



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

**WEDNESDAY, MAY 16, 2018
3:00 P.M.**

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

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE

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

CHIEF EXECUTIVE OFFICER
Michael Schrader

CHIEF COUNSEL
Gary Crockett

CLERK OF THE BOARD
Suzanne Turf

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

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

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

CALL TO ORDER

Pledge of Allegiance
Establish Quorum

PUBLIC COMMENTS

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

CONSENT CALENDAR

1. [Approve Minutes of the February 20, 2018 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee](#)

REPORTS

2. [Receive and File 2017 Utilization Management Program Evaluation](#)
3. [Consider Recommending Board of Directors Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to Participating Health Networks](#)
4. [Consider Recommending Board of Directors' Approval of the Modification of the Previously Approved Pay for Value Payment Methodology for Measurement Year 2017 for CalOptima Community Network Providers by Incorporating an Improvement Factor](#)

INFORMATION ITEMS

5. [PACE Member Advisory Committee Update](#)
6. [PACE Primary Care Physician Incentive Program Update](#)
7. [Perinatal Support Services Update](#)
8. Quarterly Reports to the Board of Directors' Quality Assurance Committee
 - a. [Quality Improvement Committee First Quarter 2018 Update](#)
 - b. [Member Trend Report – Fourth Quarter 2017](#)

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 20, 2018

CALL TO ORDER

Chair Paul Yost called the meeting to order at 3:03 p.m. Director Berger led the pledge of Allegiance.

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

Members Absent: Dr. Nikan Khatibi

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

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

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

Action: On motion of Director Nguyen, seconded and carried, the Committee approved the Minutes of the November 15, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Director Khatibi absent)

REPORTS

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

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend that the Board of Directors ratify CalOptima's Pharmacy Management Residency Program and approve Policy GG.1426, Residency Program, Pharmacy Management.

Nicki Ghazanfarpour, PharmD, Pharmacy Clinical Programs Manager, provided an overview of the CalOptima Pharmacy Management Program that began in 2010 and is included in CalOptima's 2017 Utilization Management Program. The Pharmacy Resident position is 12-months in duration that consists of structured rotations through different areas in Pharmacy Management, and residents are required to complete a longitudinal drug utilization review (DUR) project that contributes to the Centers for Medicare & Medicaid Services (CMS) and Department of Managed Health Care (DHCS) DUR requirements. It was noted that Pharmacy Residents have consistently engaged in quality improvement and assessment activities, assisted in staff development, and have supported innovative approaches to care that have positively impacted CalOptima members.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors ratify CalOptima's Pharmacy Management Residency Program and approve Policy GG.1426, Residency Program, Pharmacy Management. (Motion carried 3-0-0; Director Khatibi absent)***

3. Receive and File the CalOptima 2017 Quality Improvement Program Evaluation

Dr. Bock presented a review of the 2017 Quality Improvement (QI) Program evaluation accomplishments during 2017, including: recognition by the National Committee for Quality Assurance (NCQA) for top quality care for Medi-Cal members and maintaining "Commendable" NCQA accreditation status; revised Health Network Pay for Value (P4V) program that demonstrated improved performance in adult and children P4V measures; implementation of eight targeted quality initiatives with member and/or provider incentives to improve HEDIS scores; transitioned the administration of Medi-Cal behavioral health services in-house; and redesigned and expanded the childhood obesity program, Shape Your Life, and the perinatal program, Bright Steps. QI opportunities for 2018 include continued maintenance of NCQA accreditation and top Medicaid health plan rating, implementing a P4V program for CalOptima Care Network (CCN) providers, implementing provider and office staff coaching program, and implementation of the newly redesigned Shape Your Life and Bright Steps programs.

Action: ***On motion of Director Berger, seconded and carried, the Committee received and filed the CalOptima 2017 Quality Improvement Program Evaluation as presented. (Motion carried 3-0-0; Director Khatibi absent)***

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

Dr. Bock presented the action to recommend Board of Directors' approval of the recommended revisions to the 2018 QI Program and 2018 QI Work Plan.

Esther Okajima, Quality Improvement Director, presented an overview of the proposed revisions to the 2018 QI Program Description and Work Plan. As proposed, the recommended revisions ensure that the QI Program reflects health network and strategic organizational changes, and that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across all lines of business.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima 2018 Quality Improvement (QI) Program and 2018 QI Work Plan. (Motion carried 3-0-0; Director Khatibi absent)***

5. Consider Recommending Board of Directors' Approval of the 2018 CalOptima Utilization Management Program

Steve Chang, Long-Term Support Services Director, presented the action to recommend Board of Directors' approval of the 2018 Utilization Management (UM) Program. Mr. Chang provided an overview of the proposed revisions, including: aligning the program descriptions and committee references with the QI Program; updates to reflect the transition of mild to moderate mental health benefit administration for the Medi-Cal program from Magellan to CalOptima; incorporation of new health network risk structure models; and modified the description of Managed Long-Term Services and Supports to reflect In Home Support Services reverting to the County of Orange administrative responsibility.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima 2018 Utilization Management Program. (Motion carried 3-0-0; Director Khatibi absent)***

6. Receive and File the 2017 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance Performance Improvement Plan Annual Evaluation

Miles Masatsugu, M.D., Medical Director, presented the recommended action to receive and file the 2017 CalOptima PACE Quality Assurance Performance Improvement Plan Annual Evaluation. A review of the 2017 accomplishments was provided to the Committee, including: membership growth to 236 participants; completion of successful DHCS level of care audits; 100% of participants received influenza and pneumococcal immunizations and completed a Physician's Order for Life-Sustaining Treatment; and significant improvement in patient satisfaction. Opportunities for improvement in 2018 are in the areas of utilization, membership growth, participant satisfaction, and additional quality of care HEDIS elements.

Action: ***On motion of Director Berger, seconded and carried, the Committee received and filed the 2017 CalOptima PACE Quality Assurance Performance Improvement Plan Annual Evaluation as presented. (Motion carried 3-0-0; Director Khatibi absent)***

7. Consider Recommending Board of Directors' Approval of the 2018 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan

Dr. Masatsugu presented the action to recommend Board of Directors' approval of the 2018 CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan. The 2018 QAPI plan is based on the opportunities for quality improvement noted in the 2017 QAPI Plan Evaluation. Work plan elements for 2018 include: preventative care, quality of care, infection control, access and availability, utilization management, delegation oversight, and patient satisfaction/member experience. New work plan elements focus on comprehensive diabetes care, potentially harmful drug-disease interactions in the elderly, and transitions of care.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the 2018 CalOptima PACE Quality Assurance Performance Improvement Plan. (Motion carried 3-0-0; Director Khatibi absent)***

8. Consider Recommending Board of Directors' Ratification of Increased Payment to Primary Care Physicians for the Depression Screening Incentive Program Funded by Intergovernmental Transfer (IGT) 1

Donald Sharps, M.D., Medical Director, presented the action to recommend that the Board of Directors' ratify a \$20 increase per depression screening to \$50 for all screens completed by physicians for eligible members retroactively to May 1, 2017, and authorize incentive payments of \$50 per depression screening for members prospectively through May 2019, or until available funding has been exhausted, whichever comes first.

Dr. Sharps reported that on December 1, 2016, the Board of Directors authorized the reallocation of \$1,000,000 from 2010-11 IGT 1 funds to support a physician incentive program aimed at increasing the rate of depression screenings conducted during annual wellness visits for members ages 12 to 18. At that time, \$30 per screening was approved as the incentive payment amount to be made directly to primary care physicians. In January 2018, the discrepancy between the Board approved \$30 per screening amount and the actual \$50 per incentive payment per screen gained broader visibility within the organization.

Based on the screenings completed to date, the rate change resulted in an increase in payment of \$38,960, or 66% through December 2017. The annual increase in payment is projected to be \$66,000. It was noted that with an annual utilization rate of approximately 20%, the \$50 incentive payment per screen will use approximately 33% of the \$1,000,000 allotted to the program within a two-year period. As proposed, Board ratification of the higher incentive payments and authorizing payments at the higher level going forward, will enable CalOptima to build on the momentum created during the first eight months of the program. Staff will continue to monitor the volume of screenings and depression diagnosis, and will keep the Board updated on the program, and return with further recommendations. Additionally, staff will implement internal validation and control measures to ensure that system and process implementations are consistent with Board-approved actions.

After discussion of the matter, the Committee took the following action.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors ratify a \$20 increase per depression screening to \$50 for all screens completed by physicians for eligible members retroactively to May 1, 2017, and authorize incentive payments of \$50 per depression screening for members prospectively through May 2019, or until available funding has been exhausted, whichever comes first. (Motion carried 3-0-0; Director Khatibi absent)***

9. Consider Recommending Board of Directors' Approval of Policy GG.1656, Conflict of Interest

Dr. Bock presented the action to recommend Board of Directors' approval of CalOptima Policy GG.1656, with the following revised title: Quality Improvement and Utilization Management Conflicts of Interest. This new policy was developed in response to a Department of Health Care Services and the

Centers for Medicare & Medicaid Services contract requirement to ensure rules of confidentiality in quality improvement discussions, as well as avoidance of conflict of interest on the part of committee members. As proposed, the new policy will ensure that the Quality Improvement Committee and its subcommittees who oversee quality and utilization activities fully disclose any actual or perceived conflicts of interest.

Action: On motion of Chair Yost, seconded and carried, the Committee recommended Board of Directors' approval of CalOptima Policy GG.1656: Quality Improvement and Utilization Management Conflicts of Interest. (Motion carried 3-0-0; Director Khatibi absent)

INFORMATION ITEMS

The following Information Items were accepted as presented:

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

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:22 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: May 16, 2018



CalOptima
Better. Together.

2017 Utilization Management Program Evaluation

**Board of Directors' Quality Assurance Committee Meeting
May 16, 2018**

**Tracy Hitzeman, RN CCM
Executive Director, Medical Management**

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2017 UM Program Evaluation

- Describes CalOptima's Utilization Management (UM) Program activities
- Analyzes performance against 2017 approved goals
- Based upon the 2017 UM Work Plan
- Focused initiatives for the 2017 UM Program and Work Plan

Accomplishments

- Upgrade of the Guiding Care Utilization Review Module (CalOptima's medical management system)
- Enhancement of the CalOptima Link (COLA) authorization electronic portal
- Continued development of CalOptima Reporting Environment (CORE) to align necessary operational reports with existing data structure
- Further refinement of data standards to track and trend operational metrics
- Developed specialists to support excellence in UM processes for CalOptima's Medi-Cal, OneCare Connect and OneCare product lines
- Prepared for transition of Medi-Cal mild to moderate Behavioral Health to CalOptima from a vended benefit
- Implementation of DHCS Palliative Care Guidelines for Medi-Cal

Operational Performance

- Timeliness of decision-making and notification

Cohort	Routine	Expedited
HN	98%	97%
CCN	99%	98.7%
Pharmacy	97.7%	

- Appropriateness of clinical decision making
 - Scores ranged between 67-100%
- Letter Review- (member friendly language, citing guidelines)
 - Scores varied from 74-100%

2017 UM Outcomes

Medi-Cal

- Hospitalizations: Bed Day PTMPY goal met for all LOBs
- ED rates PTMPY met 1 out of 4 reporting quarters

One Care Connect

- Hospitalizations: Bed Day PTMPY goals met 3 out of 4 quarters
- ED rates PTMPY met goal 1 out of 4 quarters

OneCare

- Hospitalizations: Bed Day PTMPY goal met 3 of 4 quarters
- ED rates PTMPY met the goal 1 out of 4 quarters

Retail Pharmacy PMPM costs below goal for all LOBs

Member and Provider Satisfaction

- Member concerns:
 - Pharmacy Home program/quantity limits on opioid medications
 - Quality of service by pain management practitioners
 - Supplemental dental benefits (OCC)
- Positive trends:
 - Significant decrease in complaints regarding transportation
- Provider concerns:
 - Redirection from tertiary level of care for management of non-complex conditions
 - Payment disputes, particularly from non-participating providers
- Positive trends:
 - Decreasing complaints regarding redirection from tertiary care

Opportunities 2018

- Continuous improvement of operational performance
- Focus on transitions (home → ED, hospital → home)
- Assure appropriate utilization of behavioral health services
- Successfully transition members receiving BHT for non ASD conditions from the Regional Center
- Support growth of the Palliative Care Program
- Whole Child Model planning (Implementation 1/1/19)
- Health Homes planning

Recommended Action

Receive and File the 2017 Utilization Management Program Evaluation.

2017 Utilization Management Program Evaluation

Date: January 19, 2018

EXECUTIVE SUMMARY

The 2017 Utilization Management Program and Work Plan describe CalOptima's activities to promote optimum utilization of health care services for our members in a high-quality, compassionate and cost-effective manner.

The evaluation is completed on an annual basis, approved by the Utilization Management Committee (UMC), the Quality Improvement Committee (QIC), the Quality Assurance Committee (QAC) and CalOptima's Board of Directors.

I. PROJECTS AND INITIATIVES:

A. Utilization Management

In 2017, the UM department initiated several projects to support improved efficiency, decreased administrative burden and improved quality of provider and member facing documentation.

