shape Your Life program interventions.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VI. C. Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve final expenditure plan for \$12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds;
2. Approve expenditure plan for \$7.4 Million in FY 2011-12 IGT funds;
3. Authorize the CEO to initiate the required process for FY 2012-13 IGT and execute the required application documents consistent with Board approved terms.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date. The two transactions are summarized below:

- IGT 1 was authorized by the CalOptima Board on March 3, 2011, and covers the claiming period of Fiscal Year (FY) 2010-11. CalOptima retained \$12.4 Million, UCI retained \$8.4 Million, and the state disbursed the funds in August 2012.
- IGT 2 was authorized by the CalOptima Board on March 7, 2013 for the FY 2011-12 claiming period. CalOptima retained \$7.4 million, UCI retained \$4.8 Million, and the state disbursed the funds in June 2013.

IGTs are transfers of public funds between governmental entities. The revenue generated through the CalOptima /UCI IGTs must be used to finance improvements in services for Medi-Cal beneficiaries. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives for Medi-Cal beneficiaries.

The present item seeks: 1) authorization to adjust the expenditure plan for IGT 1 to reflect the final funding distribution needed to fully implement the approved uses; 2) approval of the proposed expenditure plan for IGT 2; and 3) authorization to initiate the process to secure a third IGT.

Discussion

Final Expenditure Plan for IGT 1

On March 7, 2013, the CalOptima Board approved the following expenditure plan for IGT 1:

Table 1. Approved Expenditure Plan for IGT 1	Budget
Complex Case Management – Part 1 <ul style="list-style-type: none"> Case management for high-risk members across various care settings 	Year 1: \$5.1M Year 2: \$4.2M
Complex Case Management – Part 2 <ul style="list-style-type: none"> Improved health network documentation of clinical needs 	Year 1: \$1.8M Year 2: \$200K
Expanded Access Pilots <ul style="list-style-type: none"> Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points 	Year 1: \$450K Year 2: \$650K
Total Budget	\$12.4 M

As reported at the February 2014 CalOptima Board meeting, recent data analyses indicate that the need for improved health network documentation of clinical needs (i.e., Complex Case Management – Part 2 in the above table) is not consistent among the networks, and thus will not require the entire budgeted amount. At the same time, full implementation of the uses proposed under Complex Case Management – Part 1, including reimbursement of health networks for enhanced care coordination, requires more funding than originally budgeted. To allow for greater efficiency and ensure that funds are used most effectively, staff recommends merging the two Complex Case Management budget categories, as reflected in Table 2 below.

Table 2. Final Expenditure Plan for IGT 1	Budget
Complex Case Management <ul style="list-style-type: none"> Case management for high-risk members across various care settings, including improved documentation of clinical risk 	Year 1: \$6.9M Year 2: \$4.4M
Expanded Access Pilots <ul style="list-style-type: none"> Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points 	Year 1: \$450K Year 2: \$650K
Total Budget	\$12.4 M

Proposed Expenditure Plan for IGT 2

As previously stated, CalOptima retained \$7.4 million from the second IGT. Per the state's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must be used for any of three Board-approved general purposes:

1. Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care;
2. Continue and/or expand on services and initiatives developed with FY 2010-11 IGT funds; and/or
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health, preventive dental services and supplies, and incentives to encourage members to participate in preventive health programs.

Based on an analysis of current and emerging priorities, staff proposes the budget allocation plan presented in the attached presentation and summarized below:

Table 3. Proposed Expenditure Plan for IGT 2	Budget
Enhancement of Core Data Systems	\$3.0 M
Continuation/Expansion of IGT 1 Initiatives	\$3.0 M
Wraparound Services/Optional Benefits to Address Critical Gaps	\$1.4 M
Total Budget	\$7.4 M

Proposed FY 2012-13 IGT

UCI has notified CalOptima of its interest to secure a third IGT for FY 2012-13. The Department of Health Care Services (DHCS) is in the process of calculating the amount of funds that would be available for this transaction. Authorization is requested to begin working with UCI to determine feasibility of securing a third IGT under the same general terms as the prior two IGTs, and to initiate the process. If IGT 3 is secured, funds will be applied to uses consistent with the categories outlined in Table 3 above.

Fiscal Impact

The recommended action is to be funded from DHCS capitation receipts which are currently reserved. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. It should be noted that the proposed expenditures under IGTs 1 and 2 are aligned with many of the system improvements required in response to the recent CMS audit.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

CalOptima Board Action Agenda Referral
Approve Final Expenditure Plan for Use of FY 2010-11 IGT
Funds; Approve Expenditure Plan for Use of FY 2011-12 IGT
Funds; Authorize the CEO to Initiate Required Process for
FY 2012-13 IGT Funds and Execute the Standard Required
Application Documents
Page 4

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

2/28/2014
Date



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Intergovernmental Transfers (IGT)

Board of Directors Meeting
March 6, 2014

Ilia Rolon
Director, Strategic Development



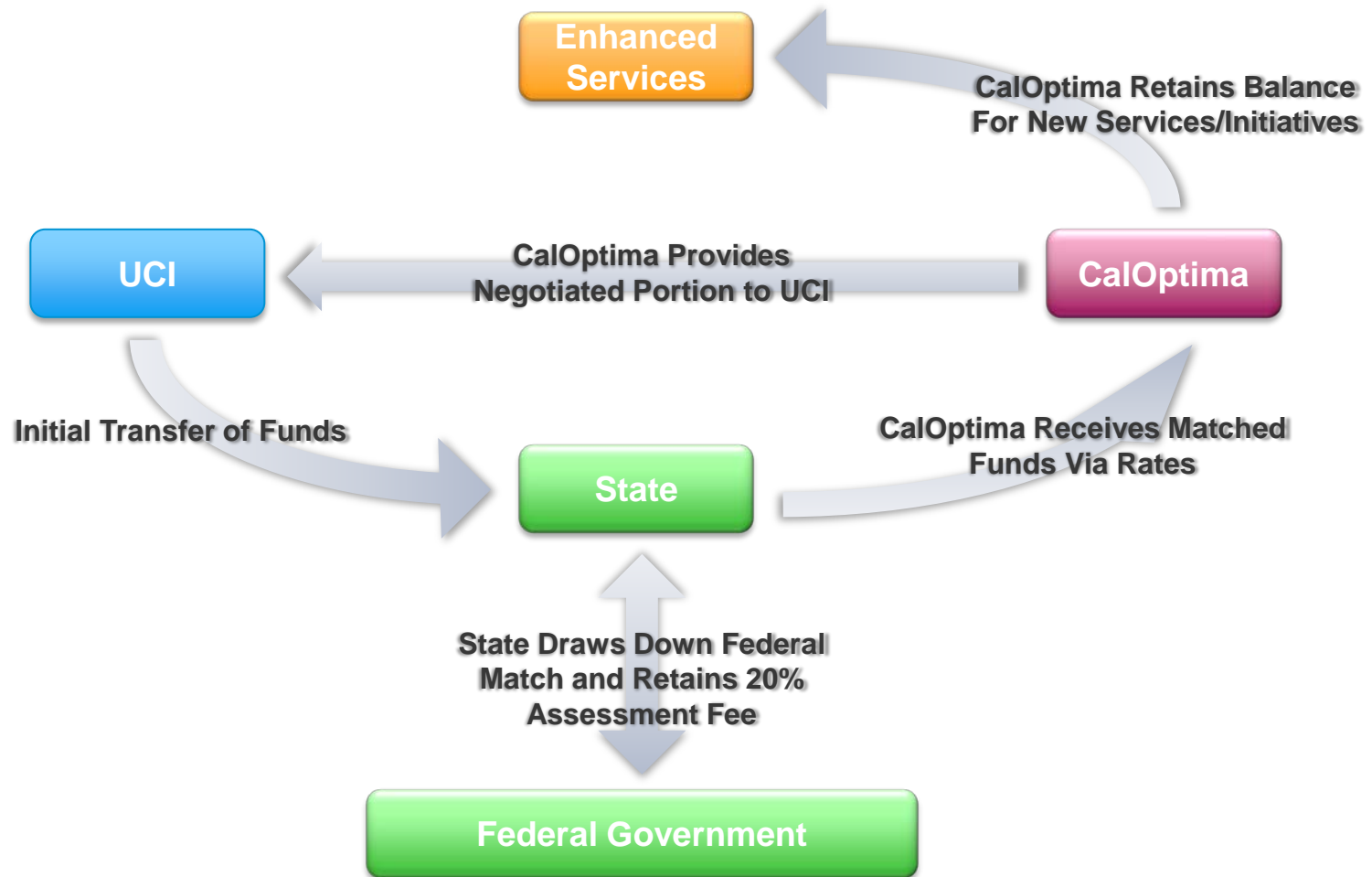
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Background

About IGTs

- Intergovernmental Transfers (IGTs) are transfers of public funds between governmental entities
- Extensive precedent of IGTs among managed care plans in California
- California managed care plans have historically saved state/federal governments millions in health care costs
 - Federal Medical Assistance Percentage (FMAP): Amount of federal match for states' expenditures on social, medical services
 - California: 50%
 - Mississippi: 73%
- IGTs are a means of leveling the field and ensuring continued investment in our healthcare systems

IGT Transaction Overview



Use of Funds

- Revenue must be used to finance improvements in services for Medi-Cal beneficiaries
- No guarantee of future IGT agreements -- thus funds are best suited for one-time investments or as seed capital for new services or initiatives
- Budgeted uses for current IGTs are consistent with system improvements that will support successful response to OneCare audit
- Agreements are silent on deadline for use of funds

IGTs Received to Date

Funding Source	Claim Year	Year Received	CalOptima Amount	UCI Amount	State Amount	Total
IGT 1	FY 10-11	2012	\$12.4 M	\$8.4 M*	\$3.1 M	\$23.9 M
IGT 2	FY 11-12	2013	\$7.4 M	\$4.8 M	\$5.4 M	\$17.6 M
Total Funds			\$19.8 M	\$13.2 M	\$8.5 M	\$41.5 M

- IGT 1 included a one-year community vetting process; proposed uses for IGTs 2 and 3 are consistent with results of this earlier process
- Status of IGT Year 1 expenditures: \$2 M contract award for new case management system; agreements with health networks for approximately \$2 M in funding for personal care coordinators pending

* UCI's net revenue was \$3.4 Million due to exclusion from approximately \$5.0 million in state disproportionate share (DSH) payments



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Proposal

IGT 1 Expenditure Plan

Proposed Uses	Year 1	Year 2	Impacted Programs	Timing	Description
Complex Case Management I	\$5.1 M	\$4.2 M	—	—	
Personal Care Coordinators	\$1.85 M	\$1.95 M	CMC	CY 14	Additional PMPM line item payment to networks
Case Management System	\$2.0 M	\$0	All	CY 14	Replace existing case management system
Strategies to Reduce Readmission	\$1.0 M	\$2.0 M	MC, CMC OneCare	CY 14	Post-discharge follow up; transitions of care
Program for High-Risk Children	\$250 K	\$250 K	MC	FY 14/15	Services for children affected by both obesity and asthma
Complex Case Management II	\$1.8 M	\$200,000	N/A	N/A	Merge this category with CCM 1
Access Strategies	\$450,000	\$650,000	—	—	
e-Referral/ Telemedicine	TBD	TBD	All	CY 14	Dermatology project in development
Total Funds	\$7.35 M	\$5.05 M			

Proposed IGT 2 Expenditure Plan

CMS and CalOptima Board Approved Categories	Proposed Allocation	
Enhanced Core Systems <ul style="list-style-type: none"> • Facets system upgrade and reconfiguration • Provider network management solution • Security audit remediation • Funding to continue COREC services for two years 	\$3.0 M	
Continued / Expanded IGT 1 Services <ul style="list-style-type: none"> • Personal care coordinators • Strategies to reduce hospital readmissions 	\$3.0 M	
Wraparound Services & Optional Benefits <ul style="list-style-type: none"> • To be developed further. • May include: school-based vision and dental services for children; recuperative care for homeless members discharged from hospital; and/or backfilling Medi-Cal cuts to payments and/or benefits. 	\$1.4 M] 60% for direct services
Total Funds	\$7.4 M	

Next Steps

- Execute approved expenditure plan for IGT 1
- Begin implementation of IGT 2 funded activities
- Initiate process to explore feasibility of securing third IGT
- Periodic Board updates on progress

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 21, 2016 **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

Report Item

4. Consider Recommending Board of Directors' Approval to Distribute Provider Payments that Support Initiatives to Reduce 30-day All Cause (Non Maternity Related) Avoidable Hospital Readmissions for Medi-Cal

Contact

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

Recommended Actions

1. Recommend Board of Directors' approval to distribute 30 day all cause (non maternity related) avoidable readmission reduction program for Medi-Cal incentive payments to the highest performing health networks and hospitals; and
2. Recommend discontinuing Readmission Program.

Background

At its March 6, 2014 meeting, the CalOptima Board of Directors heard and approved staff's recommendation for a 30 day all cause (non maternity related) avoidable readmission reduction program for Medi-Cal. The following program parameters and payment methodology were included in the initial request.

Measurement Periods and Criteria for Reimbursement

The first year measurement period for this project began July 1, 2014 and ended June 30, 2015. The second year measurement period began July 1, 2015 and ended June 30, 2016. The proposed hospital and health network performance incentive, if paid, will be paid in October following the respective measurement period.

For a hospital to be eligible the hospital must be contracted with CalOptima through the respective measurement and payment distribution period with the performance parameters discussed below.

For a health network to be eligible they must also be in good standing with CalOptima, be contracted with CalOptima through the respective measurement and distribution period with the performance parameters described below, and be without changes in risk assignment (e.g., Shared risk group changing to HMO or PHC arrangement). Current HMO and PHC exclusions include Kaiser, CHOC, AMVI and Family Choice).

Provider Performance Incentives

A proposed distribution was presented at the February 19, 2014 Quality Assurance Committee meeting and is presented again below for reference.

- 100,000 for health network with lowest readmission rate (dependent on statistically significant sample size)

- \$100,000 for hospital with lowest readmission rate (dependent on statistically significant sample)
- \$50,000 for most improved health network (representing the greatest readmission rate improvement with a statistically significant sample size)
- \$50,000 for most improved hospital (representing the greatest readmission rate improvement with a statistically significant sample size)

As noted in the March 6, 2014 staff report, actual payment and methodology were to be finalized after the end of the first year, based on funds available and review of performance by the Health Networks and hospitals. Currently, there is \$442,874 remaining in IGT 1 for this program; therefore the payments will be adjusted accordingly.

Discussion

Given the variation in member demographics and the populations served by each of the health networks and hospitals, staff concluded that the best approach to calculate a more accurate relative performance representation between the health networks and hospitals was to segment the population into three main member demographic categories:

- SPD>18,
- TANF<18,
- TANF>18

A significant sample size was determined to be 500 admissions for each hospital and health network (HN) for each incentive year.

As proposed, payment will occur as follows:

HN:	\$242,874	SPD	TANF >18	TANF <18
Top performer:		\$50,958	\$50,958	\$50,958
Most improved:		\$30,000	\$30,000	\$30,000

Facilities: \$200,000			
Top performer:	\$40,000	\$40,000	\$40,000
Most improved	\$20,000	\$20,000	\$20,000

Health Network Performance (Total award: \$242,874)

HEALTH NETWORKS		
	Top Performer	Most Improved
SPD> 18	United Care	United Care
TANF <= 18	AltaMed	Monarch
TANF > 18	Arta Western	Monarch

Hospital Performance (Total Award: \$200,000)

FACILITIES		
	Top Performer	Most Improved
SPD> 18	Fountain Valley Regional Hospital & Medical Center	Orange Coast Memorial Medical Center
TANF > 18	Anaheim Regional Medical Center	UCI Medical Center
TANF <= 18	Fountain Valley Regional Hospital & Medical Center	Fountain Valley Regional Hospital & Medical Center

The rollout of the CPT codes for post discharge and care coordination follow-up showed very little uptake (see presentation to Utilization Management Committee, May 5, 2015). Only 181 claims were received from 45 unique providers and the average reimbursement was \$214 per claim. In addition, only one provider with previous high readmission rates participated in the incentive. Due to these results, staff recommends that this component of the overall readmissions program be discontinued.