These projects included:

- Upgrades to the Guiding Care (GC) Utilization Review Module in CalOptima's medical management system
- Enhancement of the CalOptima Link (COLA) authorization electronic portal
- Continued development of CalOptima Reporting Environment (CORE) to align necessary operational reports with the data structure in GC
- Developed specialists to support excellence in UM processes for CalOptima's Medi-Cal, OneCare Connect and OneCare product lines

The Medical Director of UM provides clinical oversight for the administration of the UM Program. He supports the UM process by both ensuring that treatment requests are processed using regulatory sources and clinical, evidence-based criteria, and by evaluating the program's effectiveness against established goals. For areas not meeting goals, program changes are proposed and approved by the UM Workgroup and UMC and implemented by the UM Leadership staff. The UM Medical Director supports provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee, (BMSC) to evaluate new and changing benefits and determine the need for prior authorization. He also provides support and education to the UM department staff through twice weekly concurrent review case rounds and review and decision for adverse determinations.

During 2017, the UM Medical Director held quarterly round table meetings with the Prior Authorization team, discussing emerging treatment protocols and providing a forum for staff to identify and share best practices. During twice-weekly concurrent review case rounds, the UM

Medical Director led discussions with the nursing and physician group on current cases, including both clinical and practical aspects of managing the cases and assisting with discharge planning. Topics discussed in 2017 included genetic testing, management of administrative days, appropriate LTAC criteria, Letter of Agreement (LOA) process, and one-day inpatient stays.

In 2017, the UM Medical Director adequately supported the UM process and met the needs of the UM team through education, case review, and availability.

B. Behavioral Health

In 2017, a significant change in the delivery of behavioral health services to CalOptima members began. CalOptima's Behavioral Health Managed Care Organization, Magellan, has been responsible for mild to moderate mental health services for the Medi-Cal population and for the full spectrum of mental health services for OneCare Connect and OneCare. CalOptima Behavioral Health Integration was responsible for oversight of these services. In mid-2017, Magellan advised CalOptima that they no longer would be able to support the Medi-Cal product line. In cooperation with DHCS and Magellan Health, CalOptima negotiated the transition date of December 28, 2017.

Intensive, agency-wide effort was focused to ensure the transition of mild- moderate mental health service administration for Medi-Cal members was completed with the minimum possible disruption to our members. The Behavioral Health Integration team established processes for ensuring access to mental health providers for the treatment of disorders including, but not limited to depression, anxiety and Autism Spectrum Disorder. Behavioral Health Integration ensured the provision of treatment in accordance with mental health parity legislation. For the limited number of procedures that require prior authorization, processes were developed to ensure that authorization is performed in accordance with all federal, state, contractual, regulatory and accreditation guidelines.

Magellan Health continues to provide mental health services for CalOptima's OneCare Connect and OneCare members with oversight by the Behavioral Health Integration Department. The Behavioral Health Integration (BHI) department manages the BHQI subcommittee, which reports to the Quality Improvement Committee (QIC). The BHQI meets quarterly to trend, analyze and identify improvement areas Behavioral Health (BH) services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers.

The BHQI is chaired by the Medical Director of BHI and comprised of internal and external subcommittee members, including delegated network participants, community partners, behavioral health practitioners, and the Orange County Mental Health Plan (MHP), administered by the Orange County Health Care Agency (OC HCA). The Chair is responsible for leading and presenting subcommittee recommendations to the QIC. In addition, a BHQI workgroup met regularly throughout 2017 for additional work and analysis on Behavioral Health Quality initiatives. This group served to address suggestions from the BHQI that assisted with strengthening interventions, data review and key areas for improving the member experience. In 2017, the BHI Medical Director adequately supported the BH process and was able to meet the needs of the BHI team and CalOptima members.

C. UM Data Management

Continued refinement applied to data standards for tracking and trending of metrics for both CalOptima and the delegated health networks. Decreased data lag was accomplished by implementation of a new file format for health network submission of authorization information. Additional efforts are planned to leverage availability of this information to UM, Quality and Audit and Oversight by configuring standard queries of the data mart.

D. UM Delegated Provider Oversight

Medi-Cal

In 2017, oversight of the delegated Health Networks for UM was performed by CalOptima's Audit and Oversight Committee. Monthly, each of the delegates was monitored for the following activities:

- Timeliness of decision and notification
- Clinical Decision Making
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, in the member's preferred written language).

Timeliness:

The delegated Health Networks performed well for timeliness of decision and notification for routine pre-service authorizations (98%). For expedited requests, the health networks, scoring 97%, had a negative variance to goal of 1%. One of the delegates encountered challenges in the first and second quarters with timeliness, but made marked improvement by the third and fourth quarters, following a corrective action plan

Clinical Decision Making

The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are denied or modified. In 2017, the HN files ranged between 67-100% compliance with the standard, representing an opportunity for continued focus in this area.

Notifications

The delegated HNs are audited regularly on member notifications (NOAs). In 2017, compliance to standard ranged from 74-100%; this continues to be a focus for improvement.

OneCare Connect

In 2017, oversight of the delegated Health Networks for UM was performed by CalOptima's Audit and Oversight Committee. On a quarterly basis, each of the delegates were monitored for the following activities:

Timeliness of decision and notification

Clinical Decision Making

Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, in the member's preferred written language).

Timeliness

The delegated Health Networks performed at 98% compliance rate for timeliness of decision and notification for routine pre-service authorizations. For expedited requests, the health networks, scoring 97%, had a negative variance to goal of 1%.

Clinical Decision Making

The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are denied or modified. In 2017, the HN files ranged between 85-100% compliance with the standard.

Notifications

The delegated HNs are audited regularly on member notifications (NODs). In 2017, compliance to standard ranged from 53-100%. This continues to be a focus for improvement.

OneCare

In 2017, oversight of the delegated Health Networks for UM was performed by CalOptima's Audit and Oversight Committee. On a quarterly basis, each of the delegates were monitored for the following activities:

- Timeliness of decision and notification
- Clinical Decision Making
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, in member's preferred written language).

Timeliness

The delegated Health Networks performed at 85-100% compliance rate for timeliness of decision and notification for routine pre-service authorizations. For expedited requests, the health networks, scoring 83-100%, had opportunities for improvement.

Clinical Decision Making

The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are denied or modified. The 2017 scores ranged from 72% (one outlier) to 100%.

Notifications

The delegated HNs are audited regularly on member notifications (NODs). In 2017, compliance to standard ranged from 95-100%, representing significant improvement over 2016.

E. Utilization Performance

- For the Medi-Cal Shared Risk networks, the Bed Days/PTMPY goal for 2017 was consistently met for all subpopulations (SPD, TANF >18 and TANF ≤18). However, the goal for Emergency Department (ED) Visits/per thousand members per year (PTMPY) was not met for the Temporary Assistance for Needy Families (TANF) population, except for the third quarter for the TANF ≤18, and only met in quarters one and four for the SPD population.

Shared Risk - MC	Goal	Q1	Q2	Q3	Q4
SPD					
ALOS	-	5.1	4.8	4.6	4.1
Bed Days/PTMPY	1120	1104	1064	991	801
Readmissions	-	20%	23%	21%	19%
ED Visits/PTMPY	700	700	725	742	698
TANF >18					
ALOS	-	4.3	3.9	3.9	4.0
Bed Days/PMPY	360	280	255	278	281
Readmissions	-	15%	16%	17%	15%
ED Visits/PTMPY	430	442	452	481	450
TANF ≤18					
ALOS	-	2.8	2.7	3.0	3.0
Bed Days/PTMPY	40	41	32	33	36
Readmissions	-	5%	3%	2%	2%
ED Visits/PTMPY	310	350	341	308	338

- For the Medi-Cal CalOptima Community Network (CCN) population, 2017 Bed Days goals were met for each of the subpopulations, while ED visit goals were not met, except for the SPD member group for three of the four quarters. Over the past 2 years, CCN has demonstrated steady improvement in all inpatient metrics.

CCN	Goals	Q1	Q2	Q3	Q4
SPD					
ALOS	-	5.1	5.0	4.3	4.3
Bed Days/PTMPY	1830	1347	1297	1119	1433
Readmissions	-	23%	17%	23%	27%
ED Visits/PTMPY	640	619	642	545	600
TANF >18					
ALOS	-	4.9	4.4	3.9	4.7
Bed Days/PTMPY	710	466	441	368	431
Readmissions	-	16%	19%	18%	19%
ED Visits/PTMPY	490	506	496	509	513
TANF ≤18					
ALOS	-	2.3	2.1	2.7	2.3
Bed Days/PTMPY	100	55	47	33	34
Readmissions	-	7%	0%	0%	0%
ED Visits/PTMPY	470	530	521	426	580

- The CalOptima Direct Administrative population met the 2017 Bed Day and ED visit goals for the year, except for the first quarter for TANF members ≤18.

COD	Goals	Q1	Q2	Q3	Q4
SPD					
ALOS	-	5.4	5.1	4.9	6.6
Bed Days/PTMPY	1920	1908	1223	1165	1641
Readmissions	-	19%	25%	21%	19%
ED Visits/PTMPY	1120	1033	1011	973	828
TANF >18					
ALOS	-	5.1	5.2	4.7	5.0
Bed Days/PMPY	600	416	448	443	435
Readmissions	-	17%	18%	20%	18%
ED Visits/PTMPY	580	503	502	551	514
TANF ≤18					
ALOS	-	2.2	2.2	3.8	2.4
Bed Days/PTMPY	75	69	55	68	40
Readmissions	-	7%	8%	0	0
ED Visits/PTMPY	400	435	383	324	371

- One Care Connect Shared Risk results show progressive improvement in both Bed Days and ED visits over the course of the year, apart from the third quarter for members in the TANF group. This may be due to the virulent flu season in 2017.

Shared Risk - OCC	Goals	Q1	Q2	Q3	Q4	
SPD ALOS						
	-	5.3	4.9	4.0	4.7	
	1340	1486	1181	787	937	
	Readmissions	-	23%	21%	14%	18%
ED Visits/PTMPY	410	522	498	395	412	
TANF>18 ALOS						
	-	4.3	3.8	4.6	4.1	
	-	882	768	834	402	
	Readmissions	-	21%	25%	30%	8%
	ED Visits/PTMPY	-	547	477	722	435

- OneCare Connect CCN demonstrated improvement in bed day utilization in 2017, though ED usage was higher than anticipated.

CCN - OCC	Goals	Q1	Q2	Q3	Q4
SPD					
ALOS	-	5.1	5.0	4.8	4.5
Bed Days/PTMPY	1980	1992	1324	1468	1544
Readmissions	-	26%	16%	26%	23%
ED Visits/PTMPY	410	703	606	593	600
TANF>18					
ALOS	-	7.1	4.7	7.3	6.0
Bed Days/PTMPY	-	3966	1134	2277	2054
Readmissions	-	16%	21%	16%	10%
ED Visits/PTMPY	-	806	781	798	882

- OneCare results were variable, likely related to the small population size, but did show improvement in bed day utilization for the first three quarters.

OC	Goals	Q1	Q2	Q3	Q4
ALOS	-	5.4	3.9	4.6	6.8
Bed Days/PTMPY	1370	935	610	728	1885
Readmissions	-	14%	8%	11%	15%
ED Visits/PTMPY	480	374	519	507	504

To ensure over and under-utilization management activities were appropriately trended and evaluated, and multi-disciplinary team, consisting of Quality Analytics, Quality Improvement, UM and Case Management was implemented. The group met regularly to define and develop standard reporting mechanisms for CalOptima, including delegated Health Networks.

II. OPERATIONAL PERFORMANCE

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

Annual summary of referral volume:

<u>Authorization Processed</u>	<u>Referrals Processed</u>	<u>Turnaround Time</u>
<u>Compliance (TAT)</u>		
Routine: 125,620	Faxed: 49,127	Routine TAT: 99%
Urgent: 3157	COLAS: 79,650	Urgent TAT: 98.7%
Retro: 5231	Total: 128,777	Retro TAT: 98%
Total: 134,038		

Prior Authorization for Expedited / Urgent / Routine / Retro Requests - Pharmacy

Annual summary of turnaround time compliance, 2017:

One Care: 100%
OneCare Connect: 99.92%
Medi-Cal: 97.7%

Pharmacy Prior Authorization turnaround time (TAT) processing time are above goal of 97% for OneCare and OneCare Connect. The TAT for Medi-Cal fell below goal in 2Q17 due to a change in the PBM PA system. Pharmacy metric targets were achieved for 2017.

Authorization for Expedited / Urgent / Routine / Retro Requests - LTSS (CBAS, LTC)

- LTSS consistently met or exceeded required turnaround times throughout the year. LTSS metric targets were achieved for 2017.
- CBAS CEDT TAT: Average of 11.10 days
- CBAS Routine TAT: Average of 2.47 days
- CBAS Expedited TAT: 1 processed throughout the year with a TAT of 1 day
- LTC Routine TAT: Average of 2.09 days
- LTC Urgent TAT: Zero (0) processed throughout the year.

B. Online Referral Rate Submission Increase

Online referral submission rate over 4 quarters was 63%.

C. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review of UM, CBAS, MSSP, LTC by annual assessment of appropriate guideline application.

The IRR was administered in compliance with the UM Program. IRR metric targets were achieved for 2017. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

UM - 95%
Physicians - 92%
Pharmacy - 100%
LTSS – 99.3%

D. Denial Letter Process

Performance has continued to improve throughout 2017. A specific area of focus was the appropriate lay language, which has demonstrated significant improvement, though there remains some variability across the health networks. A workgroup begun in 2017 consisting of participants from the health networks, CalOptima's UM, Grievance and Appeals, and Audit and Oversight departments will continue to identify and share best practices to attain further improvement in this area.