Fiscal Impact

The recommended action to distribute a total of \$442,874 in IGT 1 funds for Medi-Cal incentive payments for the 30 day All Cause (Non Maternity Related) Avoidable Readmission Reduction Program is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

The proposed readmission reduction incentive program was expected to guide CalOptima in constructing a long term reduction readmission strategy and improving health outcomes for members discharged from inpatient care by incentivizing post-hospital visits. With payout of remaining funds, this initiative will be discontinued and restructured to meet CalOptima's long term goal of a sustainable reduction in readmissions.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated March 6, 2014, Approve Provider Payments to Support Initiatives to Reduce 30-Day All Cause (Non Maternity Related) Avoidable Hospital Readmissions for Medi-Cal
2. May 5, 2015 presentation to Utilization Management Committee

/s/ Michael Schrader
Authorized Signature

09/16/2016
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014

Regular Meeting of the CalOptima Board of Directors

Consent Calendar

V. A. Approve Provider Payments to Support Initiatives to Reduce 30-Day All Cause (Non Maternity Related) Avoidable Hospital Readmissions for Medi-Cal

Contact

Roberto Madrid, M.D., Medical Director, Quality and Analytics, (714) 246-8400

Recommended Action

Approve provider payments to support initiatives to reduce 30-day All Cause (Non Maternity Related) Avoidable Readmission Reduction Program for Medi-Cal to begin during Fiscal Year 2014-15.

Background

Managing all cause 30-day hospital readmission rates is critical to the viability of any health plan. CalOptima's inpatient costs for calendar year 2012 exceeded \$348 million, making this the highest driver of medical costs. Of these inpatient costs, approximately \$32.6 million were the result of readmissions. Although CalOptima has experienced a reduction in hospital costs during the past two years, this is not expected to be a long-term trend in the absence of interventions that successfully target readmission rates.

Reasons for readmission vary greatly by provider and according to geography, patient demographics, and patient diagnoses. According to a February 2013 Robert Wood Johnson Foundation report, a significant portion of readmissions for Medicare are avoidable. The medical literature also shows that reductions in readmission rates can be achieved through improved discharge planning, care coordination, and post discharge follow-up by primary care providers, particularly when providers are reimbursed for these services and/or educated to achieve performance targets.

CalOptima currently has multiple programs that target readmission reductions, but prior to 2013 did not have the ability to reimburse post discharge care coordination and follow-up. Effective January 1, 2013, Medicare pays for two CPT codes (99495 and 99496) that are used to report care management services for patients discharged following a hospital or skilled nursing facility stay, outpatient observation, or partial hospitalization. Given that these codes are already being reimbursed for Medicare members, One Care post discharge visits are excluded from this program. Currently these codes are not reimbursed by the Medi-Cal program, and if at any time during the 2-year program Medi-Cal should begin to pay for these services, the program will cease. Payments to providers will be made up to dates of service prior to Medi-Cal adopting these new codes. Any payments made to contracted hospitals and or Health Networks will also reflect dates of service prior to Medi-Cal adoption of the new codes and take into account a modified measurement period. To qualify for reimbursement, services must be rendered by a physician or qualifying non-physician practitioner within a 7 to 14-day post discharge period, depending on severity and continue to 30 days post discharge for non-maternity related diagnoses.

CalOptima's proposed program will employ a two-pronged approach to the reduction of readmission rates: 1) Promote physicians' appropriate use of the post discharge visit for care coordination and follow-up care by educating providers about newly available reimbursement for these services; and 2) Leverage current Health Network and hospital's readmission reduction efforts by providing performance supplements to those organizations that demonstrate lowest readmission rates and or most significant decrease in readmission rates if additional funds are available after fee-for-services visits are paid.

Discussion

Reimbursement for Post Discharge Follow-up

The first year measurement period for this project will start July 1, 2014 and end June 30, 2015. The second year measurement period will follow and start July 1, 2015 and end June 30, 2016. The individual provider payments for this program will be paid consistent with other Medi-Cal payment parameters 90 days from receipt of the measurement period claim. The proposed hospital and Health Network performance supplement, if paid, will be paid in the October time frame following the respective measurement period. To be eligible an individual provider must be contracted through the measurement period and distribution period with CalOptima, both directly or through at least one Health Network, and be in good standing with CalOptima. For a hospital to be eligible the hospital must be contracted with CalOptima through the respective measurement and payment distribution period with the performance parameters discussed below. For a Health Network to be eligible they must also be in good standing with CalOptima, be contracted with CalOptima through the respective measurement and distribution period with the performance parameters described below, and be without changes in risk assignment (e.g., Shared Risk group changing to HMO or PHC arrangement).

It is estimated that primary care providers will claim \$1 million for post discharge care during the first year of the program. Given the lack of historical data for the two CPT codes that physicians can now use to bill for these services, CalOptima's analyzed all cause hospital admissions for a 36-month period, excluding maternity-related diagnoses. Staff also factored in assumptions regarding providers' rate of adoption of new behaviors, as well as estimations of the percentage of claims that are likely to be submitted for moderate severity diagnoses, as compared with claims for high severity diagnoses. Based on this analysis, staff anticipates that 40% of the new post discharge claims will be for Medi-Cal, and 50% will be for One Care and that 75% of claims for these codes will be for moderate severity diagnoses, and 25% will be for high severity.

A new claims monitoring process will track each provider's transitional care management claims activity. Over or under utilization of the two CPT codes will trigger a focused audit process to validate the results. Providers demonstrating over utilization and potential abuse of this program will be referred to the Office of Compliance for appropriate action. Providers demonstrating underutilization will be further educated about the program and its goals.

Provider Performance Incentives

Health Networks and hospitals will be eligible to receive performance incentives if additional funds are available after payment for fee-for-service Transition Codes. A proposed distribution approach is presented below. However, actual payment and methodology will be finalized after the end of the first year based on funds available and review of performance by the Health Networks and hospitals. This item will be brought back to the Quality Assurance Committee and the Board of Directors for final approval ahead of payment distribution. Sample performance incentives:

- \$100,000 for Health Network with lowest readmission rate (dependent on statistically significant sample size);
- \$100,000 for hospital with lowest readmission rate (dependent on statistically significant sample size);
- \$50,000 for most improved Health Network (representing the greatest readmission rate improvement with a statistically significant sample size); and
- \$50,000 for most improved hospital (representing the greatest readmission rate improvement with a statistically significant sample size).

Fiscal Impact

CalOptima's program to reduce avoidable readmissions will begin in July 2014 and will be funded by funds set aside from an Intergovernmental Transfer (IGT) funds for this purpose. Initially, the program was budgeted at \$1 million for its first year and \$2 million for the second year. To align more accurately with the timeline and scope of the program, and given the potential to generate early and significant savings from a successful program, CalOptima proposes a reallocation of IGT funds approved by the Board of Directors in March 2013, so as to provide \$1.5 million for the first year and \$1.5 million for the second year.

Rationale for Recommendation

The proposed readmission reduction incentive program is expected to guide CalOptima in constructing a long term reduction readmission strategy and improving health outcomes for members discharged from inpatient care.

Concurrence

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

Attachments

None

/s/ Michael Schrader
Authorized Signature

2/28/2014
Date



Medi-Cal Readmissions

Utilization Management Committee

May 5, 2015

Roberto Madrid, MD

Medical Director, Quality and Analytics

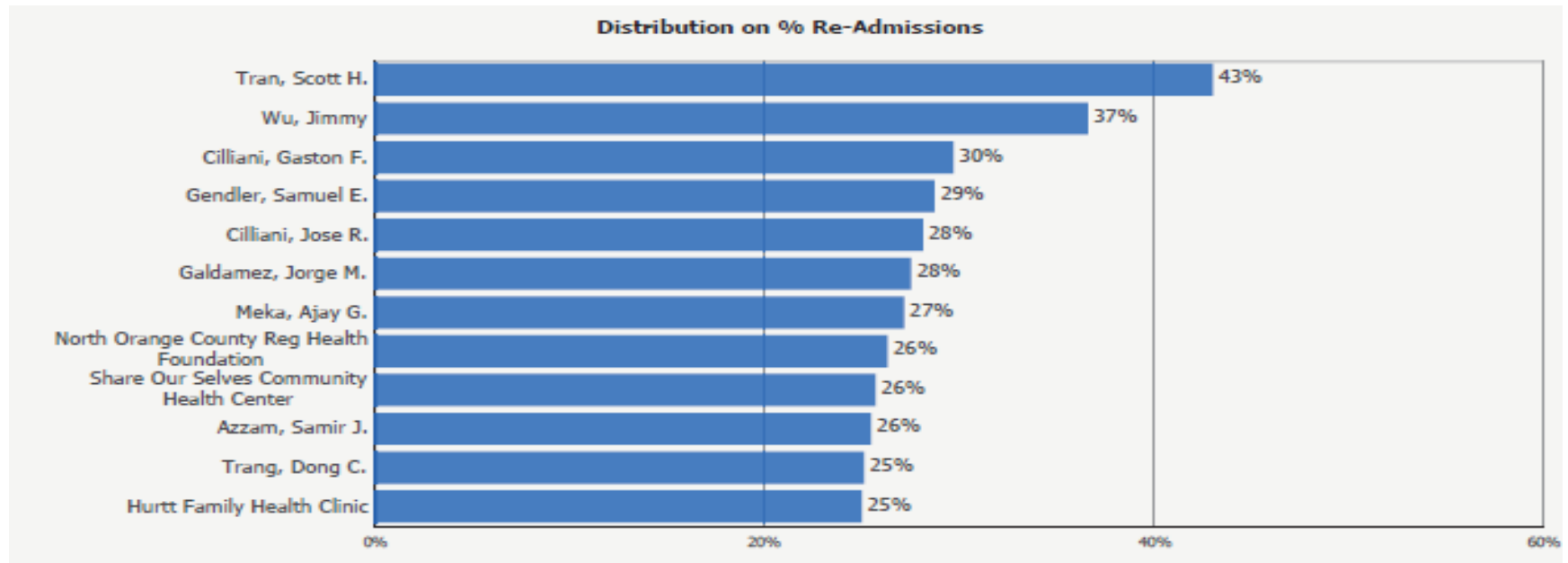
Readmission Reduction

- On July 1, 2014, CalOptima implemented a 2-year initiative aimed at lowering avoidable hospital readmissions for Medi-Cal members by extending payment for post-discharge care management services to Primary Care Providers (PCP's)
- CalOptima and the health networks will reimburse PCP's on a fee-for-service basis at 100% of the current Medicare rate for codes 99495 and 99496 (30-day transitional care management)
- The health networks will be reimbursed by CalOptima based on paid encounter submissions (beginning October 2014)

Incentive Statistics

- For Dates of Service (DOS) from 7/14 through 4/15
- 181 claims were received
- Over \$38,600 reimbursed to providers
- Average reimbursement has been \$214 per claim
- 45 unique providers have sent in a claim for transitional care management
- Significant opportunity to increase utilization of this program

Readmissions



- Data is for 2014 + Q1 of 2015
- % readmission= # of 30 day all cause readmissions/ total admissions
- 540 readmissions by 238 unique members
- 45 average readmissions per provider

Incentive

- Number of providers who are on the list of providers with the highest readmission rates and have utilized the readmission reduction incentive
 - One
- Significant room to increase awareness and utilization of this program

Intervention

- Work with Provider Relations to provide feedback
 - Letters have been composed for each of the providers with the highest readmission rates
 - Attached to letters will be the list of members that were readmitted over the measurement period
 - The provider relations team will hand deliver letters to the targeted providers
- Monitor and re-measure readmission rates
- Cross reference with incentive utilization

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 21, 2016 **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

Report Item

5. Consider Recommending Board of Directors Approval of Amendment to the 2016 Quality Improvement Program Description Regarding Culturally Competent Access and Delivery of Services

Contact

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

Recommended Action

Recommend Board of Directors' approval of amendment to the 2016 Quality Improvement Program Description regarding cultural competency training required for federal requirements.

Background

Effective September 5, 2016, the Department of Health Care Services (DHCS) required health plans to provide cultural competency training in compliance with new federal requirements (CFR, Title 42, Section 438.206(c)(2)). The requirements stated that plans must have methods to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identify.

To meet these requirements, MCP's were to include language in their written Quality Programs to ensure that all covered services are provided in a culturally and linguistically appropriate manner. This language was added to the 2016 QI Program on pages 12 and 47 of the attached.

Fiscal Impact

The recommended action is budget neutral.

Rationale for Recommendation

Regulatory compliance is a top priority for the organization; the inclusion of this language, and related implementation of the cultural competency training ensures that we have met this obligation.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Revised 2016 Quality Improvement Program Description

/s/ Michael Schrader
Authorized Signature

09/16/2016
Date



CalOptima
Better. Together.

2016

QUALITY IMPROVEMENT PROGRAM

REVISED 10/6/2016





CalOptima
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2016 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

Richard Helmer, M.D.
Chief Medical Officer

Date

Board of Directors' Quality Assurance Committee Chair:

~~Viet Van Dang~~, Paul Yost, M.D.

Date

Board of Directors Chair:

Mark Refowitz

Date

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WE ARE CALOPTIMA

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

Our Mission

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

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

Our Vision

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

Our Values — CalOptima CARES

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

Accountability: We were created by the community, for the community, and are accountable to the community. Our Board of Directors, Member Advisory Committee and Provider Advisory Committee meetings are open to the public.

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

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

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

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

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

We are “Better. Together.”

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

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unique in that we must exhibit being the best of both a public agency upholding public trust, and a health plan seeking efficiency and member satisfaction.

As both, CalOptima must:

- Make the best use of our resources, funding and expertise
- Solicit stakeholder input
- Ensure transparency in our governance procedures
- Be accountable for the decisions we make

How We Became CalOptima

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

A dedicated coalition of local elected officials, hospitals, physicians and community advocates rallied and created a solution. The answer was to create CalOptima as a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal benefits in Orange County. CalOptima began serving members in 1995. Today, CalOptima is the largest of six COHS in the United States.

CalOptima is a public agency and has, as a COHS:

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

In 2005, CalOptima became licensed to furnish a Medicare Advantage Special Needs Plan (MA SNP) through a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS). This plan, called OneCare (HMO SNP), allows

CalOptima to offer Medicare and Medi-Cal benefits under one umbrella to dual eligible individuals.

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

In July 2015, CalOptima launched OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan). This is a demonstration project in an effort by California and the Federal government to begin the process — through a single organized health care delivery system — of integrating medical, behavioral health, long-term care services and supports, and community-based services for dual eligible beneficiaries. The program’s goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community. A key feature of CalOptima is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individual care plan.

CalOptima was created as a public agency, operates like a private sector health plan and is accountable to stakeholders to build public trust.

WHAT WE OFFER:

Medi-Cal

In California, Medicaid is known as Medi-Cal. For more than 20 years, CalOptima has been serving Orange County’s Medi-Cal population. Due to the implementation of the Affordable Care Act, membership in CalOptima from 2014–16 grew by 49 percent. More low-income children and adults qualified for Medi-Cal.

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

OneCare (HMO SNP)

OneCare (HMO SNP) means total care. Our members with Medicare and Medi-Cal benefits are covered in one single plan, making it easier for our members to get the health care they need. For more than a decade, CalOptima has been offering OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. We have extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County.

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

OneCare Connect

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a new plan that launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect also integrates the Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS) and Long-Term Care (LTC).

At no extra cost, our members also get vision care, taxi rides to medical appointments and enhanced dental benefits. Plus, our members get support so they can receive the services they need, when they need them. A Personal Care Coordinator works with our members and their doctors to create an individualized health care plan that fits our members' needs.

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

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

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

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

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

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

WHO WE WORK WITH:

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima health network, and/or participate through CalOptima Direct, and/or the CalOptima Community Network.

CalOptima members can choose one of 14 health networks, representing more than 7,500 practitioners.

CalOptima Community Network (CCN)

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

CalOptima Direct (COD)

CalOptima Direct is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including foster children, dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's MA SNP), members in skilled nursing facilities, and share of cost members. COD also currently includes the following categories of vulnerable and complex/catastrophic care members: transplant, hemophilia, HIV, end-stage renal disease (ESRD), and seniors and persons with disabilities.

Not all CalOptima members are health network eligible. Members who are not eligible for enrollment in a health network may be assigned to CalOptima Direct based on the below criteria:

- Transitional members waiting to be assigned to a delegated health network
- Medi-Cal/Medicare members (Medi-Medi)
- Members who reside outside of Orange County
- Medi-Cal share of cost members
- Members residing in Fairview Developmental Center

Health Networks

CalOptima contracts with a variety of health networks to provide care to members. Since 2008, CalOptima has also included Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), Physician Medical Groups (PMGs) and Shared Risk Medical Groups (SRGs). CalOptima's HMOs, PHCs, PMGs and SRGs include more than 3,500 Primary Care Providers (PCPs) and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements are added as needed.

Health Network/Delegate No.	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	PMG	SRG
AMVI Care Health Network	PHC	PMG	PHC
Arta Western Health Network	SRG	PMG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	SRG	PMG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	SRG	PMG	SRG
Noble Mid-Orange County	SRG	PMG	SRG
OC Advantage Medical Group	PHC		PHC
Prospect Medical Group	SRG		SRG
Talbert Medical Group	SRG	PMG	SRG
United Care Medical Group	SRG	PMG	SRG

Upon successful completion of audits, the health networks may be delegated for clinical and administrative functions, which may include:

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

BEHAVIORAL HEALTH SERVICES

Medi-Cal Ambulatory Behavioral Health Services

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

CalOptima delegates to College Health Independent Practice Association (CHIPA) for utilization management of the provider network. CHIPA subcontracts and delegates to Beacon Health Strategies LLC (Beacon) other functions that include credentialing the provider network, the Access Line and several quality improvement functions.

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

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

OneCare and OneCare Connect Behavioral Health Services

CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of OneCare and OneCare Connect. CalOptima delegates utilization management (UM) to Windstone. Evidence-based MCG guidelines are used in the UM decision-making process.

OUR LINES OF BUSINESS:

MEDI-CAL

Scope of Services

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

These services include but are not limited to the following:

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

Home health care	Occupational therapy	
Hospice care	Outpatient mental health services – limited	

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

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California’s Denti-Cal program.

California Children’s Services

Services for children with certain physical limitations, chronic health conditions or diseases are provided through California Children’s Services (CCS), which is a statewide program. Currently, CCS authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for CCS-eligible conditions. DHCS manages the CCS program and the Orange County Health Care Agency operates the program. CalOptima is responsible for coordinating care and services for all non-CCS related conditions. There is work underway to integrate CCS services as a benefit of CalOptima. This transition is planned for 2017.

Members With Special Health Care Needs

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

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

Medi-Cal Managed Long-Term Services and Supports

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

LTSS includes four programs:

- Community-Based Adult Services (CBAS)

- Nursing Facility Services for Long-Term Care
- Multipurpose Senior Services Program (MPSS)
- In-Home Supportive Services (IHSS)

ONECARE (HMO SNP)

Scope of Services

OneCare (HMO SNP) provides a comprehensive scope of services for the dual eligible members who are not eligible for OneCare Connect.

These services include but are not limited to the following:

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

ONECARE CONNECT

Scope of Services

Launched July 1, 2015, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan offered by CalOptima to simplify and improve health care for low-income seniors and people with disabilities. OneCare Connect combines our members' Medicare and Medi-Cal benefits, adds supplemental benefits, and offers personalized support — all to ensure each member receives the right care in the right setting.

OneCare Connect is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal. These people often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OneCare Connect delivers coordinated care. Care

coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

OneCare Connect achieves these advancements via CalOptima’s innovative Model of Care. Each member has a Personal Care Coordinator whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Addressing individual needs results in a better, more efficient health care experience for the member.

These services include but are not limited to the following:

Acupuncture (pregnant women)	Hearing screenings	Over-the-counter drugs – limited
Ambulance services	Incontinence supplies – limited	Radiology
Case management	In-Home Supportive Services (IHSS)	Rehabilitation services
Chiropractic services	Inpatient hospital care	Renal dialysis
Diabetes supplies and services	Inpatient mental health care	Screening tests
Disease self-management	Institutional care	Skilled nursing care
Doctor visits	Lab tests	Specialist care
Durable medical equipment	Medical equipment for home care	Substance abuse services
Emergency care	Mental or behavioral health services	Supplemental dental services
Eye exams	Multipurpose Senior Services Program (MSSP)	Transgender services
Foot care	Prescription drugs	Transportation to a doctor’s office
Glasses or contacts – limited	Preventive care	Occupational, physical or speech therapy
Health education	Prosthetic devices	Urgent care
Hearing aids – limited	Outpatient care	“Welcome to Medicare” preventive visit

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Scope of Services

Launched August 1, 2013, CalOptima PACE is the only PACE center in Orange County. It is a community-based Medicare and Medi-Cal program that provides

coordinated and integrated health care services to frail elders to help them continue living independently in the community.

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

Membership Demographics



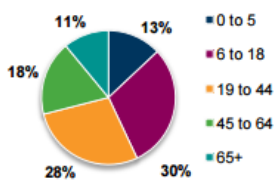
Fast Facts: February 2016

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

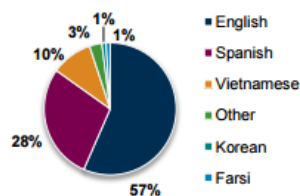
Membership Data as of December 31, 2015

<div> <p>Total CalOptima Membership</p> <p>779,410</p> </div>	Program	Members
	Medi-Cal	779,410
	OneCare (HMO SNP)*	11,891
	OneCare Connect*	4,437
	Multipurpose Senior Services Program*	464
	Program of All-Inclusive Care for the Elderly (PACE)*	129
*Membership already accounted for in total Medi-Cal membership		

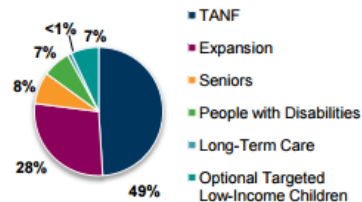
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



QUALITY IMPROVEMENT PROGRAM

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

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

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

AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY

Board of Directors

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

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

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

Quality Improvement Program, Role of CalOptima Officers

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

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

Deputy Chief Medical Officer (DCMO) along with the CMO, oversee strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics, Quality Management, Utilization Management, Case Management, Health Education & Disease Management, Pharmacy Management, and Long-Term Services and Supports.

Chief Network Officer (CNO) is responsible for developing and expanding CalOptima's programs by implementing strategies that achieve the established program objectives; leveraging the core competencies of CalOptima's existing administrative infrastructure to build an effective and efficient operational unit to serve CalOptima's networks; and making sure the delivery of accessible, cost-effective, quality health care services throughout the service delivery network. The CNO leads and directs the integrated operations of the networks, and must coordinate organizational efforts internally, as well as externally, with members, providers and community stakeholders.

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

Executive Director, Quality & Analytics (ED of QA) is responsible for facilitating the company-wide QI Program, driving improvements with Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS star measures and ratings, and facilitating compliance with NCQA. The ED of QA serves as a member of the executive team and with the CMO supports efforts to promote adherence to established quality improvement strategies and programs throughout the company. Reporting to the ED of QA is the Director of Quality Analytics, the Director of Health Education & Disease Management, and the Manager for Quality Improvement.

Executive Director of Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: Utilization, Case Management,

Long-Term Services and Supports, MSSP Services, along with new program implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

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

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

QUALITY IMPROVEMENT PROGRAM PURPOSE

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

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

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress toward established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to promote efforts that support the identification and correction of quality of care issues.

Quality Improvement, Quality Analytics, Health Education & Disease Management departments, in conjunction with multiple Medical Directors support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

QUALITY IMPROVEMENT DEPARTMENT

The Quality Improvement department supports the specific focus of monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. QI fully aligns with the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and that care and services are rendered appropriately and safely to all CalOptima members.

Quality Improvement department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality related activities
 - Drive improvement of quality of care received
 - Minimize rework and unnecessary costs
 - Measure the member experience of accessing and getting needed care
 - Empower staff to be more effective
 - Coordinate and communicate organizational information, both division and department-specific as well as agencywide
- Support the maintenance of quality standards across the continuum of care and all lines of business
- Maintain agencywide practices that support accreditation by the National Commission for Quality Assurance (NCQA)

QUALITY ANALYTICS DEPARTMENT

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

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

- Monitor outcomes
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze problems and measure improvement

- Coordinate and communicate organizational information, both division and department specific, and agencywide
- Participate in various reviews through the QI Program such as the All Cause Readmission monitoring, access to care, availability of practitioners and other reviews
- Facilitate satisfaction surveys for members and practitioners
- Evaluate and monitor provider credentials
- Provide agencywide oversight of monitoring activities that are:
 - Balanced: Measures clinical quality of care and customer service
 - Comprehensive: Monitors all aspects of the delivery system
 - Positive: Provides incentive to continuously improve

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

- Claims information/activity
- Encounter data
- Utilization data
- Case Management reports
- Pharmacy data
- STARS and HCC data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider satisfaction
- Quality Improvement Projects (QIPs, PIPs and CCIPs)
- Health Risk Assessment data

HEALTH EDUCATION & DISEASE MANAGEMENT DEPARTMENT

The Health Education & Disease Management department is the third area in Quality that provides program development and implementation for the agencywide chronic condition improvement programs. Health Education & Disease Management (HE & DM) Programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with chronic diseases. Programs and materials use educational strategies and methods appropriate for member and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics covered include Asthma, Congestive Heart Failure, Diabetes, Exercise, Nutrition, Hyperlipidemia, Hypertension, Pediatric Weight Management and Tobacco Cessation.

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

Health Education & Disease Management supports CalOptima members with customized interventions, which may include:

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

RESOURCES TO DIRECTLY SUPPORT THE QUALITY IMPROVEMENT PROGRAM AND QUALITY IMPROVEMENT COMMITTEE

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

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

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

Medical Director, Quality

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

Manager, Quality Improvement

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

- The following positions report to the QI Manager:
 - QI Nurse Specialists,
 - Data Analyst
 - Credentialing Coordinators,
 - Credentialing Program Assistant
 - Facility Site Review Master Trainer
 - Facility Site Review Nurse Reviewers

Director, Quality Analytics

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

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

Director, Health Education & Disease Management

Provides direction for program development and implementation for the agencywide health education and disease management initiatives. ensures linkages supporting a whole-person perspective to health and health care with Case Management, Care Management and Utilization Management. Also, supports the Model of Care implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agencies.

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

QUALITY IMPROVEMENT (QI) STRATEGIC GOALS

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

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

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

QI Goals and Objectives

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

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- The important clinical and service issues facing the Medi-Cal population relevant to its demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually acting on at least three identified opportunities
- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Member and provider satisfaction, including the timely resolution of complaints and grievances
- Risk prevention and risk management processes
- Compliance with regulatory agencies and accreditation standards
- Annual review and acceptance of the UM Program Description and Work Plan
- The effectiveness and efficiency of internal operations
- The effectiveness and efficiency of operations associated with functions delegated to the contracted medical groups
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values
- Compliance with Clinical Practice Guidelines and evidence-based medicine
- Compliance with regulatory agencies and accreditation standards (NCQA)
- Support of the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently
- Set expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes
- Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers

- Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals
- Make certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — Orange County Health Agency — which may include but are not limited to Methicillin resistant staphylococcus aureus (MRSA), staphylococcus aureus infections, scabies, Tuberculosis, etc. as reported by the health networks.
- Promote patient safety and minimize risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and work with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDOs) to assure that steps are taken to resolve and prevent recurrences

QI Measureable Goals from the Model of Care

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

The MOC goals are:

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

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. These are reported to the QI Committee.

WORK PLAN

(SEE ATTACHMENT A — 2016 QI WORK PLAN)

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

The QI Work Plan is the operational and functional component of the QI Program and is based on the most recent and trended HEDIS scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the State or accreditation standards where these apply.

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

- Case Management
- Client Revisions
- LTSS
- Health Education & Disease Management, Health Assessments and related CCIP, QIP, PIPs
- Access and Availability to Care
- Member Experience and Service
- Patient Safety and Pharmacy Initiatives
- HEDIS/STARS Improvement
- Delegation Oversight
- Organizational Quality Projects
- QI Program scope
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program
- Priorities for QI activities based on the specific needs of Cal Optima's organizational needs and specific needs of Cal Optima's populations for key areas or issues identified as opportunities for improvement
- Priorities for QI activities based on the specific needs of Cal Optima's populations, and on areas identified as key opportunities for improvement
- Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified

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

UTILIZATION MANAGEMENT

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

Use of evidence-based, industry-recognized criteria promotes efforts that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2016 Utilization Management (UM) Program all review staff are trained and audited in these principles. Clinical staff makes all medical necessity decisions and any denial is made only by a physician reviewer, including those decisions made by delegated health networks. Medical Directors actively engage subspecialty physicians as peer review consultants to assist in medical necessity determinations. Adherence to standards and evidence-based clinical criteria is obtained by cooperative educational efforts, personal contact with providers and monitoring through clinical studies.

BEHAVIORAL HEALTH

CalOptima focuses on the continuum of care for both medical and behavioral health services. Focusing on continuity and coordination of care, CalOptima monitors and works to improve the quality of behavioral health care and services provided to our members. The QI Program includes services for behavioral health and review of the quality and outcomes of those services delivered to the members within our network of practitioners and providers.

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

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

The Medical Director responsible for Behavioral Health services is involved in the behavioral aspects of the QI Program. The BH Medical Director is available for

assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health QI statistical data and follow-up on identified issues. The BH Medical Director shall serve as the chairperson of the BH QI Committee which is a subcommittee of the CalOptima QI Committee. The BH Medical Director also serves as a voting member of CalOptima's QI Committee.

CONFIDENTIALITY

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

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

CONFLICT OF INTEREST

CalOptima maintains a Conflict of Interest policy to make certain potential conflicts are avoided by staff and members of Committees. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees sign a Conflict of Interest statement on an annual basis.

Fiscal and clinical interests are separated. CalOptima and its delegates do not reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

STAFF ORIENTATION, TRAINING AND EDUCATION

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

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

- CalOptima New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable Department Program, Policies & Procedures, etc.
- Appeals Process
- Seniors and Persons with Disabilities Awareness Training

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

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

SAFETY PROGRAM

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

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

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

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

Member Safety prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, cultural and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care; (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)
- Collaborating with Health Networks and practitioners in performing the following activities: improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the Pharmacy & Therapeutics (P&T) Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA (Americans with Disabilities Act) and SPD (Seniors and Persons with Disabilities) site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

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

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

COMMITTEE AND KEY GROUP STRUCTURES

(SEE PAGE 52 — COMMITTEE ORGANIZATION STRUCTURE DIAGRAM)

Board of Directors' Quality Assurance Committee

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

Member Advisory Committee

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

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

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

Provider Advisory Committee

The Provider Advisory Committee (PAC) is composed of representatives from the following constituencies:

- Health Networks
- Hospitals
- Physicians
- Nurses
- Allied Health Services
- Community Clinics
- The Orange County Health Care Agency (HCA)
- Long-Term Services and Supports including (LTC Facilities and CBAS)
- Mid-Level Practitioners
- Behavioral/mental health

Quality Improvement Committee (QIC)

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

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

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

Responsibilities of the QI Committee include the following:

- Recommends policy decisions
- Analyzes and evaluates policy decisions
- Makes certain that there is practitioner participation in the QI Program through planning, design, implementation and review
- Identifies needed actions and interventions
- Makes certain that there is follow-up as necessary

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

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

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

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

- **Plan** — detailed description and goals
- **Do** — Implementation of the plan
- **Study** — data and collection
- **Act** — analyze data and develop conclusions

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

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

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

Voting Members:

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

The QIC is supported by:

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

Quorum

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

The QIC meets no less than eight times per year, and reports to the Board QAC no less than quarterly.

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

Minutes of the Quality Improvement Committee (QIC)

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

Minutes of the QIC meeting include, but are not limited to goals and objectives outlined in the QI Charter and which include but are not limited to:

- Active discussion and analysis of quality issues analysis

- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of work plan activities

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

The following are committees and subcommittees of the QIC:

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to support that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all external medical staff. The CPRC's review and findings are reported to the QIC, with recommendations for approval/denial of credentialing. All approved providers and practitioners are presented to QAC on a quarterly basis as part of the CMO's report.

The goals of the CPRC include:

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

CPRC primary responsibilities include:

1. Provide peer review and credentialing functions for CalOptima.
2. Review reports submitted by internal departments including but not limited to Audit & Oversight, Quality Improvement (PQI issues), GARS (complaints) and take action on credentialing or quality issues, as appropriate.
3. Provide guidance and peer participation in the CalOptima credentialing and recredentialing processes to ensure that all providers that serve CalOptima members meet generally accepted standards for their profession or industry.