III. UTILIZATION PERFORMANCE

A. Facility Utilization - Facility Acute Care

Analysis of inpatient data in 2017 identified positive performance against goals in Bed Days/PTMPY, though the emergency department utilization was variable, and overall, higher than anticipated.

B. Pharmacy Utilization

- Retail Pharmacy - \$PMPM costs for all LOB are below goal
- Diabetes drug utilization is the second highest drug class for OCC and highest for MCAL.
- Hepatitis C drug utilization has leveled off in CY17.
- Hydrocodone/APAP is the 10th highest drug for Medi-Cal by # Rxs in 4Q17, down from 5th highest in 4Q16.

Medi-Cal: Goal \$ PMPM \$49.86, actual CY17 \$49.81

OC: Goal \$ PMPM \$385.00, actual CY17 \$343.94

OCC: Goal \$ PMPM \$360.50, actual CY17 \$343.70

C. Member and Provider Satisfaction

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

- Providing information to members and providers about the UM Program
 - members are informed about authorization requirements through the Member Handbook and member newsletters
 - New Member Orientation is available for all CalOptima members to better understand their benefits
 - Access to a list of services requiring pre-authorization is also available on CalOptima's website

- CalOptima Customer Service and clinical staff are available to assist member's in accessing services, as needed
- Providers receive on-site visits from CalOptima's Provider Relations department, who provide tools and references for requesting authorizations for their members
- A Provider Toolkit is available on the CalOptima website for provider reference
- CalOptima Link provides an easily accessed electronic means of requesting authorizations for providers.
- Ensuring timeliness and notification of UM decisions
 - Monitored and reported quarterly to UMC: In 2017, the percent of authorization requests completed in a timely manner overall exceeded 97.5%.
- Consistent use of approved, evidence-based guidelines in clinical decision making
 - Monitored monthly by the Audit and Oversight Committee
 - Variation among the delegated Health Networks
 - Additional training provided as needed
 - Overall improvement in audit scores for clinical decision making in 2017

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals related to the UM Program. In 2017, complaints about the UM Program demonstrated some trends in the following categories:

- Member concerns:
 - Pharmacy Home Program and quantity limits on opioid medications.
 - Quality of service by pain management practitioners
 - Supplemental dental benefits
 - There was a significant decrease in the number of complaints about transportation by OneCare and OneCare Connect members. This is clearly due to the new Medi-Cal non-medical transportation benefit, which became effective in July 2017.
- Provider concerns:
 - Redirection from tertiary level of care for non-complex condition management
 - Level of payment disputes, especially from non-participating and/or out of area providers

While member concerns regarding the Pharmacy Home Program and quantity limits on opioid medications have risen, these controls remain as efforts to impact the opioid crisis strengthen. Provider, member and community education on the cautious and appropriate use of these medications will promote understanding of these programs. Complaints about pain management practitioners is likely a related issue. However, oversight of these providers and prompt review of any quality concerns will continue; appropriate peer review activities are performed by the Credentialing and Peer Review Committee.

CalOptima has worked closely with Liberty Dental to address complaints regarding supplemental dental benefits and recent updates to the contract should improve member experience.

Provider disputes regarding redirection from tertiary level of care have begun to trend downward as CalOptima has strengthened regular communication with UCI Medical Center through

quarterly joint operations meetings. Education continues with out-of-area and out-of-network providers regarding appropriate billing practices, especially for Medi-Medi members.

IV. Summary

In 2017, CalOptima made progress improving the effectiveness of the UM program and decreasing administrative barriers. Major initiatives included improvements to CalOptima's medical management system and network data interfaces as well as continued focus on interdisciplinary care coordination.

A new Medi-Cal benefit, non-medical transportation (NMT), holds promise in potentially improving member compliance and health outcomes. By increasing accessibility to health care, member visits to primary care, specialty physicians and pharmacy could become more consistent and more effective.

Quarterly evaluation of UM operational performance, health care utilization and trends in grievances and appeals discussed at the Utilization Management Committee will guide future efforts.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 16, 2018 **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

Report Item

3. Consider Recommending Board of Directors Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to Participating Health Networks

Contact

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

Recommended Action

Recommend Board of Directors to approval of the methodology for and the disbursement strategy of One Care Connect (OCC) demonstration years (DY) 2-5 (calendar years 2016 – 19), Quality Withhold payment to contracted Health Networks, including CalOptima's Community Network (CCN).

Background

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

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

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

To better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. Medi-Cal monies are not withheld from health networks. The amounts of the withhold are 1% for Year One (calendar year 2015), 2% for Year Two (calendar year 2016), and 3% for Years Three, Four, and Five (calendar years 2017-2019). All or a part of the withhold may be earned back based on a percentage of quality withhold measures that achieved benchmarks established by DHCS and CMS. Measures and benchmarks are based on final guidance received by CalOptima Regulatory Affairs from CMS and DHCS.

On August 6, 2015, the CalOptima Board of Directors approved the methodology and disbursement of the DY 1 (MY2015) quality withhold that was received from DHCS and CMS in October 2017 and

distributed to the health networks. Additional Board action is required for the methodology and distribution of earned quality withhold dollars for DY2-5.

Discussion

CalOptima began to participate in the Cal MediConnect program on July 1, 2015. Because CalOptima's participation in Cal MediConnect began midyear, the measurement period for DY 1 was considered July 1, 2015 to December 31, 2015. Subsequent years (years 2-5) began in 2016 and reflect services rendered from January 1 to December 31 of each year.

The quality withhold reduces capitation for both Medi-Cal and Medicare payments to CalOptima by two percent (2%) in Year Two and by three percent (3%) in Years Three, Four, and Five. These withheld funds can be earned back by CalOptima by "passing" a percentage of defined quality withhold measures. Measures are "passed" by managed care plans by achieving the established benchmark set by CMS for each quality withhold measure. The measures are prescribed by DHCS and CMS based on industry standard quality metrics such as HEDIS/Star measures and are communicated to plans via the Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes. Managed care plans earn their withhold back according to the following guidance:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

While the health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for and others that have shared responsibility between the delegated health networks and CalOptima.

CalOptima proposes the following methodology to distribute earned funds back to contracted health networks:

Health Network Scoring	
<ul style="list-style-type: none"> Quality Points is the sum of all points earned for each measure. 	
Health Network Measure Performance Points	
<ul style="list-style-type: none"> Uses NCQA National Medicaid HEDIS Percentiles as benchmark for NCQA HEDIS measures Uses CMS Star Cut Points as Benchmark for CMS Star Measure(s) Minimum denominator of 1% of Total Denominator 	
Quality Points	Star / Percentile
1	3 Stars / 50th Percentile
2	4 Stars / 75th Percentile
3	5 Stars / 90th Percentile

Health Plan Measure Points
<ul style="list-style-type: none"> Benchmark is set by Cal MediConnect. Points based on CalOptima’s rate for measure <ul style="list-style-type: none"> ➤ 1 point if CalOptima passes measure ➤ 0 point if CalOptima does not pass measure

Distribution of Earned Withhold Funds to the Health Networks

CalOptima’s contracts with the health networks provides that “CalOptima will allocate to Physician Group an amount of revenue withhold attributed to Physician Group’s performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval.”

- The methodology that staff is proposing for DY2-5 provides that Medicare withhold funds which are earned back by CalOptima will be distributed to the Health Networks, including the CalOptima Community Network (CCN), based on performance and percent of premium (POP). The distribution to a health network will not exceed the amount of funds originally withheld from its capitation. If CMS does not return withheld funds based on performance results, then no Quality Withhold money will be paid out to any network, regardless of their performance on the quality measures.

- Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period, as well as at the time of distribution.
- Distribution of earned back withhold funds attributable to CalOptima Community Network (CCN) membership will be similar to other health network distribution of withheld dollars. Staff will return at a later date to propose a distribution strategy specifically to CCN providers.
- Withhold money will be distributed to health networks, including CalOptima Community Network (CCN), after CalOptima receives the withhold money from CMS.
- Health Networks will receive their withhold money within 90 days of CalOptima receiving the withhold money from CMS.
- CalOptima contracts with health networks under various arrangements and the allocation for each health network will depend on the withheld amounts received from CMS and the health network performance on the quality measures benchmarked by CMS.
- Health Network payment will depend on the arrangement with CalOptima. Based on current capitation contract arrangement with health networks for CMS revenue, Health Maintenance Organizations (HMOs) will receive their contractually agreed percentage of the withheld amounts for professional services and for hospital services.
- For Physician Hospital Consortia (PHCs) however, the Physician side of the PHCs will receive their contractually agreed percentage of the withheld amounts for professional services but CalOptima will pay the contractually agreed percentage for hospital services directly to the hospitals.
- Shared Risk Groups (SRGs) will also receive their contractually agreed percentage of the withheld amounts for professional services but the hospital allocation will be contributed to the SRG pool.

Fiscal Impact

The recommended action is budget neutral to CalOptima. The amount of Medicare quality withhold funds earned back by CalOptima, if any, will be sufficient to fund distributions to health networks and CCN with no additional fiscal impact to the operating budget.

Rationale for Recommendation

These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Proposed Quality Withhold Distribution Strategy for Demonstration Years 2-5
2. Board Action dated August 6, 2015, Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

/s/ Michael Schrader
Authorized Signature

5/9/2018
Date



OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

Proposed Quality Withhold Distribution Strategy for Demonstration Years 2–5

**Board of Directors' Quality Assurance Committee Meeting
May 16, 2018**

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

OCC Quality Withhold (OCC QW) Overview

- CMS Withhold
 - Demonstration Year 2 (Measurement Year 2016): 2 percent
 - Demonstration Years 3–5 (Measurement Years 2017–19): 3 percent
- Withhold money earned back by passing OCC QW measures

Percent of Measures Passed	% Withhold CalOptima Receives
0%–19%	0%
20%–39%	25%
40%–59%	50%
60%–79%	75%
80%–100%	100%

- Medi-Cal funds are not included in the withhold program

OCC QW Measures

Measures that can be assessed by health network

QW Measure	Benchmark DY 2	Benchmark DY 3–5
CW6 — Plan All-Cause Readmissions	CMS Star Cut Points	CMS Star Cut Points
CW7 — Annual Flu Vaccine	CMS Star Cut Points	CMS Star Cut Points
CW8 — Follow-Up After Hospitalization for Mental Illness	NCQA National HEDIS percentiles	NCQA National HEDIS percentiles
CW12 — Part D Medication Adherence for Diabetes Medications	CMS Star Cut Points	CMS Star Cut Points
CW13 — Encounter Data (Timeliness)	80%	80%
CAW7 — Behavioral Health Outcome: (Reduction in ED use)	NA	10% decrease in performance rate from DY 2

OCC QW Measures (cont.)

Measures that can be assessed by health network (continued)

QW Measure	Benchmark DY 2–3	Benchmark DY 4	Benchmark DY 5
CAW8 — Documentation of Care Goals	Measured at health plan level	60%	65%
CAW9 — Interaction with Care Team	Measured at health plan level	83%	88%

OCC QW Measures (cont.)

Measures that cannot be assessed by health network

QW Measure	Benchmark DY 2	Benchmark DY 3	Benchmark DY 4	Benchmark DY 5
CW11 — Controlling Blood Pressure	53%	56%	56%	56%
CAW6 — Behavioral Health Shared Accountability Process Measure	Not Evaluated	Highest rate achieved by a health plan minus 10 percentage points	Not Evaluated	Not Evaluated
CAW8 — Documentation of Care Goals	55%	55%	Measured at the network level	Measured at the network level
CAW9 — Interaction With Care Team	78%	78%	Measured at the network level	Measured at the network level

Measure Scoring

Health Plan Measure Points

- Benchmark is set by Cal MediConnect
- Points based on CalOptima's rate for measure
 - 1 point if CalOptima passes measure
 - 0 points if CalOptima does not pass measure

Health Network Measure Performance Points

- NCQA National Medicaid HEDIS Percentiles (Follow up after Hospitalization - FUH)
- CMS Star Cut Points
- Minimum Denominator of 1 percent of Total Denominator

Points	Star/Percentile
1	3 Stars/50th Percentile
2	4 Stars/75th Percentile
3	5 Stars/90th Percentile

Measure Scoring

- Quality Points is the sum of all points earned for each measure.

HN Points Per Measure Example

Health Network (HN)	Health Network Evaluation Annual Flu Vaccine				Health Plan Evaluation Documentation of Care Goals	Quality Points
	CalOptima Rate: 71% Benchmark: 69%				CalOptima Rate: 51.58% Benchmark: 55%	
	Denominator	Rate	Stars	Points		
HN A	100	70	3	1	0	1
HN B	50	77	4	2	0	2
HN C	75	85	5	3	0	3
HN D	1	95	5	0	0	0
1% of Denominator	2.25					

1 percent of denominator will be utilized to set up the minimum denominator for each measure for scoring and health network eligibility to receive withhold payments.

Health Network Allocation Calculation

- Health Network (HN) Allocation = HN Weighted % of Allocation
 - Allocation = Withhold funds received from CMS
 - HN Weighted Allocation = HN CMS Revenue x HN Quality Points
 - HN Weighted % = HN Weighted Allocation ÷ Sum of HN Weighted Allocation

Health Network Allocation Example

Health Network	Quality Points	DY CMS Revenue	Weighted Allocation	Weighted %	Health Network Allocation
HN A	1	\$3,000	3,000	30%	\$30
HN B	2	\$2,000	4,000	40%	\$40
HN C	3	\$1,000	3,000	30%	\$30
HN D	0	\$2,000	0	0%	\$00
			10,000		\$100

HN A Example

$$\begin{array}{rcl}
 \text{(Quality Points)} & \times & \text{(DY CMS Revenue)} \\
 1 & \times & \$3,000 \\
 & & = 3,000
 \end{array}
 = \text{(Weighted Allocation)}$$

$$\begin{array}{rcl}
 \text{(HN Weighted Allocation)} & \div & \text{(Total Weighted Allocation)} \\
 3,000 & \div & 10,000 \\
 & & = 30\%
 \end{array}
 = \text{(Weighted \%)}$$

$$\begin{array}{rcl}
 \text{(Weighted \%)} & \times & \text{(Amount Received from CMS)} \\
 30\% & \times & \$100 \\
 & & = \$30
 \end{array}
 = \text{(HN Allocation)}$$

Health Network Payment Example

Health Network		HN Allocation	P 34.40%	H 50.90%	SRG Pool 50.90%	HN Payment
HN A	HMO	\$30	\$10.32	\$15.27	---	\$25.59
HN B	PHC	\$40	\$13.76	\$20.36	---	\$13.76
HN C	SRG	\$30	\$10.32	---	\$15.27	\$10.32
		\$100				

P (professional) = 34.40% x HN Allocation

H (hospital) = 50.90% x HN Allocation

- HMO: Health networks are paid for professional and hospital services
- PHC: Hospital is paid directly by CalOptima
- SRG: Hospital allocation contributed to SRG pool

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2015 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VIII. F. Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

Contact

Richard Bock, MD, Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Approve the methodology for and the disbursement of the Year One, OneCare Connect Quality Withhold payment to participating Health Networks.

Background

July 2012 marked the passage of the Coordinated Care Initiative in California. The Coordinated Care Initiative (CCI) aims to integrate the delivery of medical, behavioral, and long term care services while providing a road map to integrate Medicare and Medi-Cal for people in both programs, called “dual eligible” members.

Central to the CCI model is care coordination. And a critical piece to the model is the care coordination provided for by the member’s primary care provider (PCP) and health network. The CCI is expected to produce greater value by improving health outcomes and containing costs; primarily by shifting clinically appropriate service delivery into the home and community and away from expensive institutional settings.

In order to better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. The amounts of the withhold are 1% for Year One, 2% for Year Two, and 3% for Year Three. All or a part of the withhold may be earned back based on a methodology developed by DHCS and CMS.

Discussion

CalOptima began to participate in the CCI program on July 1, 2015. Given the delayed start date of the program, the first year of the withhold process will be shortened to reflect services rendered from July 1, 2015 to December 30, 2015.

There are ten quality withhold measures in CCI for Year one. Five of these measures are California-specific and were just released by CMS on July 8, 2015.

- Encounter data
- Getting appointments and care quickly
- Customer service
- Behavioral Health provider participates in care plan development (shared accountability measure, payout shared with county)

CalOptima Board Action Agenda Referral

Approve the Methodology for and the Disbursement of the Year One,
OneCare Connect Quality Withhold Payment to Participating Health Networks
Page 2

- Documentation of care goals
- Case Management contact with member
- OneCare Connect Member Advisory Council implementation
- Memorandum of understanding with County Mental Health
- Timely completion of Health Risk Assessments
- Physical access work plan

Capitation for both Medi-Cal and Medicare payments to CalOptima will be reduced by one percent (1%) in Year One. These withheld funds can be earned back by CalOptima in the following manner:

- Plan will pass or fail each measure based on benchmarks
- All withhold measures will be weighted equally
- If a measure cannot be calculated due to timing constraints (of the shortened Year one) or enrollment requirements, it will be removed from the total number of withhold measures on which the plan will be evaluated.
- Payout will be based on:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

Distribution of Earned Withhold Funds to the Health Networks:

CalOptima's contracts with the networks provides that "CalOptima will allocate to Physician Group, and amount of revenue withhold attributed to Physician Group's performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval." While the health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for and others that have shared responsibility between the delegated health networks and CalOptima. In addition, since the two Behavioral Health measures are governed by language in the three-way contract regarding shared responsibility with County Mental Health, disbursement for them will be described in a future staff recommendation to the Board after further guidance from the State is released. Similarly, distribution of earned back withhold funds attributable to Community Network membership will be described in a future staff recommendation. As 1% of capitation is withheld from CalOptima, the downstream percent of premium (POP) Medicare capitation payments to Health Networks will be similarly reduced. Taking into consideration the truncated duration of Year One and continuing regulatory refinement of the program, the methodology that staff is proposing for Year One provides that Medicare withhold funds which are earned back by CalOptima will be shared with the Health Networks using the identical POP formula.

- For example, if CalOptima's revenue is \$1,000 per member per month (PMPM), the quality withhold is 1%, and a network's POP is 35%, the network's capitation will be $35\% \times \$990$, which is \$346.50 PMPM.
- Assuming CalOptima recoups the full withhold of \$10, the network will receive 35%, or \$3.50 PMPM.
- Future distribution formulae for Years 2 and 3 may take into account the Health Networks' per cent responsibility for, and the relative performance on, the expanded measure set, but this simpler approach is more appropriate for Year One.
- If CalOptima does not recoup any withhold money, then no Quality Withhold money will be paid out to any network regardless of their performance on the quality measures.

Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period as well as at the time of distribution.

Fiscal Impact

The recommended action is projected to be budget neutral to CalOptima. Distributions to health networks will not exceed the amount of withheld funds that are earned back.

Rationale for Recommendation

These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

07/31/2015
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 16, 2018 **Regular Meeting of the CalOptima Board of Directors'** **Quality Assurance Committee**

Report Item

4. Consider Recommending Board of Directors' Approval of the Modification of the Previously Approved Pay for Value (P4V) Payment Methodology for Measurement Year 2017 (MY2017) for CalOptima Community Network (CCN) Providers by Incorporating an Improvement Factor

Contact

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

Recommended Action

Recommend Board of Directors' approval of the addition of an improvement factor to the MY2017 payment methodology for CCN primary care providers for Medi-Cal, subject to regulatory approval, as applicable.

Background

CCN Provider distribution was approved by the Board of Directors on November 02, 2017. This COBAR describes the proposed improvement factor which will be included with the distribution of payments to the CCN providers for earned CCN MY2017 P4V distribution.

Discussion

There are no changes to the previously approved P4V measures for MY 2016-2017 nor any changes to eligibility for payment. This amendment seeks to align the health network and CCN P4V programs by including an improvement factor for the CCN P4V program in recognition of the fact that the CCN P4V program has attained an adequate program history to measure and incentivize improvement in performance from the prior year.

To recognize performance and support sustained improvement in the overall P4V measures, staff recommends that the improvement factor for CCN providers be based on the following principles:

- The Medi-Cal CCN Clinical measures improvement payment calculations will include the percent change from the previous year. A relative point system is applied based on the percent change achieved.
- Clinical funds will be distributed 25% for improvement and 75% for performance.
- A detailed description of the improvement factor methodology is included in Attachment 2.

Distribution of Incentive Dollars

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

To qualify for payments, a physician or clinic 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 recommended action to add an improvement factor to the MY2017 payment methodology for Medi-Cal CCN providers is budget neutral. The P4V program funding for the Medi-Cal line of business is budgeted up to a maximum of \$2.00 per member per month. The distribution of incentive dollars for the MY2017 P4V program for Medi-Cal will be made in Fiscal Year (FY) 2018-19. Management will include expenses related to the program in the upcoming proposed FY 2018-19 operating budget.

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: CCN P4V Improvement Factor Methodology
2. Board Action dated November 2, 2017, Approve Measurement Year 2016 payment methodology and distribution strategy for the Pay for Value (P4V) Program for CalOptima Community Network (CCN) Providers for Medi-Cal and OneCare Connect (OCC)

/s/ Michael Schrader
Authorized Signature

5/9/2018
Date



CalOptima
Better. Together.

CCN Provider P4V Improvement Methodology

**Board of Directors' Quality Assurance Committee Meeting
May 16, 2018**

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

[Back to Agenda](#)

Medi-Cal Health Network P4V Payment Methodology

Population Included

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

SPD Members Weighted 4x Non-SPD Members

Payment Calculation

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

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

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

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

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

Medi-Cal CCN Providers

- Clinical Payment

- Clinical funds distributed 75% performance and 25% improvement
 - Provider clinical performance and membership
 - Provider clinical improvement and membership

- CAHPS Payment

- Provider membership
- No improvement for CAHPS

Medi-Cal CCN Provider Performance And Improvement Methodology

Population Included

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

Payment Calculation

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

Clinical Provider Payment

- **Clinical Performance Payment** = MM x Perform % x Clinical % x 75% Clinical Funds
- **Clinical Improvement Payment** = MM x Percent Change Pts x 25% Clinical Funds

CAHPS Provider Payment

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

Total CCN Provider Payment

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

Medi-Cal CCN Provider Payment Methodology

Clinical Calculation

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

Medi-Cal CCN Provider Payment Methodology

Clinical Improvement Factor

- Improvement Factor

- Percent Change = $(\text{MY2017PP} - \text{MY2016PP}) / \text{MY2016PP}$

- Measurement Year 2016 Performance Percentage (MY2016PP)
 - Measurement Year 2017 Performance Percentage (MY2017PP)

- Improvement Factor Scoring

Percent Change	Points
< 1%	0
1 - 24%	1
25 – 99%	2
100 – 2999%	3
> 3000%	4

Medi-Cal CCN Provider Payment Clinical Improvement Calculation Example

Provider	MM	MY 2016 Clinical Perform	MY 2017 Clinical Perform	Percent Change	Points	Points & MM Weight	Improv Percent	Improv Paymt
Provider A	90,000	1.00%	35.00%	3400.0%	4	360,000	98.63%	\$19,726
Provider B	50,000	83.33%	50.00%	-40.00%	0	0	0%	\$0
Provider C	5,000	75.00%	80.00%	7.00%	1	5,000	1.37%	\$274
Total						365,000		\$20,000

Provider A

$$\begin{array}{rclcl} \text{MM} & * & \text{Points} & = & \text{Points \& MM Weight} \\ 90,000 & * & 4 & = & 360,000 \end{array}$$

$$\begin{array}{rclcl} \text{Points \& MM Weight} & / & \text{Total Points \& MM Weight} & = & \text{Clinical Percent} \\ 360,000 & / & 365,000 & = & 98.63\% \end{array}$$

$$\begin{array}{rclcl} \text{Clinical Percent} & * & \text{CCN Clinical Improv Funds} & = & \text{Clinical Payment} \\ 98.63\% & * & \$20,000 & = & \$19,726 \end{array}$$

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contact

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

Recommended Actions

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

Background

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

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

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

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

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

Discussion

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

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

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

Distribution of Incentive Dollars

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

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

Attachments

1. PowerPoint Presentation dated September 20, 2017 - Pay for Value Program: CCN Provider Payment Methodology
2. Board Action dated October 6, 2016, Consider Approval of Amendment to the Measurement Year 2016 Pay for Value Program Payment Methodology for Medi-Cal
 - a. Attachment - Board Action dated April 7, 2016, Approve Measurement Year CY2016 Pay for Value Programs for Medi-Cal and OneCare Connect

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

/s/ Michael Schrader
Authorized Signature

10/23/2017
Date



CalOptima
Better. Together.

Pay for Value Program CCN Provider Payment Methodology

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

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

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Medi-Cal Health Network Payment Methodology

Population Included

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

SPD Members Weighted 4x Non-SPD Members

Payment Calculation

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

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

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

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

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

Medi-Cal Health Network Payments

Clinical Adult (No overall CalOptima Improvement)

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

Based upon December, 2016 Prospective Rates

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Medi-Cal Health Network Payments

Clinical Child (No overall CalOptima Improvement)

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

Based upon December, 2016 Prospective Rates

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Medi-Cal Health Network Payments

CAHPS Adult

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

Based upon measurement years 2015 and 2014 results

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Medi-Cal Health Network Payments

CAHPS Child

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

Based upon measurement years 2015 and 2014 results

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Medi-Cal CCN Providers

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

Medi-Cal CCN Health Network Payment

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

Medi-Cal CCN Provider Payment Methodology

Population Included

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

Payment Calculation

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

Clinical Provider Payment

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

CAHPS Provider Payment

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

Total CCN Provider Payment

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

Medi-Cal P4V Clinical Measures

2016 and 2017 Year Measures

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

Medi-Cal CCN Provider Payment Methodology

Clinical Calculation

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

Medi-Cal CCN Provider Payment Adult Clinical Calculation Example

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

Medi-Cal CCN Provider Payment Adult Clinical Calculation Example

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

Provider A

$$\begin{array}{rcll} \text{MM} & * & \text{Clinical Perform} & = \text{Perform \& MM Weight} \\ 400,000 & * & 83.33\% & = 333,333 \end{array}$$

$$\begin{array}{rcll} \text{Perform \& MM Weight} / \text{Total Perform \& MM Weight} & = & \text{Clinical Percent} \\ 333,333 / 397,500 & = & 83.86\% \end{array}$$

$$\begin{array}{rcll} \text{Clinical Percent} & * & \text{CCN Clinical Funds} & = \text{Clinical Payment} \\ 83.86\% & * & \$220,178 & = \$184,636 \end{array}$$

Medi-Cal CCN Provider Payment Child Clinical Calculation Example

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

Medi-Cal CCN Provider Payment Child Clinical Calculation Example

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

Provider A

$$\begin{array}{rcll} \text{MM} & * & \text{Clinical Perform} & = \text{Perform \& MM Weight} \\ 60,000 & * & 85.71\% & = 51,429 \end{array}$$

$$\begin{array}{rcll} \text{Perform \& MM Weight} / \text{Total Perform \& MM Weight} & = & \text{Clinical Percent} \\ 51,429 / 100,476 & = & 51.18\% \end{array}$$

$$\begin{array}{rcll} \text{Clinical Percent} & * & \text{CCN Clinical Funds} & = \text{Clinical Payment} \\ 51.18\% & * & \$129,091 & = \$66,075 \end{array}$$

Medi-Cal CCN Provider Clinical Payment

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

Medi-Cal P4V CAHPS Measures

2016 Measurement Year Measures

Adult and Child Measures

Getting Appointment with a Specialist

Timely Care and Service (composite)

Rating of PCP

Rating of all Health Care

Medi-Cal CCN Provider Payment CAHPS Calculation Example

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

Provider A

$$\begin{array}{rcl} \text{MM} & / & \text{Total MM} \\ 460,000 & / & 738,744 \\ & = & \text{MM Percent} \\ & = & 62.27\% \end{array}$$

$$\begin{array}{rcl} \text{MM Percent} * \text{CCN CAHPS Funds} & = & \text{CAHPS Payment} \\ 62.27\% * \$754,047 & = & \$469,529 \end{array}$$

Medi-Cal CCN Provider Total Payment

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

OneCare Connect Health Network Payment Methodology

Population Included

Total Number of Member Months (MM)

Payment Calculation

- **Allocated Funds** = Total MM for all Health Networks x the Allocated PMPM.
- Allocated PMPM for 2016 is **\$20**.