4. Make final determinations regarding the eligibility of providers to participate in the CalOptima program based on CalOptima policies and applicable standards.
5. Review, investigate, and evaluate the credentials of CalOptima Direct/CalOptima Community Network practitioners and internal CalOptima medical staff.
6. Review facility site review results and oversee all related actions.
7. Investigate, review and evaluate quality of care matters referred by CalOptima's functional departments (including, without limitation, Customer Service, Grievance and Appeals Resolution Services, Utilization Management, Case Management and Pharmacy) and/or the CMO or his/her physician designee related to CalOptima Direct/CalOptima Care Network or its delegated Health Networks.
8. Initiate and monitor imposed provider corrective actions and make adverse action recommendations, as necessary and appropriate.

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

Sentinel Event monitoring includes patient safety monitoring across the entire continuum of CalOptima's contracted providers: HMOs, PHCs, SRGs, MBHO, PMGs, and health care delivery organizations. The presence of a Sentinel Event is an indication of possible quality issues, and the monitoring of such events will increase the likelihood of early detection of developing quality issues so that they can be addressed as early as possible. Sentinel Event monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program's consumer-complaint-oriented system.

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

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

Grievance and Appeals Resolution Services Subcommittee (GARS)

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

Pharmacy & Therapeutics Subcommittee

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

Utilization Management Subcommittee

The Utilization Management subcommittee promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM subcommittee is multidisciplinary, and provides a comprehensive approach to support the Utilization Management Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

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

The UM subcommittee includes a minimum of four (4) practicing physician representatives, reflecting CalOptima's HMO, PHC, SRG, MBHO, and PMG composition, and is appointed by the CMO. The composition includes a participating Behavioral Health practitioner* to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed.

The UM subcommittee is supported by:

Medical Director, Concurrent Review

Director, Utilization Management

Director, Pharmacy

Director, Enterprise Analytics

Manager, Referral/Prior Authorization

Manager, Concurrent Review

Quorum:

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

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

Long-Term Services and Supports Subcommittee (LTSS)

The LTSS subcommittee is composed of representatives from the Long-Term Care (LTC), Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) communities, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. Previously, the CBAS Quality Advisory Subcommittee was integrated into the LTSS Quality Subcommittee. The LTSS subcommittee members serve as specialists to assist CalOptima in the development, implementation, and evaluation of establishing criteria and methodologies to measure and report quality standards with Home and Community Based Services (HCBS) and in LTC facilities where CalOptima members reside. The LTSS subcommittee also serves to identify "best practices" and partner with facilities to share the information as it is identified. The LTSS subcommittee meets quarterly and reports to the QIC.

Benefit Management Subcommittee (BMSC)

The purpose of the Benefit Management Subcommittee is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its program lines of business benefits, prior authorization, and

financial responsibility requirements for the administration of benefits. The subcommittee shall also see to it that benefit updates are implemented, and communicated accordingly, to internal CalOptima staff, and that updates are provided to contracted HMOs, PHCs, SRGs, MBHO, and PMGs. The Government Affairs department provides the technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules.

Behavioral Health Quality Improvement Committee (BHQIC)

The Behavioral Health Quality Improvement Committee was established in 2011 to ensure members receive timely and satisfactory behavioral health care services, enhancing continuity and coordination between physical health and behavioral health care providers, monitoring key areas of services to members and providers, identifying areas of improvement and guiding CalOptima towards the vision of bi-directional behavioral health care integration.

The BHQIC responsibilities are to:

- Ensure adequate provider availability and accessibility to effectively serve the membership
- Oversee the functions of delegated activities
- Monitor that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure that Member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize Member and Network Provider satisfaction study results when implementing quality activities
- Maintain compliance with evolving National Committee for Quality Assurance (NCQA) accreditation standards
- Communicate results of clinical and service measures to Network Providers
- Document and report all monitoring activities to appropriate committees

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

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

- Medical Director, Behavioral Health Integration (Chair)
- Chief Medical Officer/Deputy Medical Officer
- Medical Director, Quality and Analytics
- Executive Director, Clinical Operations
- Executive Director, Quality Analytics
- Medical Director, Utilization Management
- Director, Behavioral Health Integration

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

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

METHODOLOGY

QI Project Selections and Focus Areas

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

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

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

- Access to and availability of services, including appointment availability, as described in the Utilization Management Program and in policy and procedure
- Coordination and continuity of care for seniors and persons with disabilities
- Provisions of chronic, complex care management and case management services
- Access to and provision of preventive services

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

- Staff, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
- Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes

- Project coordination occurs through the various leadership structures: Board of Directors, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
- These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

QI Project Quality Indicators

Each QI Project will have at least one (and frequently more) quality indicator(s). While at least one quality indicator must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Quality indicators will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, MBHO, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS & STARS measures are acceptable.

Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized. See explanation of Clinical Data Warehouse below.

For studies/measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5 to 10% over sampling), so as to allow performance of statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

CalOptima also uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

- | | |
|-------------|---|
| Plan | 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan |
| Do | 5) Communicate change/plan
6) Implement change plan |

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

CARE OF MEMBERS WITH COMPLEX NEEDS

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs
- Management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt-out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education and member incentive programs
- Use of evidenced based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)
- Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
- Coordinating services for members for appropriate levels of care and resources
- Documenting all findings
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. All members are stratified using a plan-developed stratification tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. The members are stratified into complex, care coordination and basic care management levels.

The Interdisciplinary Care Team (ICT) for low risk members — is basic — and occurs at the PCP level. Moderate and high risk members are managed by an ICT at the Medical Group level for delegated groups or at the plan level in the instance of the Community Network.

The members of the ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, but not limited to a Medical Director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietician, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — Basic Team at PCP level
 - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
 - Roles and responsibilities of this team:
 - Basic case management, including advanced care planning
 - Medication reconciliation
 - Identification of member at risk of planned and unplanned transitions
 - Referral and coordination with specialists
 - Development and implementation of an ICP
 - Communication with members or their representatives, vendors, and medical group
 - Review and update the ICP at least annually, and when there is a change in the members health status
 - Referral to the primary ICT, as needed
- Primary ICT for Moderate to High-Risk Members — ICT at the Physician Medical Group (PMG) level or the Health Plan for Community Network
 - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, PMG Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, PMG Utilization Management staff, behavioral health specialist and social worker
 - Roles and responsibilities of this team:
 - Identification and management of planned transitions
 - Case management of high risk members
 - Coordination of ICPs for high risk members
 - Facilitating member, PCP and specialists, and vendor communication
 - Meets as frequent as is necessary to coordinate and care and stabilize member's medical condition

- Complex ICT for High-Risk Members — ICT at the Physician Medical Group (PMG) level or Health Plan for Community Network
 - Team Composition (As appropriate for identified needs): member, caregiver, or authorized representative, PMG Medical Director, CalOptima clinical/PMG case manager, PCP and/or specialist, social worker, and behavioral health specialist
 - Roles and responsibilities of this team:
 - Consultative for the PCP and PMG teams
 - Encourages member engagement and participation in the IDT process
 - Coordinating the management of members with complex transition needs and development of ICP
 - Providing support for implementation of the ICP by the PMG
 - Tracks and trends the activities of the IDTs
 - Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the IDTs to identify areas for improvement
 - Oversight of the activities of all transition activities at all levels of the delivery system
 - Meets as often as needed until member's condition is stabilized

Dual Eligible Special Needs Plan (SNP)/OneCare and OneCare Connect

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help patients regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow-up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of re hospitalization
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals (e.g., patients dually eligible for Medicare and Medicaid or patients who are institutionalized)

- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning
- Care management program focused on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life

CalOptima's goals for 2016 are:

- Continue with the comprehensive assessment strategy
- Measure and assess the quality of care CalOptima provides
- Evaluate how CalOptima addresses the special needs of our beneficiaries
- Drive interventions and actions when opportunities for improvement are identified

Please reference the 2016 Case Management Program Description for further details and program plans.

DISEASE MANAGEMENT PROGRAM

The Disease Management (DM) Program is a targeted program for the management, coordination, and intervention for a highly vulnerable patient population. CalOptima assumes responsibility for the Disease Management program for all of its lines of business, therefore the management for Disease Management is non-delegated to the PHCs, SRGs, and PMGs. The contracted PHCs, SRGs, and PMGs must participate collaboratively with interventions necessary to produce compliant quality outcomes. The DM program is a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the healthcare practitioner and CalOptima. The DM program coordinates care for members across time, locates and provides services and resources, and supports the members as they learn to care for themselves.

A detailed description of the Disease Management Program is contained in the Disease Management Program Description document. The DM Program is evaluated on an annual basis.

CLINICAL DATA WAREHOUSE

The Clinical Data Warehouse aggregates data from CalOptima's core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy. The clinical data warehouse allows staff to apply evidence-based clinical practice guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures and outcomes measures. CalOptima staff creates and maintains the data base with quarterly data updates.

Based upon evidence-based practice guidelines built into the system, the clinical data warehouse can assess the following:

- Identify and stratify members with certain disease states
- Identify over/under utilization of services
- Identify missing preventive care services
- Identify members for targeted interventions

Identification/Stratification of Members

Using clinical business rules, the database identifies members with a specific chronic disease condition, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease condition, the database is designed to detect treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.

Identify Over/Under Utilization of Services

Using clinical business rules, the database can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days.

Identify Missing Preventive Care Services

The data warehouse can identify members who are missing preventative care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50 or a retinal eye exam for a diabetic.

Identify Members for Targeted Interventions

The rules for identifying members and initiating the intervention are customizable to CalOptima to fit our unique needs. By using the standard clinical rules and customizing CalOptima specific rules, the database is the primary conduit for targeting and prioritizing health education, disease management and HEDIS-related interventions.

By analyzing data that CalOptima currently receives (i.e. claims data, pharmacy data, and encounter data) the data warehouse can identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS measures. This information will guide CalOptima in not only targeting the members, but also the HMOs, PHCs, SRGs, MBHO, PMGs, and providers who need additional assistance.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality indicator) is accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be conducted by the Director, Quality Analytics or designee. If validation is not achieved on all records samples, a further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, are maintained for a minimum period, in accordance with applicable law and contractual requirements.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there is no other regulatory reporting requirement related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal.
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality indicator
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection, and analysis timelines
- Evaluation of re-measurement performance on each quality indicator

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical “home” for each member. The primary care practitioner is this medical “home” for members who previously found it difficult to access services within their community. The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the CalOptima model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.
- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

Clinical Care and Service:

- Access and availability
- Continuity and coordination of care
- Preventive care, including:
 - Initial Health Assessment
 - Initial Health Education
 - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions
- Complex Case Management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management department, which details this process in its UM/CM Program and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/under utilization
- Disease management

Administrative Oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

* CalOptima has a zero tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to HMO, PHC, SRG, MBHO, and PMG contractors who are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. Predelegation review is conducted through the Audit and Oversight department and overseen by the Delegation Oversight Committee reporting to the Compliance Committee. (See Attachment B for the 2016 Delegation Grid.)

Non-Delegated Activities

The following activities are not delegated, and remain the responsibility of CalOptima:

- Quality Improvement, as delineated in the Contract for Health Care Services
- QI Program for all lines of business, HMOs, PHCs, SRGs, MBHO, and PMGs must comply with all quality related operational, regulatory and accreditation standards
- Disease Management Program, may otherwise be referred to as Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, peer review process on specific, referred cases
- Development of system-wide indicators, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and healthcare delivery organizations (HDOs)
- Credentialing and re-credentialing of HDOs
- Development of Utilization Management and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with State and Federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

PEER REVIEW PROCESS

Peer Review is coordinated through the QI Department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases are presented to CPRC to assess if documentation is complete, and no further action is required. The QI department also tracks, monitors, and trends, service and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the CPRC at time of re-credentialing. Quality of care case

referral to the QI department are based on referrals to the QI department originated from multiple areas, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or grievances and appeals resolution.

CULTURAL & LINGUISTIC SERVICES

CalOptima serves a large and culturally diverse population. The five most common languages spoken for all CalOptima programs are: English at 57 percent, Spanish at 28 percent, Vietnamese at 10 percent, Farsi at one percent, Korean at one percent, Chinese at one percent, Arabic at one percent and all others at three percent, combined. CalOptima provides member materials in:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic
- OneCare member materials are provided in three languages: English, Spanish and Vietnamese
- OneCare Connect member materials are provided in five languages: English, Spanish, Vietnamese, Korean and Farsi.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. See CalOptima Policy DD. 2002 – Cultural and Linguistic Services for a detailed description of the program.

Objectives for serving a culturally and linguistically diverse membership include:

- Analyze significant health care disparities in clinical areas
- Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Consider outcomes of member grievances and complaints
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language or gender specific risks
- Identify and reduce a specific health care disparity with culture, race, gender
- Provide information, training and tools to staff and practitioners to support culturally competent communication

COMPREHENSIVE CREDENTIALING PROGRAM STANDARDS

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system. Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS and NCQA). The scope of the credentialing program includes all licensed M.D.s, D.O.s, allied health and midlevel practitioners, which include, but are not limited to: behavioral health practitioners, certified nurse midwives, nurse practitioners, optometrist, etc., both in the delegated and CalOptima direct environments.

Health Care Delivery Organizations

CalOptima performs credentialing and re-credentialing of ancillary providers and HDOs (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every three years thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

Use of Quality Improvement Activities in the Re-credentialing Process

Findings from quality improvement activities are included in the re-credentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns and member complaints between re-credentialing periods.

FACILITY SITE REVIEW, MEDICAL RECORD AND PHYSICAL ACCESSIBILITY REVIEW SURVEY

CalOptima does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted HMOs, PHCs, SRGs, MBHO, and PMGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD Policy Letter 02-02. CalOptima assumes responsibility and conducts and coordinates FSR/MRR for the non-delegated SRGs and PMGs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs and PMGs to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on

another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 02-02 and CalOptima policies. Medical records of new providers shall be reviewed within ninety calendar days of the date on which members are first assigned to the provider. An additional extension of ninety calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CalOptima conducts an additional DHCS-required facility audit for American with Disabilities Act compliance for seniors and persons with disabilities (SPD) members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Exterior ramps
- Exterior stairways
- Entrances
- Interior circulation
- Interior doors
- Interior ramps
- Interior stairways
- Elevators
- Controls
- Sanitary facilities
- Reception and waiting areas
- Diagnostic and treatment areas

Medical Record Documentation Standards

CalOptima requires that its contracted HMOs, PHCs, SRGs, MBHO, and PMGs make certain that each member medical record is maintained in a accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, x-ray, consultation notes, etc). The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima's contracts with CMS, DHCS, and MRMIB.

The medical record should be protected in that medical information is released only in accordance with applicable Federal and/or State law.

CORRECTIVE ACTION PLAN(S) TO IMPROVE CARE, SERVICE

When monitoring by either CalOptima Quality Improvement Department or Audit & Oversight Department identifies an opportunity for improvement, the delegated or functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit and Oversight Department as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the Quality Improvement Department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation of performance via the appropriate clinical monitor. (This process shall determine if follow up action has resolved the original problem.)
- Discussion of the results of clinical monitoring. (The committee/functional area may refer an unresolved matter to the appropriate committee/functional area for evaluation and, if necessary, action.)
- Intensified evaluation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e. when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- Prescribed continuing education
- Intensive monitoring and oversight
- De-delegation
- Contract termination

Performance Improvement Evaluation Criteria for Effectiveness

The effectiveness of actions taken and documentation of improvements made are reviewed through the monitoring and evaluation process. Additional analysis and action will be required when the desired state of performance is not achieved. Analysis will include use of the statistical control process, use of comparative data, and benchmarking when appropriate.

COMMUNICATION OF QUALITY IMPROVEMENT ACTIVITIES

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. The QI Subcommittees will report their summarized information to the QIC quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Board of Directors, and/or the QAC, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of CalOptima staff. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- Annual synopsised QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on CalOptima's website, in addition to the annual article in both practitioner and member newsletter. The information includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
- Annual PCP pamphlet

ANNUAL PROGRAM EVALUATION

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC, QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and incorporated into the QI Work Plan and reported to DHCS & CMS on an annual basis. In the evaluation, the following are reviewed:

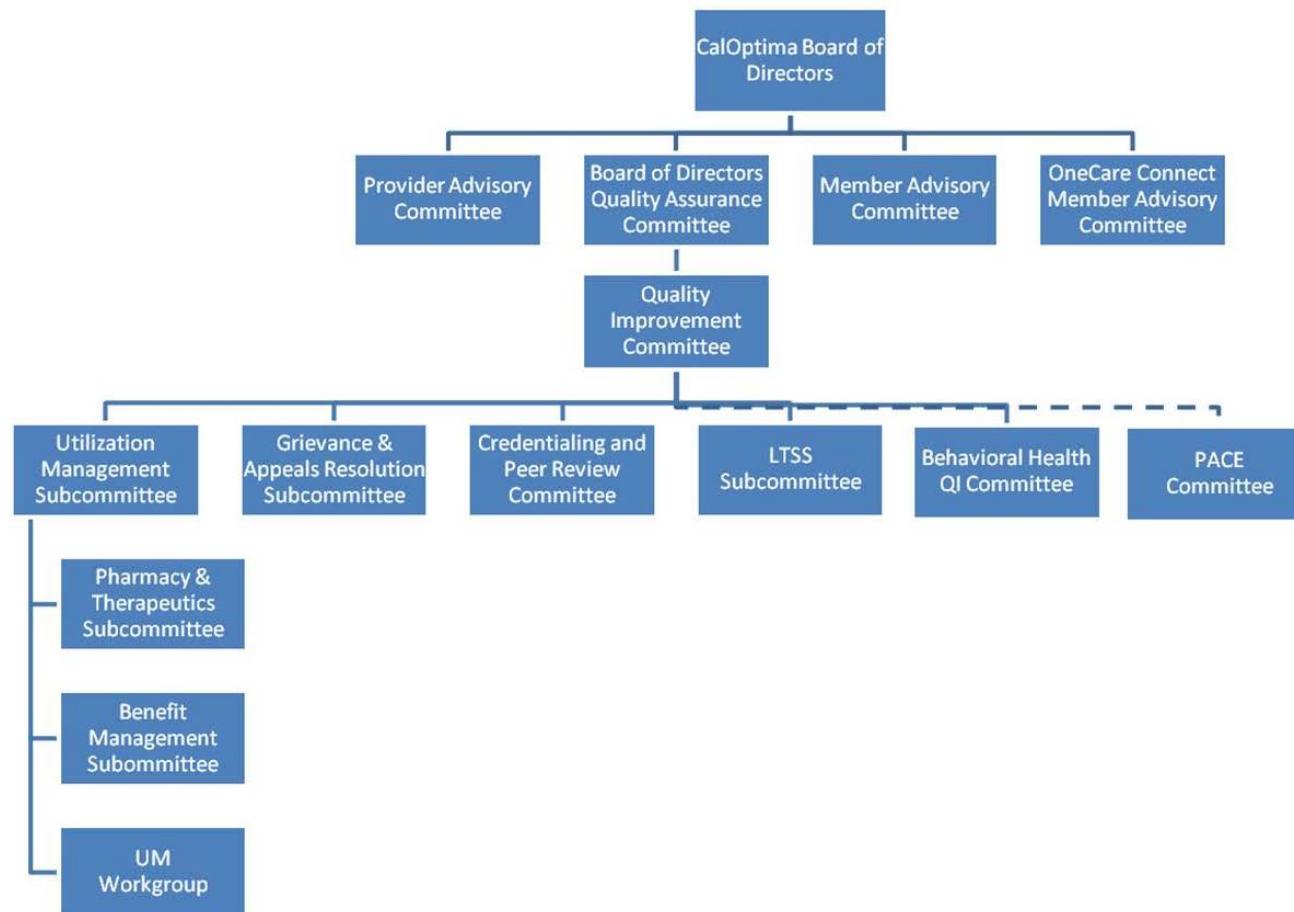
- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization,
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions
- An evaluation of each QI Activity, including Quality Improvement Projects (QIPs), with any area showing improvements in care or service as a result of QI activities receiving continued interventions to sustain improvement

- An evaluation of member satisfaction surveys and initiatives
- A report to the QIC and QAC of a summary of all quality indicators and identification of significant trends
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process
- The recommended changes, included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors for review and approval

IN SUMMARY

As stated earlier, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

QUALITY IMPROVEMENT COMMITTEE STRUCTURE – 2016



CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 21, 2016 **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

Report Item

6. Consider Recommending Revisions to the FY 2016-17 Board of Directors' Quality Assurance Committee Meeting Schedule

Contact

Michael Schrader, Chief Executive Officer, (714) 246-8400

Recommended Action

Recommend Board of Directors' approval of revisions to the adopted FY 2016-17 CalOptima Board of Directors Meeting Schedule to change the Board of Directors' Quality Assurance Committee meeting time through June 30, 2017.

Discussion

On June 2, 2016, the Board of Directors adopted the FY 2016-17 schedule of meetings for the Board of Directors, Board of Directors' Finance and Audit Committee, and Board of Directors' Quality Assurance Committee through June 30, 2017. As adopted, the Board of Directors' Quality Assurance Committee meeting schedule reflects quarterly meetings at 5:30 p.m. on the fourth Wednesday of the months of September, November, February and May.

Due to conflicting schedules, staff proposes revising the Board of Directors' Quality Assurance Committee regular meeting time to 3:00 p.m. on the following scheduled meeting dates:

- Wednesday, November 16, 2016
- Wednesday, February 15, 2017
- Wednesday, May 17, 2017

Rev.
9/21/16

Unless otherwise notified, all QAC meetings will be held at CalOptima's offices located at 505 City Parkway West in Orange, California.

Fiscal Impact

None

Rationale for Recommendation

The recommended action will revise the Board of Directors' FY 2016-17 Meeting Schedule as required in Section 5.2 of the Bylaws.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Proposed Revised FY 2016-17 Board of Directors' Meeting Schedule

/s/ Michael Schrader
Authorized Signature

09/16/2016
Date



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Proposed Revised
Board of Directors Meeting Schedule
July 1, 2016 – June 30, 2017

All meetings are held at the following location, unless notice of an alternate location is provided:

505 City Parkway West
Orange, California 92868

Board of Directors Monthly – First Thursday Meeting Time: 2:00 p.m.	Finance and Audit Committee Quarterly – Third Thursday Meeting Time: 2:00 p.m.	Quality Assurance Committee Quarterly – Third Wednesday Meeting Time: 5:30 3:00 p.m.
<i>July 2016</i> [^]		
August 4, 2016		
September 1, 2016	September 15, 2016	September 21, 2016
October 6, 2016		
November 3, 2016	November 17, 2016	November 16, 2016
December 1, 2016		
<i>January 2017</i> [^]		
February 2, 2017	February 16, 2017	February 15, 2017
March 2, 2017		
April 6, 2017		
May 4, 2017	May 18, 2017	May 17 10 , 2017
June 1, 2017 [†]		

[^]No Regular meeting scheduled

[†]Organizational Meeting

Adopted June 2, 2016

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Board of Directors' Quality Assurance Committee Meeting May 18, 2016

PACE Member Advisory Committee (PMAC) Update

PMAC Meeting April 25, 2016

CalOptima PACE held a quarterly meeting of the PACE Membership Advisory Committee on April 25, 2016.

The PACE Director reviewed the items requiring follow up from the previous meeting, including an update on the Transportation Department and a follow up regarding Specialty appointments.

The Director informed the Committee that PACE now has a new Transportation Coordinator (TC) from Secure Transportation, Rene Ramos. Rene started in April and will train with current the TC for 6 weeks. The Director also reported that, due to the growth in census, Secure Transportation will be adding another van to the PACE fleet (this happens periodically as the program grows).

The Director also informed the Committee that PACE is working with community providers to expand network, and also working to ensure that specialty appointments are scheduled only when appropriate. Per the PACE program philosophy, the Primary Care Physician (PCP) will continue to handle most of the care and may refer to consultations with specialists as is medically indicated.

A staffing update was given to the committee as well, including the announcement of Christine Sisil, RN starting her role as the Clinical Operations Manager on April 25, two Personal Care Attendants being promoted to Medical Assistants in the Clinic, and two team members currently on leave.

New topics of discussion included:

1. Patient-Centered Care: Team members from PACE attended a seminar regarding the provision of Patient-Centered Care. CalOptima purchased the videos and training materials and are currently in the process of educating the entire PACE team on this manner of providing individualized care.

The meeting concluded with the PMAC member forum. Topics of discussion included:

1. Mallory Vega, our community representative, stated that she reports the events of this meeting to the Quality Assurance Committee of the Board of Directors and that their voices are heard.
2. Discussed physician hours and Participants were told that as the census continues to grow, the provider hours will continue to increase.
3. Many complements were extended for the staff - very dedicated and the Participants are happy at PACE.

Next meeting is scheduled for September 26, 2016 at 11:00 a.m.



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Intergovernmental Transfer (IGT) Update

**Board of Directors' Quality Assurance Committee Meeting
September 21, 2016**

**Cheryl Meronk
Director, Strategic Development**

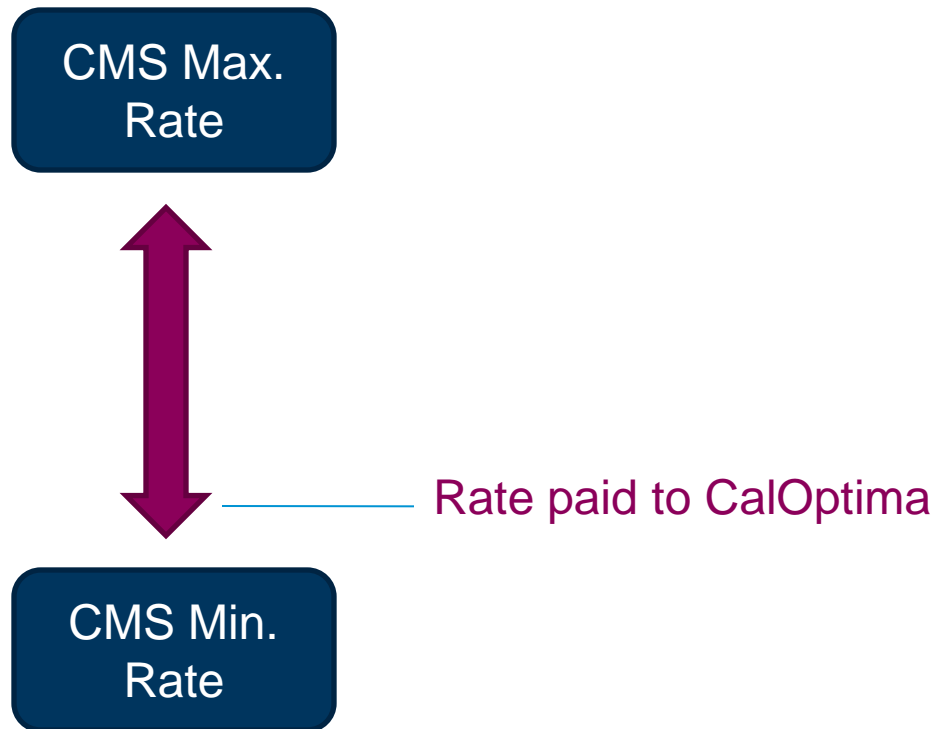
Intergovernmental Transfers (IGT)

Background

- Medi-Cal program is funded by State and Federal funds
- IGT process allows CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds are used to deliver enhanced benefits/services for the Medi-Cal population

Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near bottom of the range



IGT Funds Availability

- Maximum IGT funds available based on difference in rates paid to CalOptima and the maximum allowable rate
- IGT funds contingent on availability of local government dollars to be used as match for federal dollars

IGT Funding Process

- Funds secured through cooperative transactions between eligible governmental funding entities, CalOptima, DHCS and CMS
- Funding entities contribute to matching dollar pool
 - Past IGT transactions included only one funding entity – UCI
 - Current IGT transaction includes five funding entities, allowing CalOptima to access a greater amount of available dollars

IGT 5 Funding Entities

Funding Entities	Initial Investment*
Children & Families Commission	\$6,269,000
Orange County Health Care Agency	\$2,610,190
City of Orange, Fire Department	\$383,596
City of Newport Beach, Fire Department	\$257,087
UCI	\$29,500,000
Totals	\$39,019,873

* To be confirmed by funding entities and approved by DHCS

Cumulative IGT 5 Funds Flow

*Estimates Based On Potential Funding Partners LOI	Amount
1. Funding Entities' Initial Investments to DHCS (IGT) - a separate 20% admin fee is paid by each funder to DHCS (\$7.8m total)	\$ 39,019,873
2. Federal Match of Funding Entities' IGT	39,019,873
3. Additional payment to cover Managed Care Tax	3,072,815
4. Payment from DHCS to CalOptima*	81,112,561
5. CalOptima pays Managed Care Tax (3.9375% Tax)	(3,072,815)
6. IGT Funds Available (After Tax)	78,039,746
7. CalOptima Returns Original Funds to Funding Entities (Initial Investment + 20% State Fee of \$7.8 million)	(46,823,847)
8. Net IGT Revenue for Transaction to Orange County	31,215,898
50% Share for Funding Entities	(15,607,949)
50% Share for CalOptima	\$ 15,607,949

IGT 5 Approved Funding Categories

Adult Mental Health

Children's Mental Health

Childhood Obesity

Strengthening the Safety Net

Improving Children's Health

Pilot Programming Planning & Implementation

IGT 1-5 CalOptima Share Totals

IGTs	CalOptima Amount
IGT 1	\$12.52 M
IGT 2	\$8.60 M
IGT 3	\$4.88 M
IGT 4	\$6.96 M
IGT 5	≈\$15M
Total	\$47.96 M*

IGT 1 Status*

Project	Budget	Balance	Notes
Personal Care Coordinators	\$3,850,000	\$125,136	Complete by 12/31/2016
Case Management System	\$2,099,000	\$3,620	Complete
Strategies to Reduce Re-admissions	\$533,585	\$442,874	Complete by 10/31/2016
Program for High Risk Children	\$500,000	\$500,000	Reallocate
Telemedicine	\$1,100,000	\$1,069,190	IGT Ad Hoc/Reallocate
Case Management System Consulting	\$866,415	\$252,285	Complete by 12/31/2017
OCC PCC Program	\$3,550,000	\$2,264,233	Complete by 12/31/2016
Unallocated	\$28,231	\$28,231	IGT Ad Hoc/Reallocate
Total	\$12,527,231	\$4,685,569	

*As of 7/31/2016

IGT 2 Status*

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	\$1,250,000	\$268,575	Complete by 12/31/2016
Security Audit Remediation	\$101,000	\$0	Complete
Continuation of COREC	\$1,000,000	\$548,845	Complete by 6/30/2017
OCC PCC Program	\$2,400,000	\$2,400,000	Complete by 6/30/2017
Children's Health/Safety Net Services	\$1,300,000	\$140,409	Complete by 5/31/2017
Wraparound Services	\$1,400,000	\$936,000	Complete by 11/1/2017
Expansion of IGT 1 Initiatives - Recuperative Care	\$500,000	\$322,100	Complete by 3/1/2017
Provider Network Management Solution	\$500,000	\$500,000	Reallocate
Project Management	\$100,427	\$26,325	Complete by 9/30/2016
PACE EHR System	\$50,000	\$13,990	Complete by 12/31/2016
Total	\$8,601,427	\$5,156,244	

*As of 7/31/2016

IGT 3 Status*

Project	Budget	Balance	Notes
Pay for Performance for PCPs	\$4,200,000	\$4,200,000	IGT Ad Hoc/Reallocate
Recuperative Case (Phase 2)	\$500,000	\$500,000	Complete by 6/30/2018
Project Management	\$180,552	\$180,552	Complete by 6/30/2017
Total	\$4,880,552	\$4,880,552	

*As of 7/31/2016

IGT Timeline

Date	Activity
September 15	FAC Update and Review
September 21	QAC Update and Review
October/November	IGT Ad Hoc
November 10	PAC and MAC Update and Review
December 1	Board of Directors IGT Expenditure Plan Presentation



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CMS/DHCS PACE Year Three Preliminary Audit Results

**Board of Directors' Quality Assurance Committee Meeting
September 21, 2016**

**Dr. Miles Masatsugu
Medical Director, Medical Management**

Overview of Year Three CMS/DHCS PACE Audit

- CMS/DHCS were onsite at the PACE facility from 8/29/16 – 9/1/16
- Review period was from November 2015 – August 2016
- Preliminary Audit Findings
 - 11 Elements Met
 - 3 Elements Not Met
- Auditors were impressed with both our facility and the progress we have made over the first 3 years of our program

First Three-Year Audit Results Comparison

	Year 1	Year 2	Year 3
Met	12	11	11
Met with Note	3	5	0
Total Met	15	16	11
Not Met	4	3	3

First Three-Year Audit Results Comparison Detail (Administrative Elements)