Clinical Funds = 100% of Allocated Funds (\$20 PMPM)

- **Clinical Funds** = Performance Funds (\$10 PMPM) + Improvement Funds (\$10)
- **Performance Payments** = Performance Funds
- **Improvement Payments** = Improvement Funds x CalOptima Overall Improvement Pct.

OneCare Connect CCN Health Network

Payment

CCN	Payment	PMPM
Clinical		
Clinical Performance	\$139,246	\$6.15
Clinical Improvement	\$0	\$0
Total Clinical Payment	\$139,246	\$6.15

OneCare Connect Provider Payment Methodology

Population Included

Total Number Member Months (MM)

Payment Calculation

- **Funds** = Total Clinical Payment for CCN Health Network

Clinical Provider Payment

- **Provider Payment** = Membership Percentage x Funds
(Minimum payment of \$100)

OneCare Connect P4V Measures

2016 Measurement Year Measures

Antidepressant Medication Management:
Effective Acute Phase Treatment

Antidepressant Medication Management:
Effective Continuation Phase Treatment

Controlling High Blood Pressure

Part D Medication Adherence for Oral Diabetes Medications

Plan All-Cause Readmissions

OneCare Connect CCN

Provider Calculation and Payment Example

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

Provider A

$$\begin{array}{rclcl} \text{MM} & / & \text{Total MM} & = & \text{MM Percent} \\ 15,000 & / & 22,642 & = & 66.25\% \end{array}$$

$$\begin{array}{rclcl} \text{MM Percent} & * & \text{CCN Funds} & = & \text{Provider Payment} \\ 66.25\% & * & \$139,246 & = & \$92,248 \end{array}$$

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contact

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

Recommended Action

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

Background

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

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

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

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

Discussion

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

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

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:	
<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 th percentile 2 points: \geq 75 th percentile 3 points: \geq 90 th percentile No points <50 th percentile
Improvement points – 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.)

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

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

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

Distribution of Incentive Dollars

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

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

Attachments

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

/s/ Michael Schrader
Authorized Signature

09/29/2016
Date

[Back to Agenda](#)



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Pay-for-Value 2016

**Board of Directors Meeting
October 6, 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 - Amended

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

Improvement points – HEDIS & CAHPS

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

Negative one (-1) point for decreasing
1 percentile level
(e.g. -1 point for 75^{th} percentile to 50^{th} percentile;
-2 points for 50^{th} percentile to 10^{th} 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 March 2, 2017 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

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

Contact

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

Recommended Action

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

Background

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

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

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

Discussion

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

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

Medi-Cal Changes:

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

OneCare Connect Changes:

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

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

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

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

Distribution of Incentive Dollars

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

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

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

Fiscal Impact

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

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

Time of Payment

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

Rationale for Recommendation

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

Concurrence

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

Attachments

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

/s/ Michael Schrader
Authorized Signature

2/23/2017
Date

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

Adult Measures	2017 Measurement Year / HEDIS 2018 Specifications Anticipated Payment Date: Q3 2018	Measurement Assessment Methodology
<p>Clinical Domain - HEDIS Weight: 60.00%</p> <p>SPD Weight 4.0</p> <p>TANF Weight 1.0</p>	<p><u>Prevention:</u></p> <ul style="list-style-type: none"> Breast Cancer Screening (BCS) Cervical Cancer Screening (CCS) <p><u>Diabetes:</u></p> <ul style="list-style-type: none"> HbA1c Testing Retinal Eye Exams <p><u>Access to Care:</u></p> <ul style="list-style-type: none"> Adults Access to Preventive/Ambulatory Care <p><u>Respiratory:</u></p> <ul style="list-style-type: none"> Medication Management for People with Asthma (MMA) 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> NCQA National HEDIS percentiles Percentile Improvement
<p>Patient Experience Domain - CAHPS</p> <p>Weight: 40%</p>	<p><u>Adult Satisfaction Survey (Adult CAHPS):</u></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 California CAHPS percentiles Percentile Improvement

Pediatric Measures	2017 Measurement Year / HEDIS 2018 Specifications Anticipated Payment Date: Q3 2018	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><u>Respiratory:</u></p> <ul style="list-style-type: none"> • Medication Management for People with Asthma (MMA) • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) <p><u>Prevention:</u></p> <ul style="list-style-type: none"> • Childhood Immunization Status Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • Adolescent Well-Care Visits (AWC) <p><u>Access to Care:</u></p> <ul style="list-style-type: none"> • Children's Access to Primary Care Physician 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA National HEDIS percentiles • Percentile Improvement
<p>Patient Experience Domain - CAHPS</p> <p>Weight: 40%</p>	<p><u>Child Satisfaction Survey (Child CAHPS)</u></p> <ul 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 California CAHPS percentiles • Percentile Improvement

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

OneCare Connect Measures	2017 Measurement Year / HEDIS 2018 Specifications Anticipated Payment Date: Q3 2018	Measurement Assessment Methodology
<p>Clinical Domain - HEDIS</p> <p>Weight: 60.00%</p> <p>Each measure weighted equally</p>	<p><u>Measures:</u></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 • Percentile Improvement
<p>Patient Experience Domain - CAHPS</p> <p>Weight: 40%</p>	<p><u>Adult Satisfaction Survey (Adult CAHPS):</u></p> <ul 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 California CAHPS percentiles • Percentile 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 (CAP) to CalOptima which outlines, at a minimum, the following items:

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

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

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

MEASUREMENT DETAILS:

1. Clinical Domain (HEDIS measures)

Program Specific Measurement Sets

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

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

Criteria

The following criteria were considered in selecting these indicators:

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

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

Incentive Measure Definition

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

II. Customer Satisfaction

Member Satisfaction

Background

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

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

Survey Methodology

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

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

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

Board of Director's Quality Assurance Committee Meeting May 16, 2018

PACE Member Advisory Committee (PMAC) Update

PMAC Meeting March 26, 2018

- Updates from the Director
 - New staff welcomed to the PACE team include a new Nurse Practitioner, 2 Nurses, Dietician and Receptionist.
- New Items Discussed
 - PACE Director Elizabeth Lee presented the results of the 2017 Participant Satisfaction Survey. The overall satisfaction rating was 90%, higher than California and national PACE organization averages. For 9 of the 11 domains measured, CalOptima PACE scored 90% or higher. PMAC members shared their feedback on the scores and how their personal experiences may be reflected in the survey results.
 - PACE Director shared that CalOptima PACE will have some upcoming changes to the number and type of vehicles used for participant transport. The growing enrollment and changes in where participants reside are leading to more 8-passenger vans and fewer sedan vehicles. All participants impacted by this change in fleet will be notified in advance. Participants will see these changes in April.
- The following suggestions and comments were provided by PACE Participants:
 - A participant shared that he has gotten healthier through his physical therapy services at PACE.
 - A participant shared that sometimes her home caregiver does not have her ready prior to transportation arriving.
 - Members of the committee complimented the two PACE schedulers, Bertha and Maria, for keeping up with their specialty appointments.
 - A participant requested information on PACE emergency codes, specifically what 'code pink' was since a recent drill at the PACE center. The group discussed codes and appropriate actions in response to codes.



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PACE PCP Incentive Program

**Board of Directors' Quality Assurance Committee Meeting
May 16, 2018**

Miles Masatsugu, M.D.

Overview of the PACE Program

- To be eligible for PACE, a person must be:
 - 55 years or older
 - Residing in the PACE service area
 - Certified to need nursing facility level care
 - Able to live safely in community
- PACE serves the frailest seniors
 - Average age is older than 80 years
 - Multiple chronic medical conditions
 - High level of functional dependencies (need help bathing, walking, toileting, etc.)

Background

- University of California, Irvine (UCI) had been providing all of the PCP clinic-based care at PACE since the program began in October 2013.
- Staff started working on a contract update with UCI in December 2016.
- At that time, PACE did not have a pay-for-value or savings sharing program.
- Inpatient care is one of the highest costs for PACE.

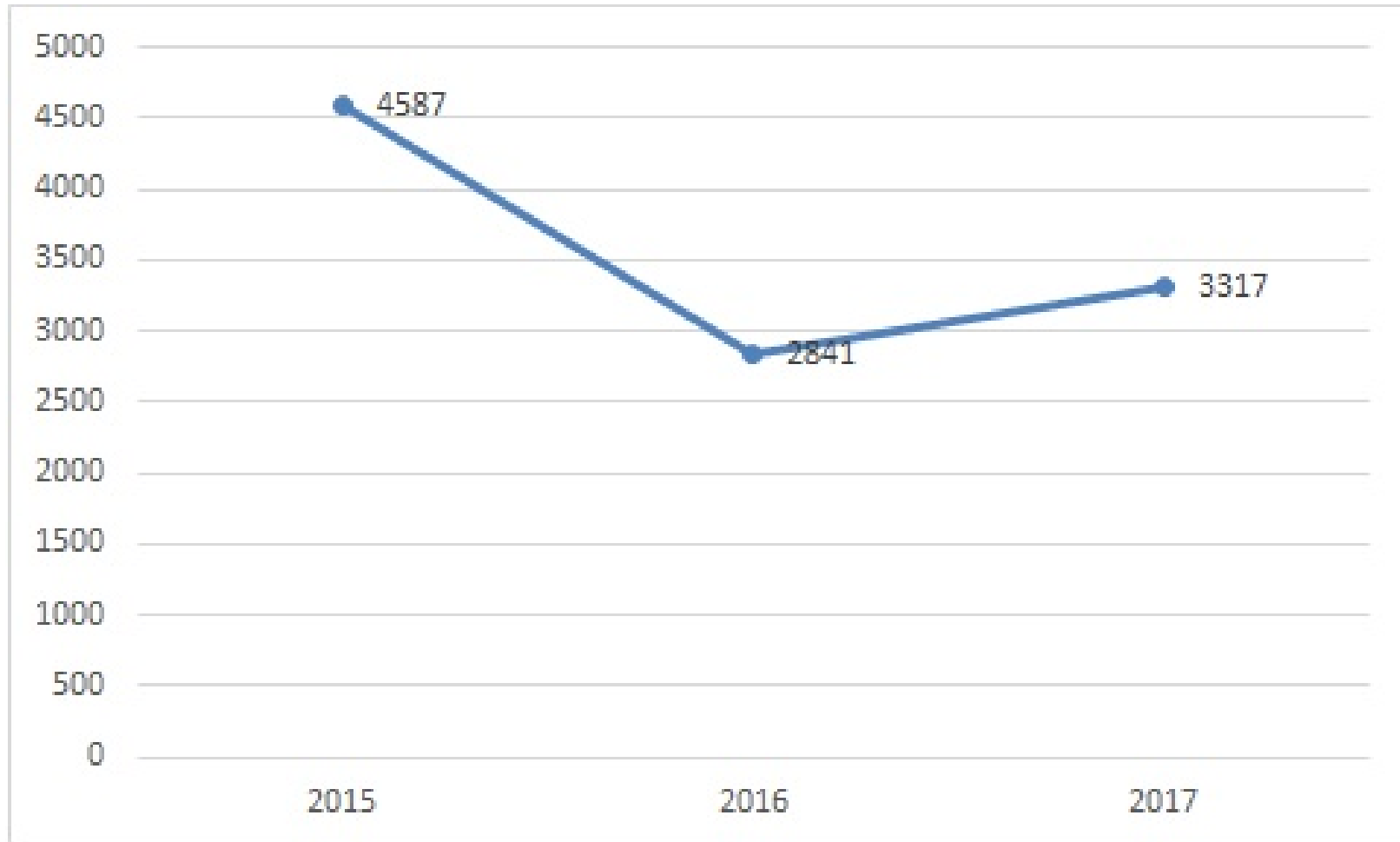
Board Actions

- September 7, 2017: Board authorized three actions
 - Establish a UCI PACE PCP incentive program with two components
 - Pay-for-value Quality Improvement (QI) component
 - Overall participant satisfaction
 - Participation satisfaction with medical care
 - Coding error rate
 - A savings sharing Utilization Management (UM) component
 - Based on actual inpatient costs
 - Allow fellows and residents to rotate at PACE
 - Contract with non-UCI PCPs
- March 2018: PACE community-based physician waiver approved

2017 Annual Participant Satisfaction Survey

Domain	2016 CalOptima PACE	2017 CalOptima PACE	2017 CalPACE Average	2017 National Average
Transportation	98%	98%	93%	95.5%
Center Aids	92%	96%	93%	91.7%
Home Care	92%	93%	87%	87.8%
Medical Care	86%	92%	88%	89.5%
Health Care Specialist	85%	92%	87%	87.4%
Social Worker	96%	95%	94%	95.5%
Meals	71%	63%	71%	73.1%
Rehabilitation Therapy and Exercise	98%	97%	95%	93.2%
Recreational Therapy	82%	86%	84%	82.7%
Other Indicators	92%	94%	89%	89.4%
Overall Satisfaction	89%	90%	88%	88.4%

Utilization Results: Hospital Bed Days (Goal: 2,100 Bed Days/1,000 Participants/Year)



Challenges

- Small number of QI elements
- Funding of the QI component is small compared with other comparable lines of business
- Only UCI PACE PCPs participate in the incentive program
- UCI PCPs are not directly involved in inpatient and nursing home care
- The frail population and unfamiliarity with PACE leads to unnecessary hospitalizations.

Steps Taken

- September 2017: Board approves UCI PACE PCP incentive program
- October 2017: UCI PACE PCP contract amended
- October 2017: PACE contracts with House Call Medical Associates (HCMA) for PCP services
- November 2017: HCMA assumes most inpatient and Skilled Nursing Facility (SNF) care
- January 2018: UCI PACE PCP incentive begins for remainder of fiscal year (ends 6/30/18)

Proposed Modifications to PACE PCP Incentive Program

- Allow all PACE PCPs to participate in the PACE incentive program, including community-based physicians
- Increase the number of QI elements
- Increase QI incentive from \$3 PMPM to \$10 PMPM.
- Change distribution of UM component (savings sharing) to support inpatient avoidance strategies
 - After-hours telephonic coordination of care
 - After-hours home visit evaluations
 - Admission directly to SNFs for appropriate cases
 - ER evaluations with observation stays

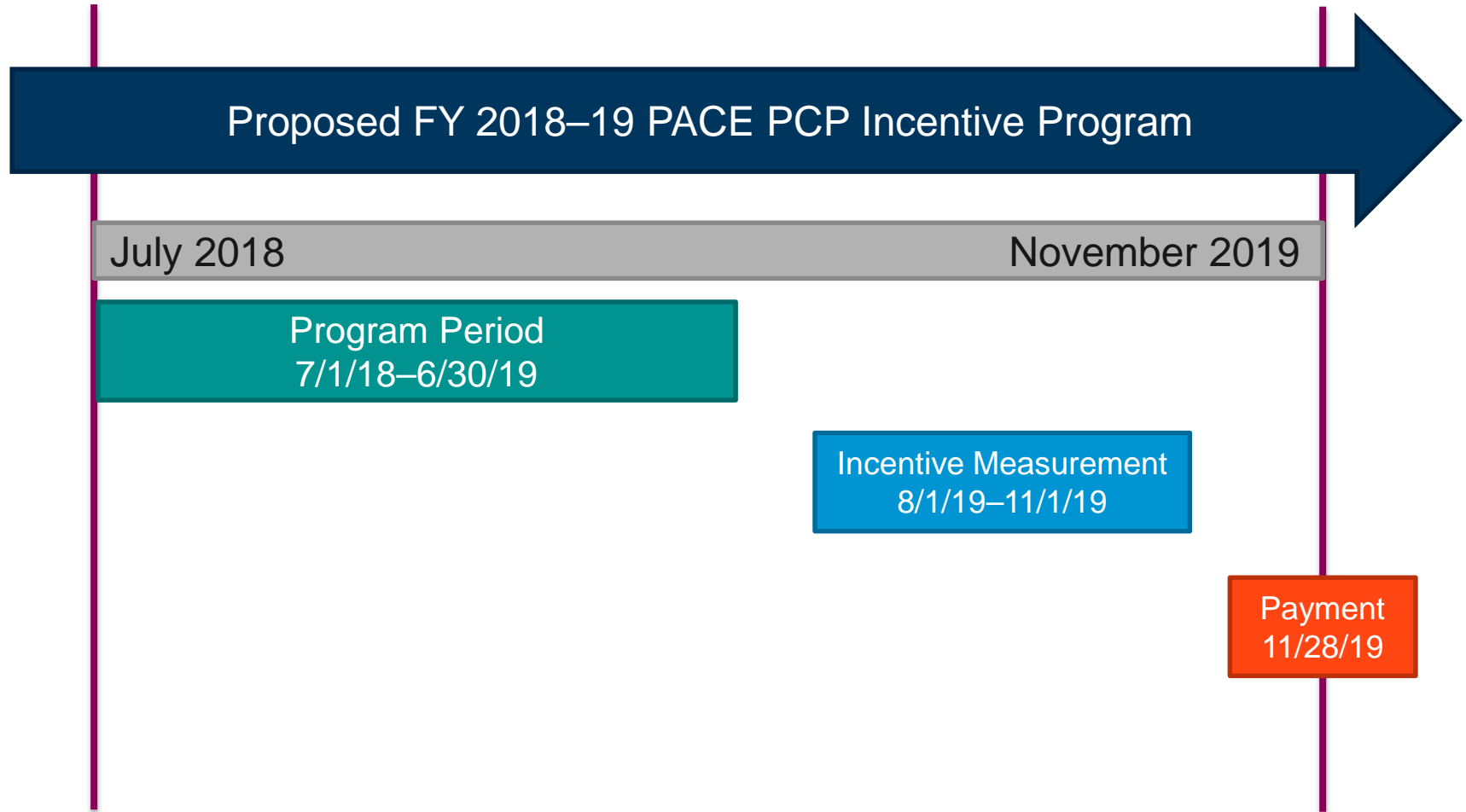
Proposed QI Incentive Elements

Elements	Current	Proposed
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	✓	✓
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	✓	✓
Coding Errors	✓	
Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus tricyclic antidepressants or antipsychotics		✓
Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia plus tricyclic antidepressant or anticholinergic agents		✓
Functional Status Assessment		✓
Total Potential QI Incentive	\$3 PMPM	\$10 PMPM

Proposed UM Incentive (Savings Sharing)

	Budget	Sharing by Tier Level		Cumulative Total Savings		PCP Role (Distribution by Tier)	
	100%	CalOptima	PCP	CalOptima	PCP	Nonclinic- based (IP, ER, SNF, Home Visits)	Clinic- based
Tier 1	95%–100%	100%	0%	100%	\$0	N/A	N/A
Tier 2	90%–95%	50%	50%	75%	25%	75%	25%
Tier 3	85%–90%	50%	50%	67%	33%	80%	20%
Tier 4	80%–85%	50%	50%	63%	38%	85%	15%
Tier 5 (Incentive Ends)	75%–80%	50%	50%	60%	40%	90%	10%

Proposed Timeline



Next Step

- Staff recommends Board approval in June 2018 of modifications to PACE PCP incentive program



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Perinatal Support Services Program Update

**Board of Directors' Quality Assurance Committee Meeting
May 16, 2018**

**Richard Bock, M.D., Deputy Chief Medical Officer
Pshyra Jones, Director, Health Education & Disease Management**

[Back to Agenda](#)

Perinatal Support Services (PSS)

- DHCS requires Contractors to provide the following Comprehensive Perinatal Support Program (CPSP) services:
 - All medically necessary services for pregnant members per the most current standards or American College of Obstetricians and Gynecologists (ACOG) guidelines
 - A comprehensive risk assessment
 - Individual care plans addressing obstetrical, nutrition, psychosocial, and health education
 - Timely high risk clinical referrals to appropriate specialists and for delivery services
 - Referrals to other CalOptima and community-based resources
- CalOptima PSS program provides all of the above, plus:
 - Enhanced Care Coordination (home visitation)

Our Current Program Model

Per 2008 Board Action:

Approval of capitated contract for Perinatal Support Services with MOMS Orange County

- MOMS Orange County utilizes a home visitation program model to provide CPSP as well as care coordination services

Community obstetricians continue to provide CPSP services on a fee-for-service basis at Medi-Cal rates.

Perinatal Support Services (PSS) Value Comparison

CY 2016 HEDIS Rates

	Members	Prenatal Rate	Postpartum Rate	Cost	Cost/Member
Non-CPSP PSS Vendor	1,596	73.5%	48.8%	\$4.1 million	\$2,568
CPSP Fee-for-Service PSS Providers	5,912	73.2%	51.7%	\$1.3 million	\$230

CY 2017 HEDIS Rates

	Members	Prenatal Rate	Postpartum Rate	Cost	Cost/Member
Non-CPSP PSS Vendor	977	77.2%	65.9%	\$3.2 million	\$3,275
CPSP Fee-for-Service PSS Providers	6,663	72.6%	57.8%	\$1.6 million	\$247

Timeline Review

- Proposed Program revision presented to QAC (Nov. 2016) and FAC (Feb. 2017)
- March 2017: Board of Directors approved changes:
 - Issue a Request for Proposal (RFP)
 - Amend-capitated contract with existing PSS vendor to carve out Medi-Cal Expansion population
- April 2018: RFI, RFP, literature review and PSS provider community survey completed

RFI/RFP Findings

- Only two qualified respondents to RFP.
- Current RFP allows contracting with only these two vendors for non-CPSP PSS services.
- Limited program participation with non-CPSP vendor in parts of the county.
- Analysis identified >250 current CPSP providers as well as one of the responding vendors willing to participate at or below Medi-Cal rates.
- Enhanced care coordination (i.e., home visitation) may lead to improved outcomes.

Next Steps

- Staff to bring a recommendation to the June 7, 2018 Board of Directors meeting requesting authority to:
 - Withdraw PSS RFP
 - Authorize CalOptima to contract with all willing, qualified PSS providers and vendors at Medi-Cal rates.
 - Authorize the addition of an enhanced care coordination rate to compensate for authorized home visits.

CalOptima Perinatal Program Rates

	Code	Description	**Max units/ member	Cost/ unit 100% Medi-Cal	Total 100% Medi-Cal Cost
Initial Visit	Z6500	Initial Visit	1	\$135.83	\$135.83
1st 1-12 weeks	Z6406	Health Education	2.7	\$8.41	\$22.43
	Z6204	Nutrition	2.7	\$8.41	\$22.43
	Z6304	Psychosocial	3	\$8.41	\$33.64
2nd 13-28 weeks	Z6406	Health Education	2.7	\$8.41	\$22.43
	Z6204	Nutrition	2.7	\$8.41	\$22.43
	Z6304	Psychosocial	3	\$8.41	\$33.64
3rd 29-40 weeks	Z6406	Health Education	2.7	\$8.41	\$22.43
	Z6204	Nutrition	2.7	\$8.41	\$22.43
	Z6304	Psychosocial	3	\$8.41	\$33.64
Post- partum	Z6414	Health Education	4	\$8.41	\$33.64
	Z6208	Nutrition	4	\$8.41	\$33.64
	Z6308	Psychosocial	6	\$8.41	\$50.46
Classes					
	Z6412	Group Classes	20	\$2.81	\$56.20
Case Mgmt Rate	T1017	Care Coordination	4	\$50.00	\$200.00
Total					\$509.77

**1 unit = 15 minutes



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Quality Improvement Committee 1st Quarter 2018 Update