	Year 1	Year 2	Year 3
Transportation Services	Not Met	Met	Not Met
Appeals Process	Met	Not Met	Met
Voluntary Disenrollment	Met w/Note	Met w/Note	N/A (QI)
Involuntary Disenrollment	Met w/Note	Met w/Note	N/A (QI)
Enrollment Process	Met w/Note	Met w/Note	N/A
Grievance Process	Met	Met w/Note	Met
Appeal Rights	Met	Met	Met
Contracted Services	Met	Met	N/A (QI)
Governing Body	Met	Met	Met

First Three-Year Audit Results Comparison Detail (Clinical Elements)

Audit Element	Year 1	Year2	Year 3
Quality Assessment Performance Improvement	Met	Met	Not Met
Participant Assessment	Met	Not Met	Met
Service Delivery & Emergency Care	Met	Not Met	Met
Dietary Services	Met	Met w/Note	Met
Physical Environment	Not Met	Met	Met
Infection Control	Not Met	Met	Not Met
Medical Records	Not Met	Met	Met
Personnel Training & Oversight of Direct Participant Care	Met	Met	Met
Interdisciplinary Team	Met	Met	Met
Plan of Care	Met	Met	Met

Year 3 Audit Remediation

- Transportation
 - Secure Transportation added a program specialist to directly supervise the project improvement
 - The fleet was increased and the routes were reconfigured
 - > 1 hr violations are being reported daily to our care team
 - Extending Secure's contract for 6 months to allows us time to send out an RFI to find any alternative vendors
- QAPI
 - QA Coordinator will be reviewing manual logs and doing unannounced ride-alongs weekly
- Infection Control
 - Refuting results, and retrain staff if needed



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Quality Improvement Committee (QIC) 2nd Quarter Update

**Board of Directors' Quality Assurance Committee Meeting
September 21, 2016**

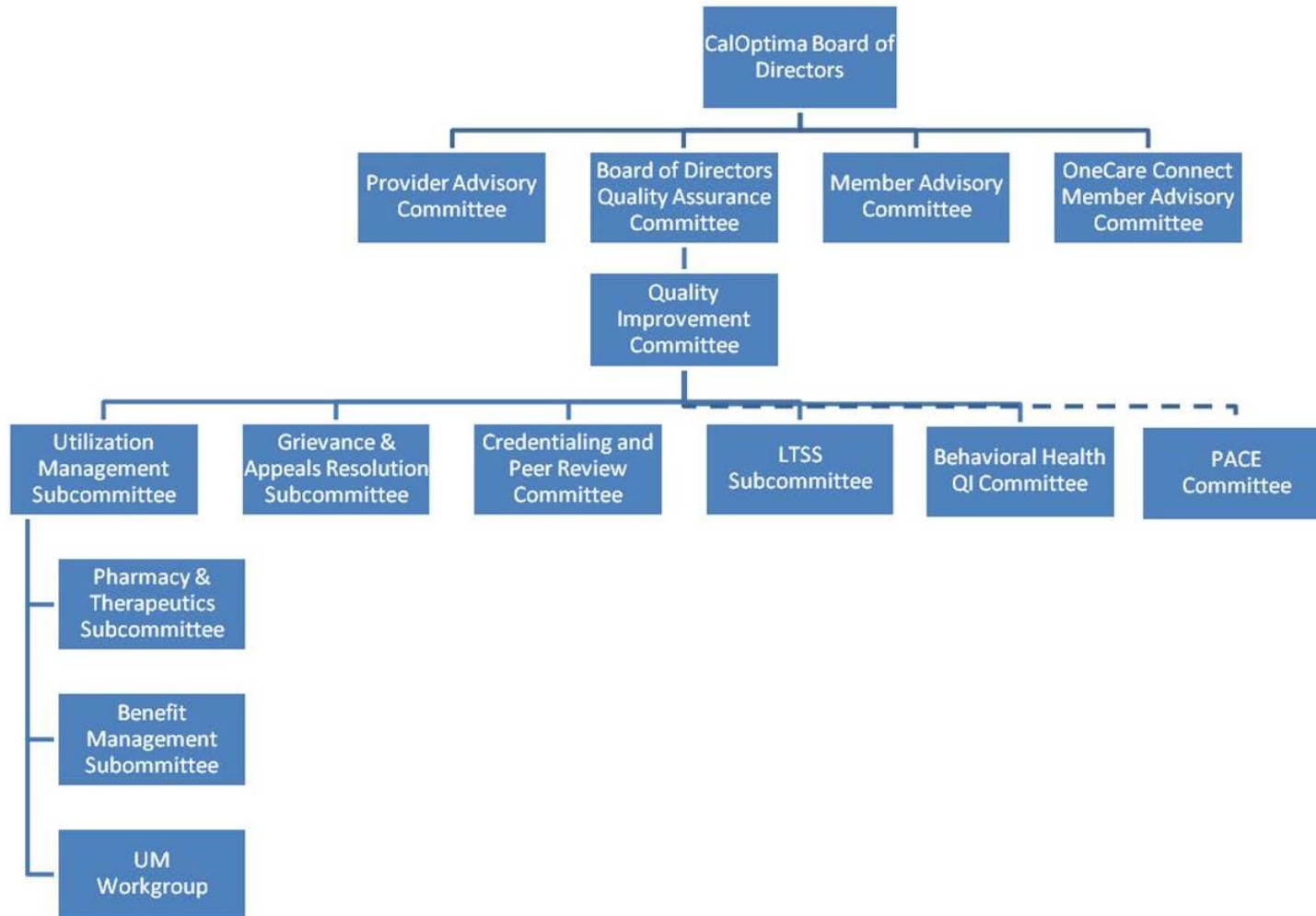
**Caryn Ireland
Executive Director, Quality and Analytics**

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Quality Improvement Program

- CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to our members
- Encompasses Clinical Care, Clinical Services and Member Experience
- Uses Multiple “levers” to improve care & service
 - Direct-to-Member
 - Through our Health Networks
 - Pay-for-Value
 - Model of Care
 - Partners:
 - Behavioral Health, Pharmacy Benefit Manager

Our Committee Structure



QIC Reporting Department

The following departments report to the QIC quarterly at a minimum:

- Case Management
- Behavioral Health
- Case Management
- Customer Service
- Health Education
- GARS
- Long Term Services and Support
- Provider/Network Management
- OneCare
- PACE
- Pharmacy
- Utilization Management

Committee Updates

- Reviewed & Approved:
 - Utilization Management Committee Report & Minutes (June 8, 2016)
 - GARS Sub-Committee Report (June 8, 2016)
 - LTSS Sub-Committee Report (May 10, 2016)
 - Behavioral Health Sub-Committee Report (June 8, 2016)
 - Clinical Practice Guidelines (April 13, 2016)

Utilization Management Committee Update

- Behavioral Health RFP Process Initiated
- Prior Authorizations
 - 47% referral increase over 2015; Q1 intake over 1500 referrals per day
- LTSS
 - CBAS Turn-Around-Times (TAT) in compliance with standards
- Inter-Rater Reliability
- Facility Utilization Review
- Pharmacy Utilization Review
- Emergency Department Utilization Review
- Benefit Management Subcommittee Report

QIC Highlights

Health Education & Disease Management

- Asthma:
 - Health Coach prioritization of members with persistent asthma and no evidence of controller medication
 - Asthma Aware DM newsletter (May edition) includes articles on medication and action plan.
- Diabetes:
 - HSAG Diabetes A1C testing PIP modules 1&2 approved
 - Health coach prioritization for members with A1C>9
- Initial Health Assessment:
 - Implemented IVR outreach
 - Incorporated IHA data into Health Network Prospective Rates report
- Conduct 2016 Group Needs Assessment (GNA)
 - Reviewing RFP responses

QIC Highlights:

Credentialing Activity	1 st Quarter, 2016	2 nd Quarter, 2016
Total number of initial and recredentialing files completed	168	217
Number of clean files completed	99	201
Number of files with issues – presented to CPRC	17	17
Number of issue files requiring CPRC action	2	3
Number of issues identified through ongoing monitoring of adverse activity	24	33
Timeliness (*Initials within 6 months, Recreds within 36 Months)	77%	97.8%

QIC Highlights

FSR/MRR/PAR

Site Reviews Activity	1 st Quarter, 2016	2 nd Quarter, 2016
Total number of FSR/MRR Completed (PCP)	60	83
Total number of PARS Completed (PCP & HVS)	96	70
Number Critical Element CAPS Issued, % closed within 10 Day TAT	22 Issued 82% within TAT	25 Issued, 96% within TAT
Number of FSR CAPs Issued, % closed within 45 TAT	27 Issued 81% within TAT	41 Issued, 95%within TAT
Number of MRR CAPS Issued, % closed within 45 day TAT	43 Issued 93% within TAT	39 Issued, 97% within TAT

Highlights

Potential Quality Issues & Critical Incidents

PQI Cases

462 cases closed

39% were closed within 90 days

23% were closed between 90-180 days

38% were closed over 180 days

Critical Incidents

CBAS

1

Nursing Facilities

0

IHSS

0

MSSO

0

Highlights: Potential Quality Issues

Outcome Score	Description	# of Cases Closed 1 st Q	Primary Issue for Level 3	# of Cases Closed	Actions
0	No quality of care issue identified	440 No further action		408 (90%)	336 – No further action 4 – More information Requested 56 – Track & Trend 6 – Physician Letter 1 – Health Network CAP 5 – Provider Education
1	Reflects a health care delivery system problem	22		21 (5%)	10 – No further action 10 – Track & Trend 1 – Health Network CAP
2	Clinical issue or judgment impacting Member care with potential for mild to moderate effect	7		7 (1%)	1 – No further action 1 – Track & Trend 4 – Physician Letter 1 – Provider Education
3	Clinical issue or judgment impacting Member care with potential for significant to serious effect	6	1-Improper management of med regimen 1- Allergic med prescribed/dispensed 1 – Medication admin error 1- Medication error 1 – Non-compliant patient	6 (1%)	6 – Track & Trend
4	Clinical issue with significant adverse outcome, including unnecessary prolonged treatment, complications, readmission, or Member management resulting in impairment, disability or death	0		0	
SO	No quality of care issue (service issue)	18		13 (3%)	13 – No further action

QIC Highlights

- Case Management

- Continued focus on improving Health Risk Assessment (HRA) outreach and completeness for OCC and SPD members
- Continued monitoring of participation in ICT/ICPs
- Presented Complex Case Management (CCM) Quality Review:
 - 7/15 Health Networks reported no Complex Case Management cases in Jan 2016
 - Completed retraining of Health Networks on identification of members for CCM
- Presented the 2015 Member Experience with Case Management Results
- Presented the results of the Population Assessment for Case Management

Highlights (Continued)

- Quality Analytics

- Presented status report on the OneCare Connect Quality Withhold Program
 - Report on Year 1 measures and review of Year 2 & 3 measures
- Presented an update on Member Experience
 - Summary of the Supplemental Survey Results
 - Proposed activities to improve satisfaction
- Presented 2016 Accessibility Goals (Timely Access/Appointment Availability & Member Services)
- Presented 2016 Availability Goals (Ratio & Distance)
- Presented an update on HEDIS Measures & required Quality Improvement Projects

- Cultural & Linguistics

- Presented Availability of Practitioners report
 - Results of the Cultural Needs & Preferences 2016 Study

Highlights (Continued)

- LTSS

- Presented 1st Quarter performance reports for CBAS, LTSS, IHSS, MSSP
 - Data presented on Hospital Admissions & Readmissions, ED Visits, LTC Admissions
 - Presented the review of findings and next steps

- Audit & Oversight

- Reviewed summary of the Quality Improvement Work Plans from the Health Networks
 - 4 Health Networks met the requirements for a QI Work Plan, 7 did not meet the requirements
 - Most common areas of non-compliance: Continuity & Coordination of Care, Health Appraisals

- PACE

- Presented 2016 Quality Work Plan
 - 2015 Evaluation Completed
 - Reported performance on quality improvement projects:
 - Immunizations, Medical Utilization, Diabetic Retinal Eye, Patient Satisfaction

Highlights (Continued)

- Pharmacy Management

- Presented an update on Safety & Quality of Clinical Care
 - Over/Under Utilization, Monitoring of Hepatitis C
- Presented an update on the implementation of the new PBM

- Behavioral Health

- Presented delegation oversight of Behavioral Health report
- Presented progress on Quality of Clinical Care: Integration of BH Services & related HEDIS activities
- Presented progress on Access & Availability for Behavioral Health Practitioners

Highlights (Continued)

- Customer Service

- Reviewed 1st Quarter 2016 Call center results
 - Met all Call Center Targets for 2015
- Reviewed results of Medi-Cal Telephone Member Survey
 - First Call Resolution Statistics
 - Top CallbackCategories (Pharmacy, Provider Inforamtion)

- Member Complaints & Grievances

- Presented member grievances by category (Medi-Cal)
 - 63% related to Quality of Service
 - 25% related to Quality of Care
- Presented member grievances by category (OneCare Connect)
 - 79% related to Quality of Service
 - 13% related to Quality of Care
- Presented member grievances by category (OneCare)
 - 79% related to Quality of Service
 - 21% related to Quality of Care

What's new

- Achieved NCQA Accreditation – Commendable Status
- Received our Health Plan Rating



CalOptima
Better. Together.

Member Trend Report 1st Quarter 2016

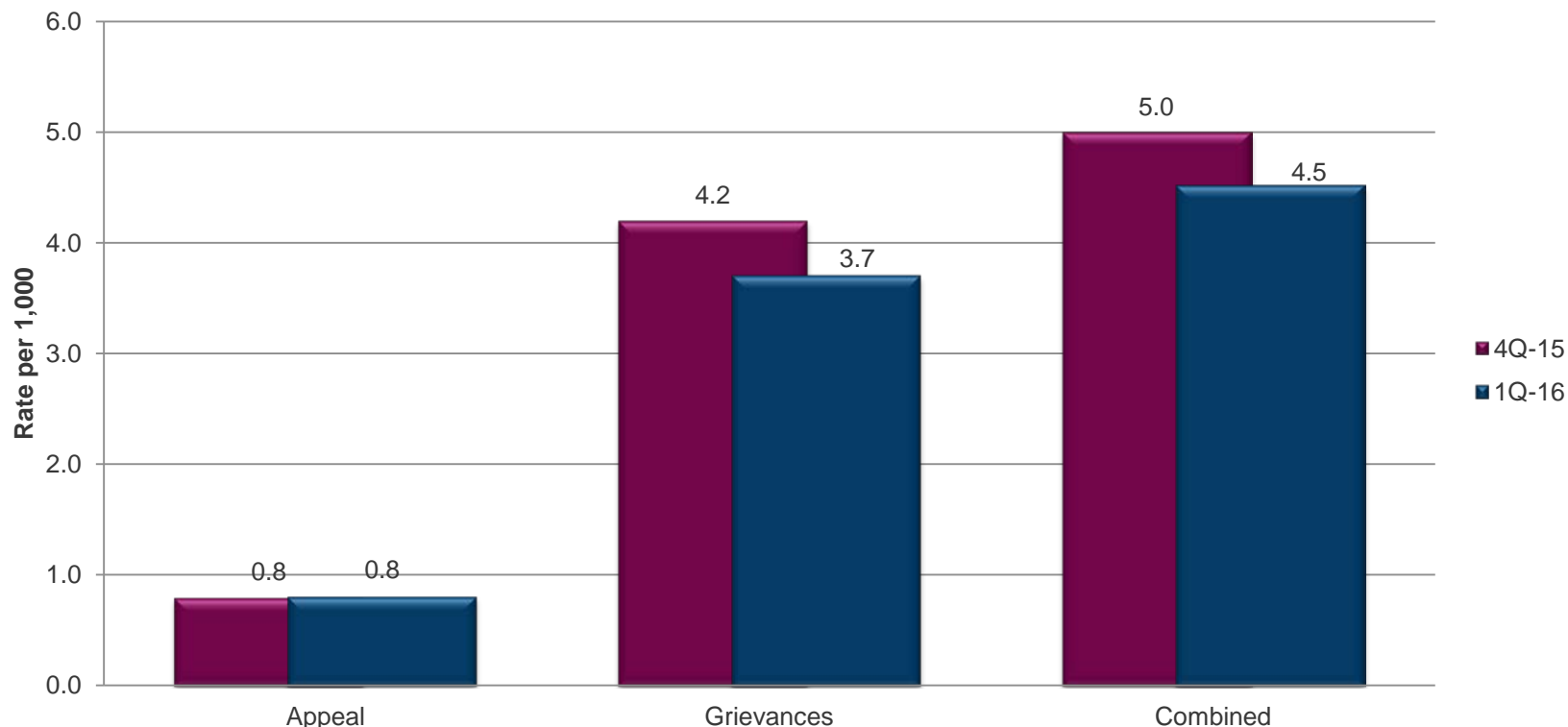
**Board of Directors' Quality Assurance Committee Meeting
September 21, 2016**