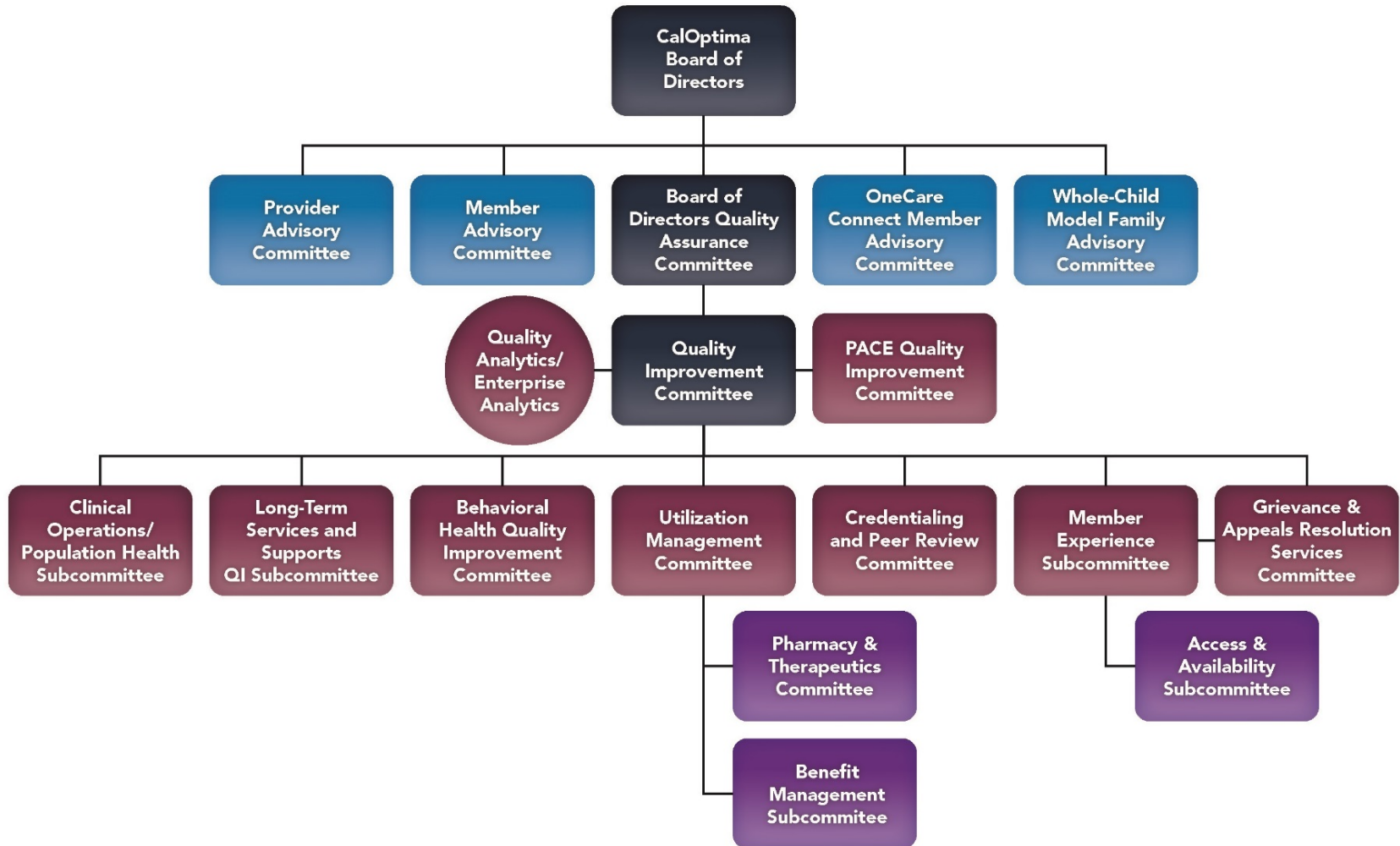
**Board of Directors' Quality Assurance Committee Meeting
May 16, 2018**

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

Quality Improvement Committee (QIC) Reporting

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

2018 QI Reporting Structure



Q1 Subcommittee Updates

- Accepted minutes from the following subcommittees:
 - Utilization Management Committee: November 30, 2017
 - Behavioral Health Integration QI Committee: November 14, 2017
 - PACE Quality Improvement Committee: October 31, 2017 and December 5, 2017
 - Long-Term Services and Supports: December 28, 2017
 - Member Experience: January 9, 2018, January 23, 2018, February 6, 2018 and February 20, 2018

Grievance & Appeals Committee: November 30, 2017 (will be accepted in Q2 Subcommittee updates)

1st Quarter QIC Highlights

- Present 2017 QI Program Evaluation, 2018 QI Program and Workplan, 2018 UM Program at QIC. These were also presented at February 20, 2018 QAC.
- Quarterly reports provided by all key areas, including Q4 QI Workplan Updates (dashboard)
 - Utilization Management Report
 - Update on Collaborative Efforts to Improve Diabetic Care presented by Dr. Dajee
 - Update on initiatives such as palliative care, non-medical transportation (NMT), behavioral health transition (including ABA), over and under utilization trends, LTSS utilization, opioid strategies
 - Behavioral Health QISC Report
 - Updates to Q4 QI workplan
 - PCP provider survey results shared at BHQIC
 - Updates on interventions such as LTC/SNF, ICT, PHQ-9A and HEDIS measures and outcomes

1st Quarter QIC Highlights (cont.)

➤ Long-Term Support Services Report

- Report on Q3 quarterly metrics:
 - Case turnaround time standards were met
 - Admissions — CBAS, IHSS, LTC met the goal; MSSP admission rate was not met
 - Readmissions — CBAS, LTC, and MSSP met goal; IHSS goal was not met
 - Emergency Room Visits — CBAS, IHSS, LTC and MSSP met the goal
 - Long-Term Services and Supports Utilization — LTC did not meet the goal; HCBS met goal
- Provided next steps for LTSS, CBAS and LTC in order to meet goals in Q4
- Update on Plan-Do-Study-Act (PDSA) for LTSS

➤ Clinical Operations/Medical Affairs Report

- Presentation of 2018 Health Management Program description
- Update to HE&DM Q4 workplan:
 - Update on IHEBA/SHA requirements and new goals for 2018
 - Implementation update of Shape Your Life and Bright Steps population health and wellness programs

1st Quarter QIC Highlights (cont.)

➤ Clinical Operations/Medical Affairs Report (cont.)

- Case Management of Q4 QI Workplan:
 - Update of health risk assessments
 - Update of continuity and coordination of care with BH
 - Update of ER utilization tracking. Met goal of 5 percent reduction in ER visits
 - Delegation oversight of MOC and CCM files. No health networks are under CAP
- Pharmacy QI Initiatives:
 - Provide education to providers for medication underutilization
 - Programs to prevent medication overutilization
 - Specialty drug monitoring with focus on hepatitis C
 - OneCare Medicare Part D Star measure performance: medication adherence
 - Pharmacy benefit manager (PBM) oversight

1st Quarter QIC Highlights (cont.)

➤ Quality Analytics Report

- NCQA accreditation survey preparations in full swing for submission May 22, 2018
- CCN Pay for Value (P4V) Program rollout
- HEDIS 2018 in progress with HEDIS audit March 22–23
- Quality initiatives update included 2017 Medi-Cal Quality initiative pilots, Medi-Cal Women's Health Campaign, Medi-Cal member incentive programs, provider office pilots, provider office incentives, child and adolescent initiatives "CalOptima Day"
- 2017 OCC HEDIS results update

➤ PACE Report (presented at QAC on February 20, 2018)

- Presented 2017 PACE QAPI program evaluation which includes 2017 accomplishments and opportunities for 2018
- Presented 2018 QAPI Program Description and Workplan

1st Quarter QIC Highlights (cont.)

➤ Member Experience Report

- Member Experience Subcommittee Charter update for 2018
- Customer service update on Q4 QI workplan:
 - Medi-Cal customer service met goal for First Call Resolution, Notification to Members (CCN), and Abandonment Rate; however did not meet goal for Average Speed of Answer.
 - OC/OCC customer service met goals for all three KPI
- Access and Availability Workgroup Reinstated
- DHCS Annual Network Certification Requirement (APL 18-005) effective July 1, 2018; March submission to DHCS
- Member portal update
- Provider coaching project update

➤ Grievance and Appeals (GARS) Report — will be reporting in 2nd quarter QIC highlights

1st Quarter QIC Highlights (cont.)

➤ Credentialing Peer Review Report

- Committee met on October 19, 2017, November 16, 2017 and December 14, 2017
- Reported on Q4 initial and re-credentialing of provider network and related facility site review/medical record review/physical accessibility review results
- Reported on Q4 potential quality of care (PQI) cases — Case loads continue to increase due to the volume of complaints being referred to QI from Customer Service and Grievance and Appeals (GARS)
- Assumed credentialing of behavioral health practitioners, effective January 1, 2018; added 800+ practitioners to CCN network
- Developing process for screening provider types not able to enroll in Medi-Cal, i.e. ABA providers
- Requirements for enrollment and screening in addition to credentialing is a new DHCS requirement per APL 17-019
- Volume of potential quality of care cases continues to rise. Working with GARS and Customer Service to appropriately categorize and refer quality of care versus quality of service cases to QI

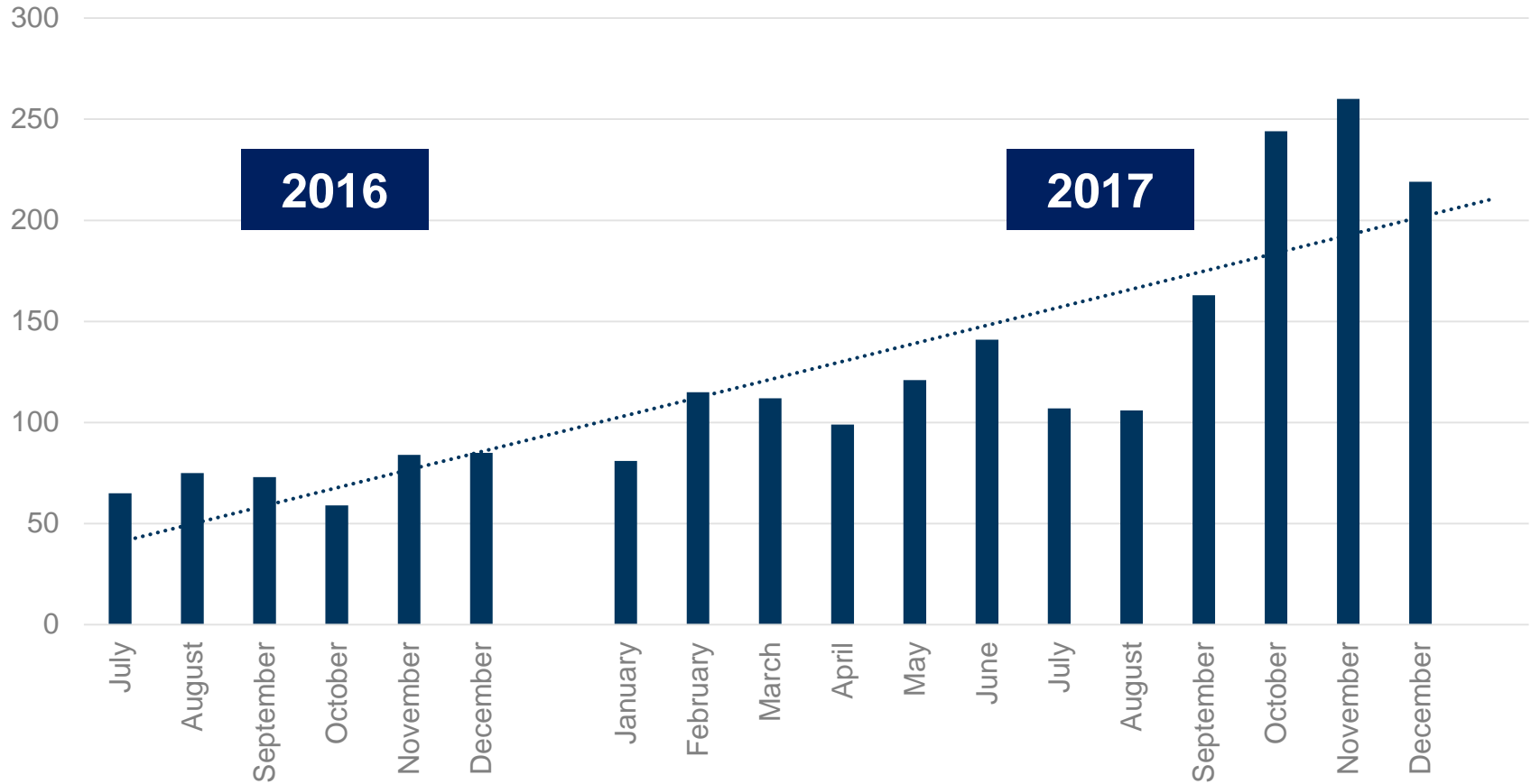
Credentialing Q4 and Year End 2017

Credentialing Activity	4th Quarter	Year End
Total number of initial files completed	65	222
Total number of re-credentialed files completed	99	417
Total Number of Initial and Re-cred files (clean list and CPRC approved)	164	639
Disciplinary Action Taken (805)	1	1
Timeliness for Initials — Goal Met (within 180 days from attestation date)	100%	100%
Timeliness for Re-creds — Goal Not Met (within 36 Months)	100%	100%