**Janine Kodama
Director, Grievance and Appeals**

Overview

- Trend of the rate of complaints (appeal/grievance) per thousand members for all CalOptima programs for the first quarter in 2016.
 - Appeal — A request by the member for review of any decision to deny, modify or discontinue a covered service.
 - Grievance — An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
- Breakdown of the complaints by type
- Interventions based on trends

Overall Medi-Cal Member Complaints

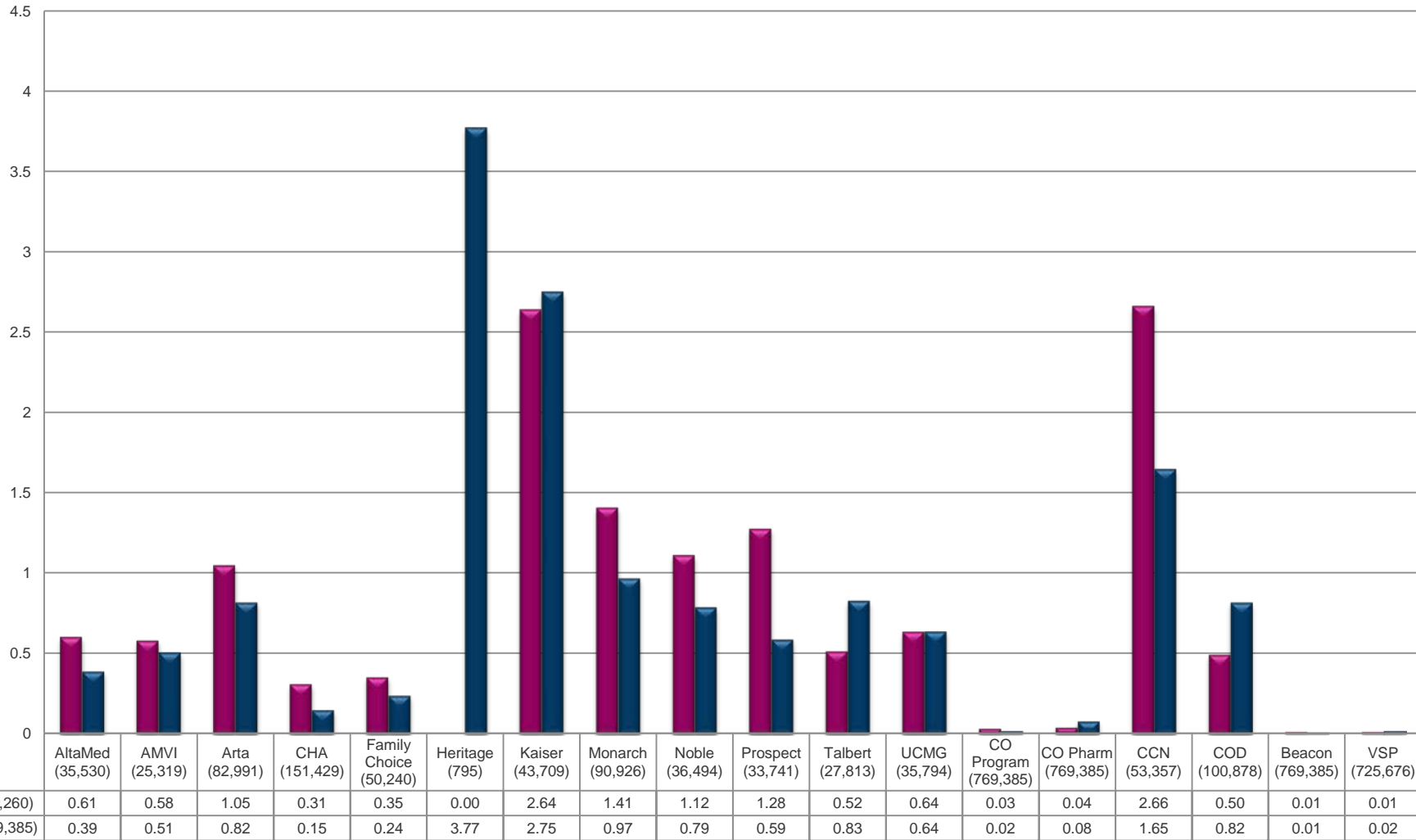


Total of 856 complaints
(154 appeals and 702 grievances) in Q1 2016
vs.
981 complaints
(164 appeals and 817 grievances) in Q4 2015

Average membership was
769,385 in Q1 2016
vs.
773,260 in Q4 2015

Medi-Cal Member Grievances

Quarterly Rate/1,000 By Health Network



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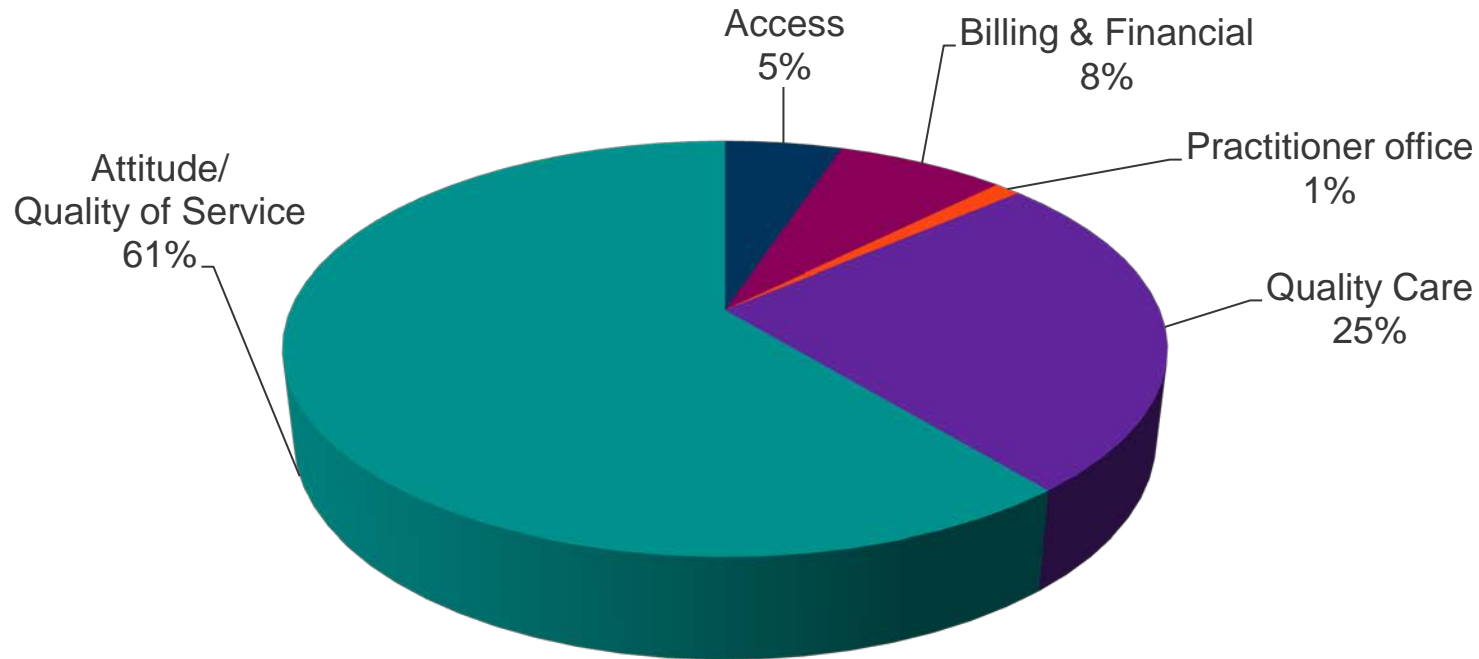
Trends

- Heritage Medical Group reports a higher rate/thousand grievances due to low membership.
 - There were only 3 grievances reported out of 795 members.
- Kaiser historically reports slightly higher grievances than other networks; mostly due to their robust system of tracking issues.
 - However, it also has high member satisfaction and loyalty among its membership. There were no specific trending of issues identified.
- There was a drop in grievances for CCN. The decreases were in both Quality of Service (QOS) and Quality of Care (QOC).
 - QOS dropped from 39 in Q4 2015 to 18 in Q1 2016
 - QOC decreased from 89 in Q4 2015 to 56 in Q1 2016

Trends (cont.)

- Review of the quality of service concerns for all health networks did not identify specific trending for provider or staff.
- Overall grievances as a rate/1,000 members remain low at 3.7 in Q1 2016, a decrease from 4.2 in Q4 2015.

Medi-Cal Grievances By Category



- There were a total of 702 grievances filed by 568 unique members in Q1 2016.
 - Of these, 428 grievances (61%) were related to QOS and 178 grievances (25%) were related to QOC concerns.
 - The percentage by categories represent the common trend.
- The Quality Improvement (QI) department continues to review for QOC issues and potential trending.

QOS Concerns

- QOS are issues resulting in inconvenience or dissatisfaction to the member.
- Common QOS issues:
 - Delay in service
 - Referrals
 - Tests/test results
 - Dissatisfied with staff, doctor or program
 - Unsatisfied with treatment
 - Rudeness
 - Member billing

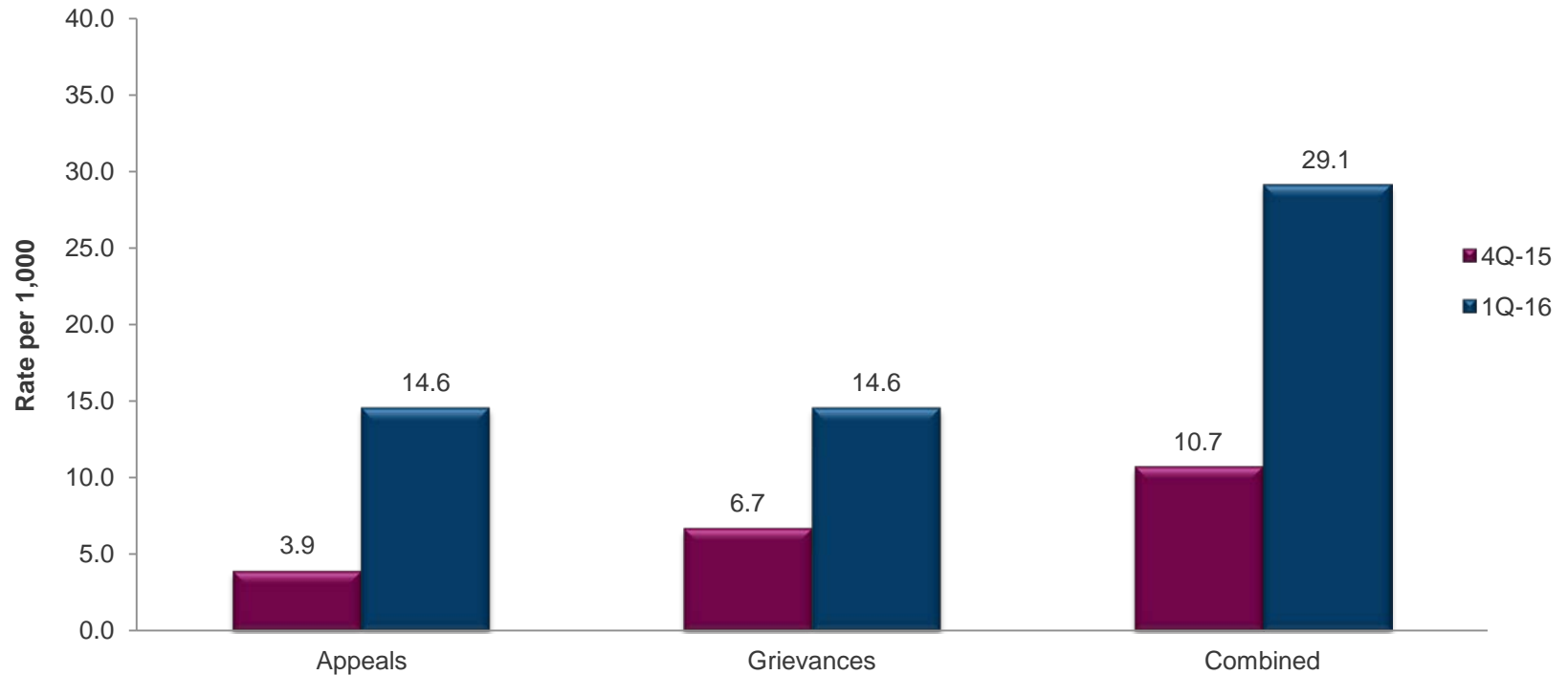
QOC Concerns (cont.)

- QOC concerns occur if the member feels there was a problem with the care they received or that they did not receive enough care.
- Common QOC issues:
 - Question diagnosis
 - Question treatment
 - Delay in treatment impacting member's care
 - Refusal to treat

Interventions

- All quality of care concerns are referred to the Quality Improvement department for investigation.
- CalOptima works with all our networks (by sharing the grievance and appeals data specific to each network) and providers to improve in these areas including QOS and QOC concerns.

Overall OneCare (OC) Member Complaints



Total of 38 complaints
(19 appeals and 19 grievances) in Q1 2016
vs.
134 complaints
(48 appeals and 86 grievances) in Q4 2015

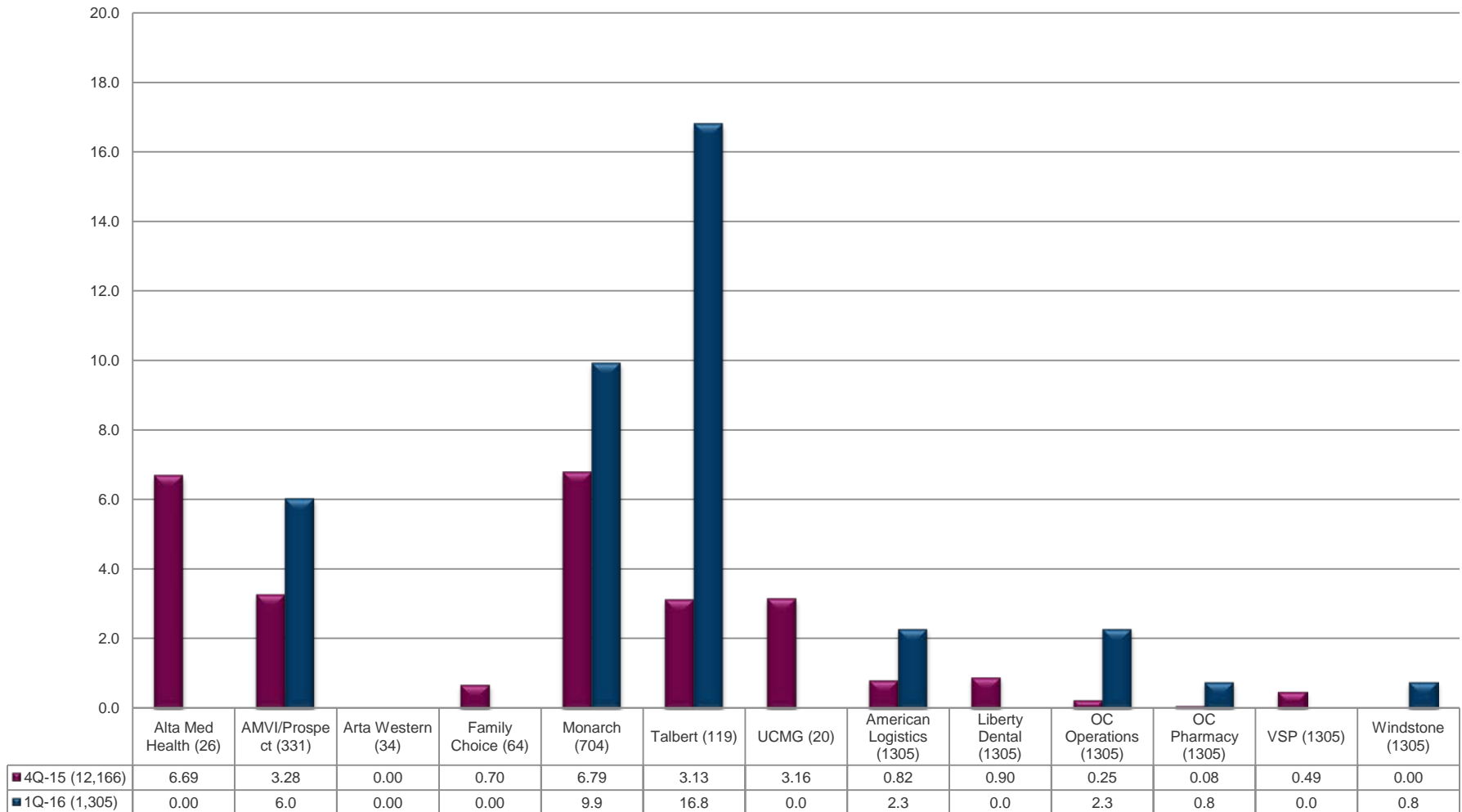
Average membership was
12,166 in Q4 2015
vs.
1,305 in Q1 2016

Trends and Interventions

- Complaints as reported by rate/1,000 members increased from Q4 2015 to Q1 2016 due to the transition of the OC members in January 2016 to OCC program.
 - Therefore, with lower membership the rate/1,000 goes up even if the number of complaints are lower.
- Membership dropped by 89 percent from 12,166 in Q4 2015 to 1,305 in Q1 2016.
 - The average rate/1,000 for grievances at 14.6 represents a total of 19 grievances in one quarter.

OC Member Grievances

Quarterly Rate/1,000 By Health Network

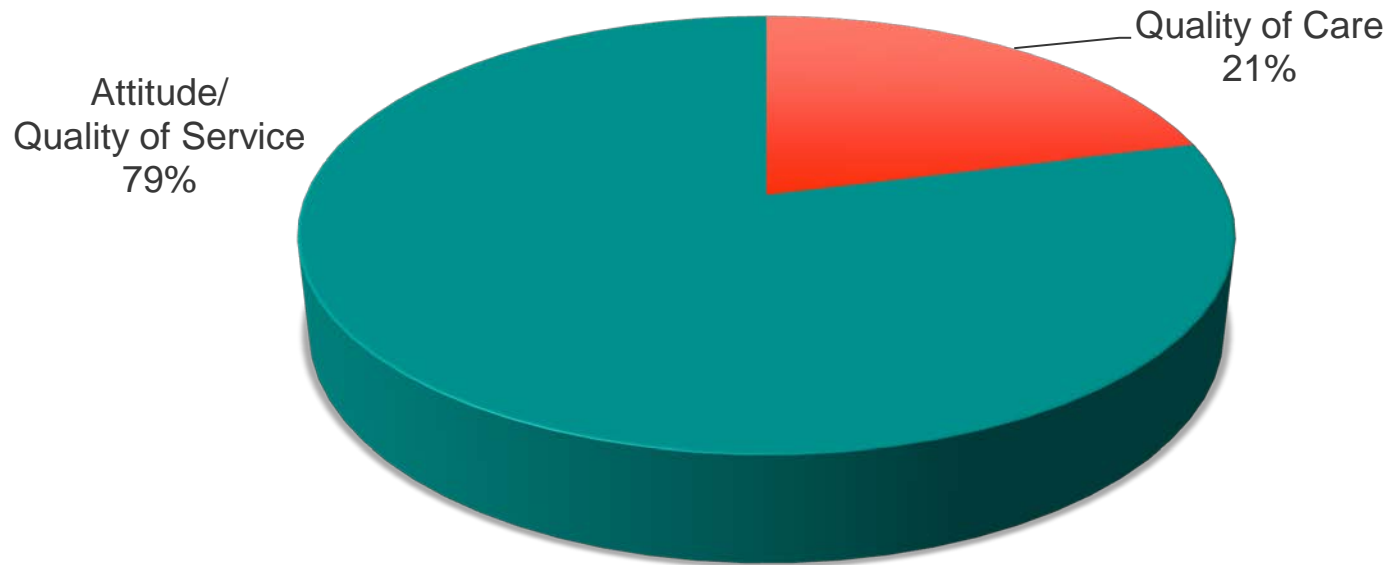


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Trends and Interventions

- AMVI, Monarch and Talbert report a higher quarterly rate/1,000 grievances due to low membership. The grievances received are as follows:
 - AMVI: 2 grievances reported out of 331 members
 - Monarch: 7 grievances reported out of 704 members
 - Talbert: 2 grievances reported out of 119 members
- No specific trending of issues or providers identified.

OC Grievances By Category



- There were a total of 19 grievances filed by 17 unique members in Q1 2016.
 - Of these, 15 grievances (79%) were related to QOS and 4 grievances (21%) were related to QOC concerns.
 - Note: The percentage by categories represent the common trend.
- The QI department continues to review for QOC issues and potential trending.

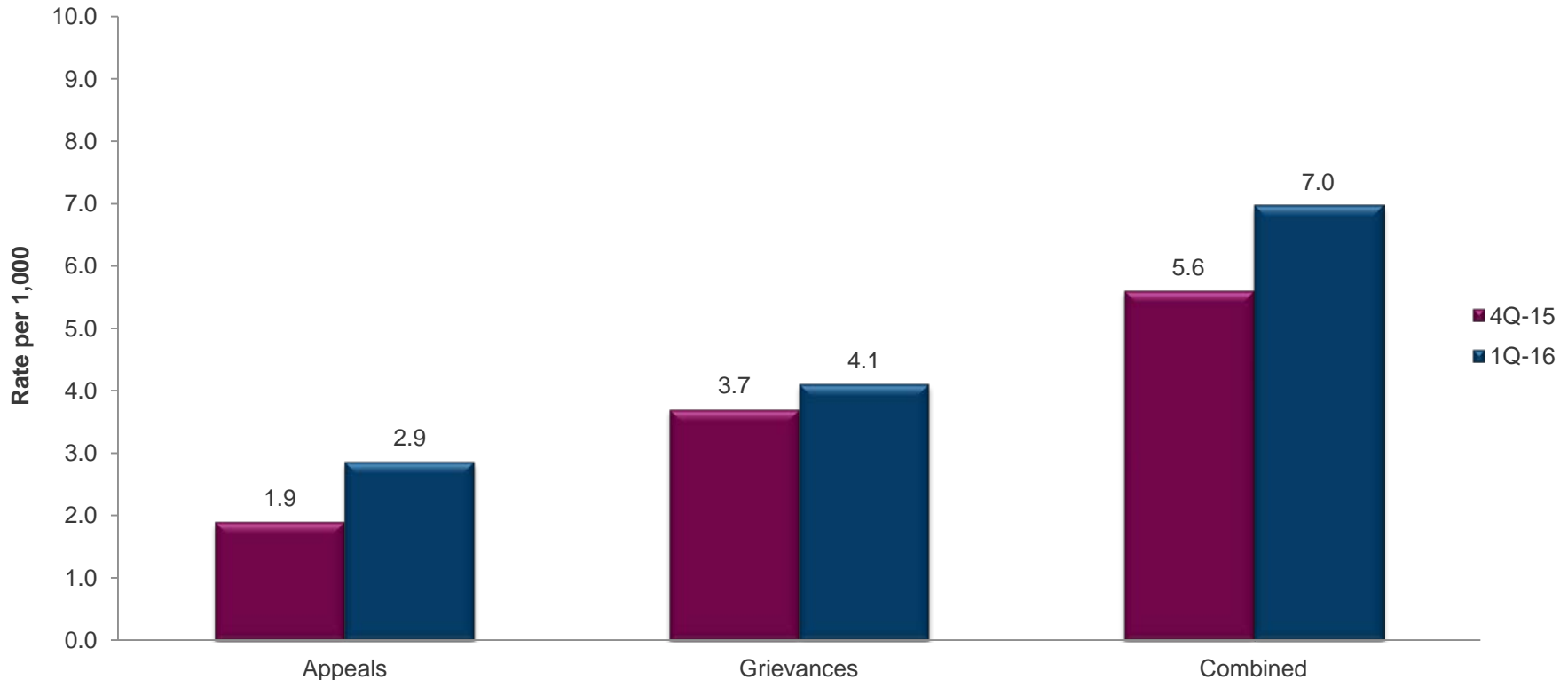
QOS Concerns

- Provider services
 - Dissatisfied with staff and doctor
- Delay in service
 - Referrals and appointment delay
- Transportation vendor (taxi – supplemental services)
 - Dissatisfied with driver (rude and/or untimely)

QOC Concerns (cont.)

- Question diagnosis
- Question treatment
- Refusal to treat
- Lack of follow up
- All QOC concerns are referred to the Quality Improvement department for investigation.

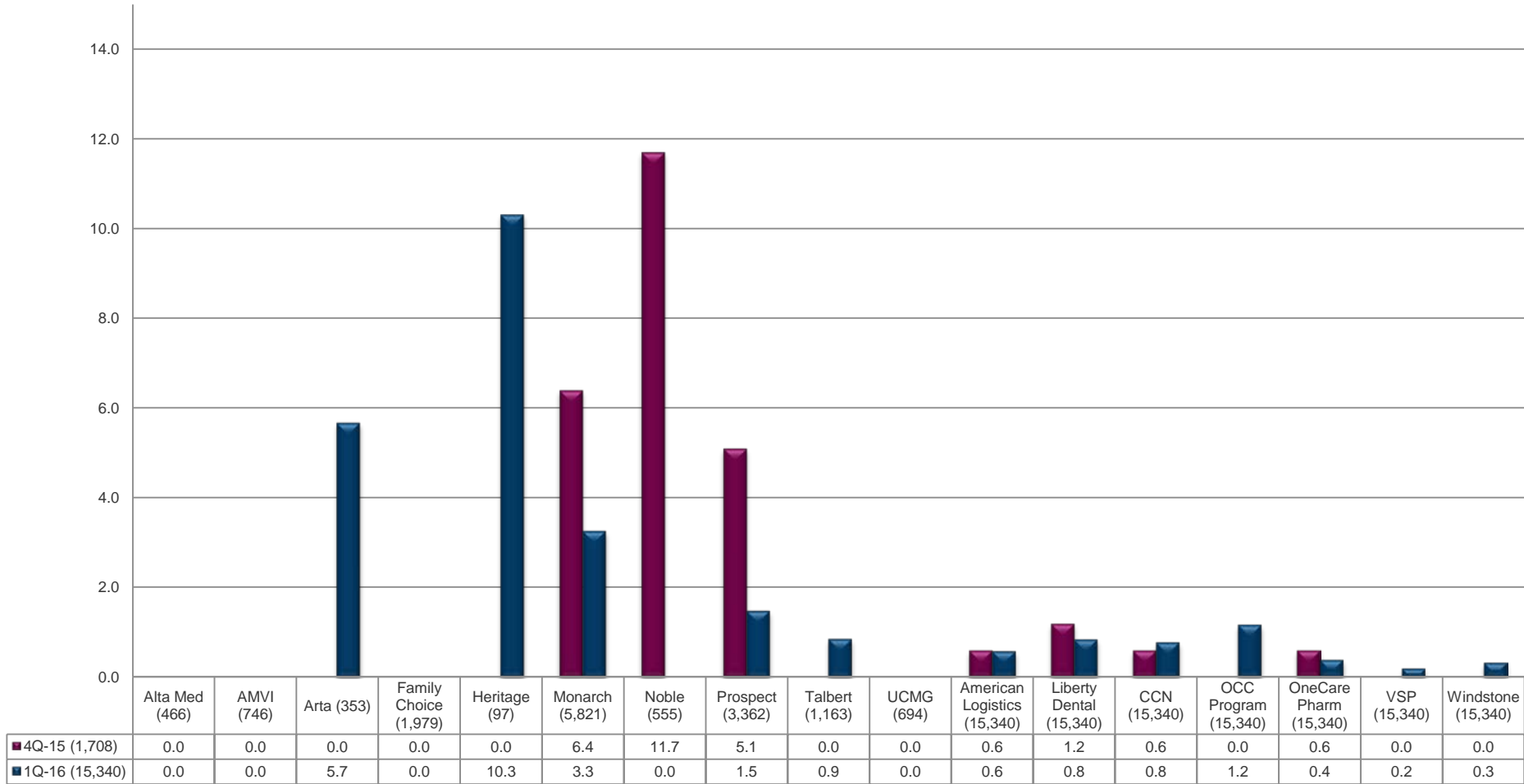
Overall OneCare Connect (OCC) Member Complaints



Total of 138 complaints
(44 appeals and 94 grievances) in Q1 2016
vs.
15 complaints
(5 appeals and 10 grievances) in Q4 2015

Average membership was
15,340 in Q1 2016
vs.
1,708 in Q4 2015

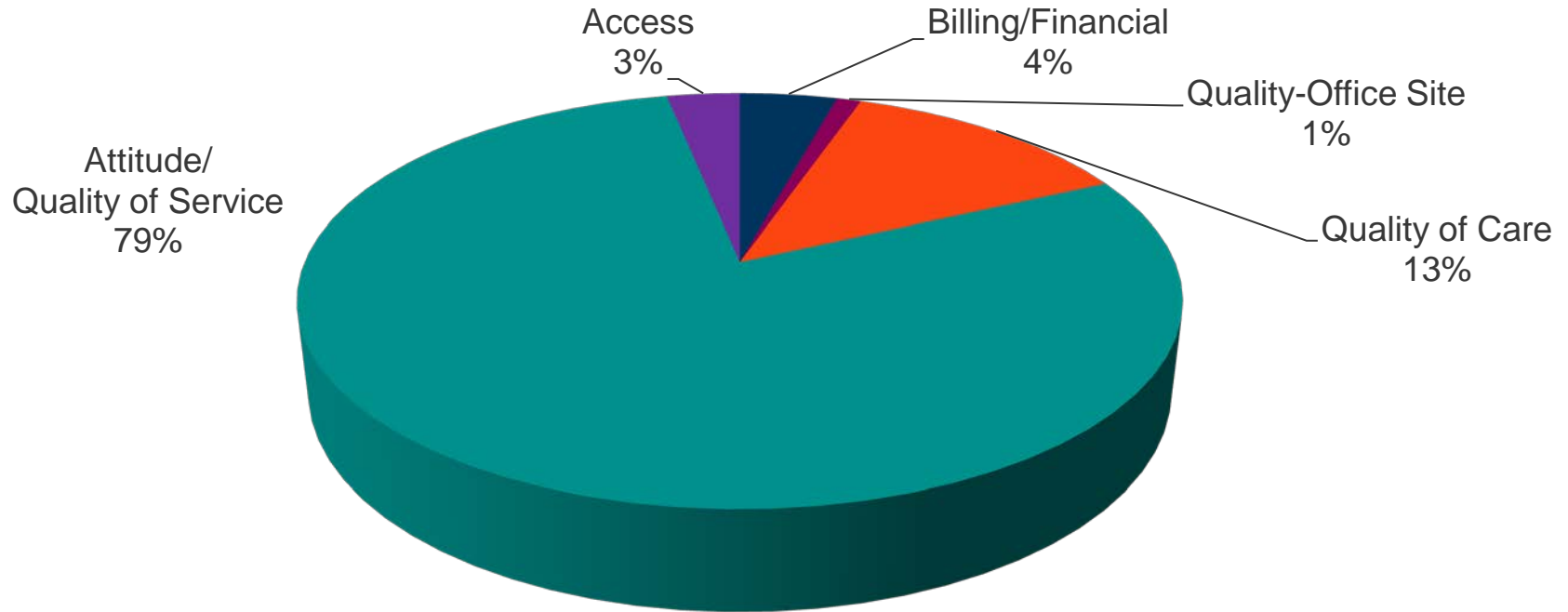
OCC Member Grievances Quarterly Rate/1,000



Trends and Interventions

- Arta and Heritage report a higher rate/1,000 grievances due to low membership.
 - Arta: 2 grievances reported out for 353 members
 - Heritage: 1 grievance reported out for 97 members
- Membership increased by 89 percent from 1,708 in Q4 2015 to 15,340 in Q1 2016.
- No specific trends identified with the Physician Medical Group or providers.

OCC Grievances By Category



- There were a total of 94 grievances filed by 76 unique members in Q1 2016.
 - Of these, 74 grievances (79%) were related to QOS and 12 grievances (13%) were related to QOC concerns.
 - Note: The percentage by categories represent the common trend.
- The QI department continues to review for QOC issues and potential trending.

QOS and QOC Concerns

- Benefit package (QOS)
 - Non-covered benefits (gym and acupuncture)
- Delay in service (QOS)
- Transportation vendor (QOS)
 - No show
 - Rudeness
 - Unsafe Driving
- Question diagnosis/treatment (QOC)

Trends and Interventions

- All quality of care concerns are referred to Quality Improvement department for investigation.
- No specific trends identified with the Physician Medical Group or providers.

CalOptima's Mission

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