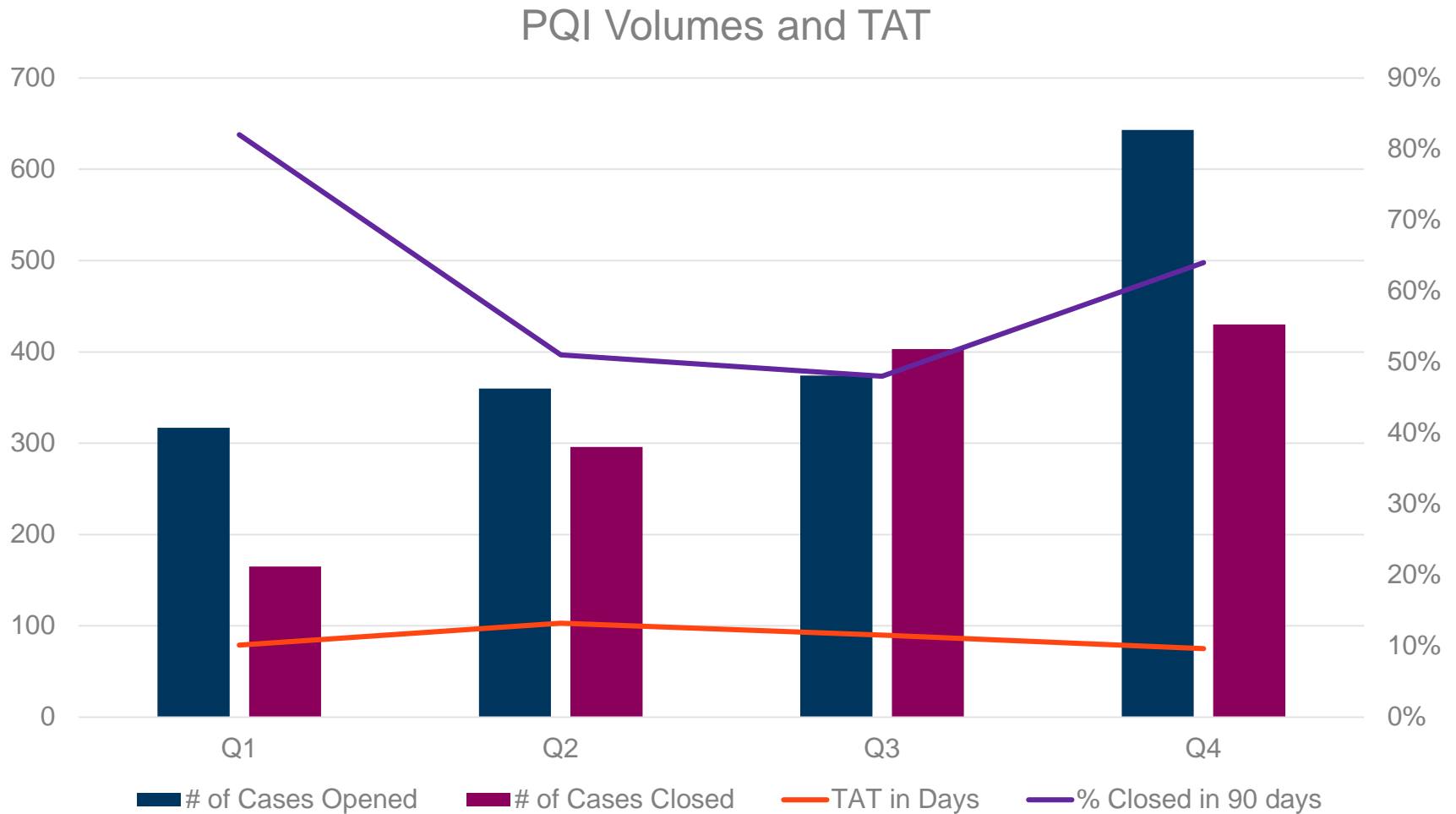
FSR/MRR/PARS – Q4 and Year End

Site Reviews Activity	4th Qtr 2017	Year End
Number of Full Scope FSR/MRR Completed (PCPs)	45	185
Number of Initial FSR/MRR	8	142
Number of FSR/MRR Completed Score >80%	44	184
% of PARS with BASIC Access	53%	55%
Number Critical Element CAPS Issued	7	36
Number of FSR CAPs Issued	20	95
Number of MRR CAPS Issued	15	67
Number of Member Panels Closed	1	4

PQI Referrals Jul 2016–Dec 2017



PQI Volumes and TAT 2017



Potential Quality of Care (PQI) Case Activity Q4 and Year End

	Q4	2017
Number of New Cases Opened	646	1740
Number of Cases Closed	503	1,300
Average Turnaround Time in Days	75	94
% Closed Within 90 Days	36%	60%

PQI Summary by Severity Code

Severity Code	Definition	Q4	2017
0	No quality of care issue	234	792
1	Clinical judgment issue without adverse outcome	14	34
2	Clinical judgment issue with a mild to moderate adverse outcome	3	14
3	Severe clinical judgment issue with or without severe adverse outcome	5	8
HDS	Health care delivery system issue with or without adverse outcome	5	28
H1	Potential clinical care issue with or without adverse outcome in hospital	2	6
S0	Service-related issue, unable to verify	134	249
S1	Service-related issue, verified	106	256



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Member Trend Report: Fourth Quarter 2017

**Board of Directors' Quality Assurance Committee Meeting
May 16, 2018**

Ana Aranda

Interim Director, Grievance and Appeals

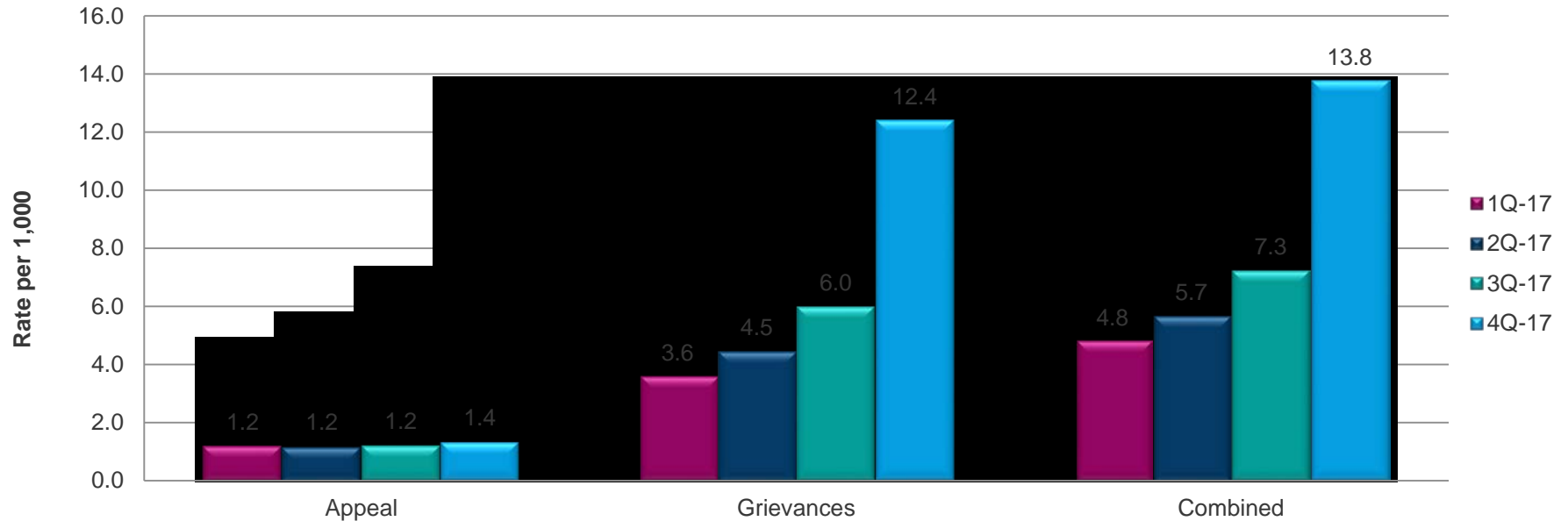
Overview

- Show trends in rates of complaints (appeals/grievances) per thousand members for three CalOptima programs for fourth quarter 2017
- Breakdown complaints by type
- Review interventions based on trends, as appropriate

Definitions

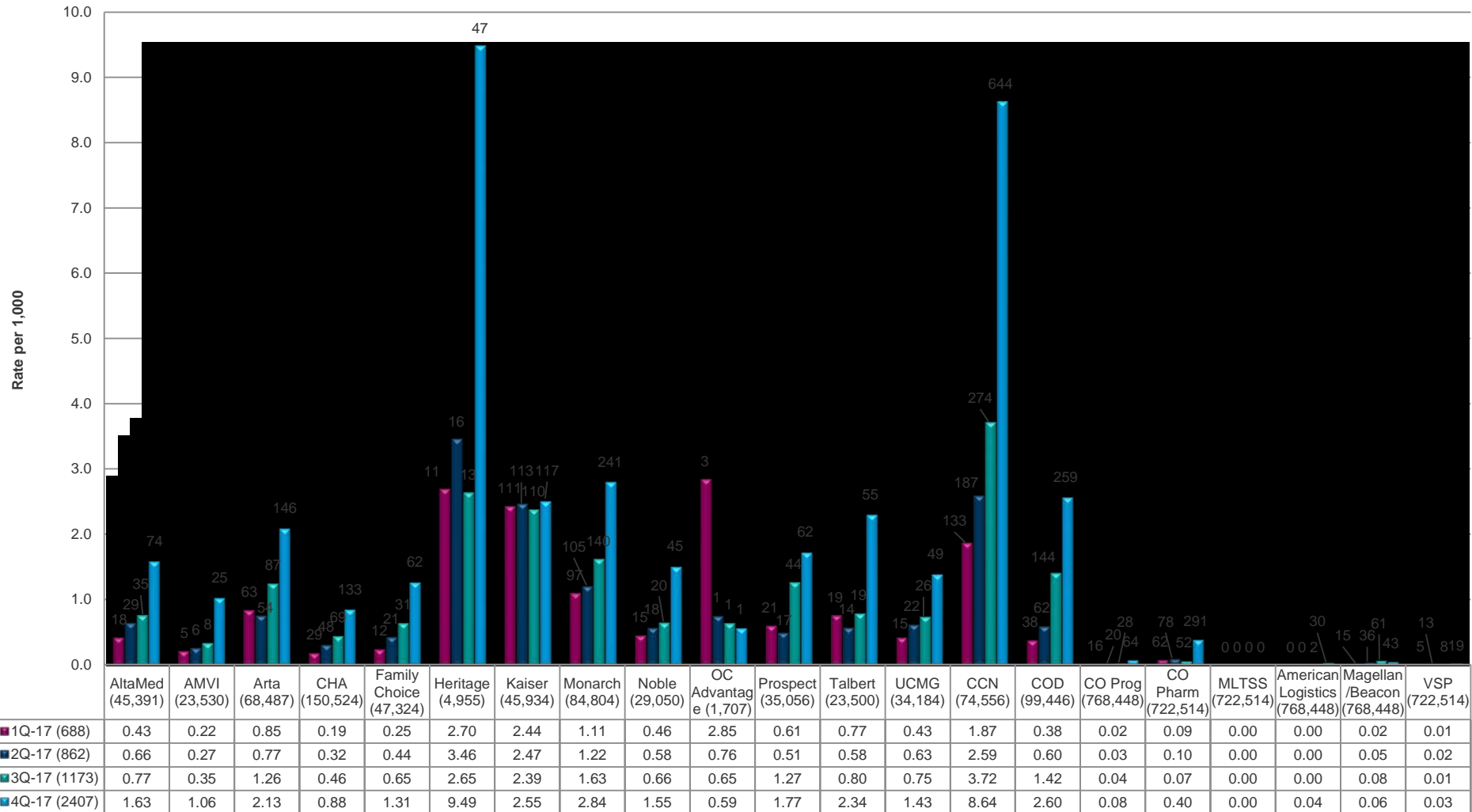
- Appeal: A request by the member for review of any decision to deny, modify or discontinue a covered service
- Grievance: An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program
- Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction.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

Medi-Cal Member Complaints



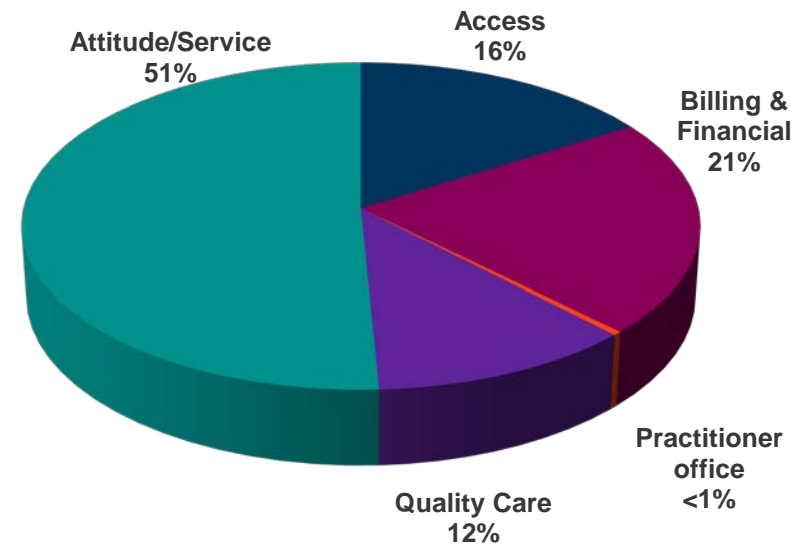
	Total Complaints	Appeals	Grievances	Membership
1Q-2017	921	233	688	774,750
2Q-2017	1,094	232	862	772,074
3Q-2017	1,427	224	1,203	773,314
4Q-2017	2,670	263	2,407	772,146

Medi-Cal Grievances Quarterly Rate/1,000



Medi-Cal Grievances by Category

- 2,407 grievances filed by 904 unique members in Q4 2017
 - 1,222 grievances (51 percent) were related to QOS
 - 275 grievances (11 percent) were related to QOC
 - The percentage by categories represents the historic trend.
- The Quality Improvement (QI) department continues to review for QOC issues.



Common QOC and QOS Concerns

QOS:

- Delay in service
 - Referrals and/or test results
- Provider services
 - Provider and/or staff attitude
- Pharmacy/prior authorization process
 - Dissatisfied with the Prescriber Restriction Program
 - Delay in the prior authorization process

QOC:

- Question treatment/diagnosis
- Delay in treatment
- Refusal to treat

Medi-Cal Summary

- Medi-Cal grievances increased by 50 percent from Q3 to Q4 2017.
 - Attributed to a process improvement in categorization of grievances
- Staff training on identification of grievances has caused an increase in the rate of grievances per 1,000 members across all health networks, with the highest increase in CalOptima Community Network (CCN).
 - American Logistics increased from two grievances in Q3 to 30 in Q4.
 - Utilization of taxi rides continues to increase from quarter to quarter with rides increasing 59 percent from Q3 to Q4.
 - The rate of grievances per 1,000 rides remains relatively low.
 - GARS continues to track transportation-related grievances and meet with American Logistics.

Medi-Cal Summary (cont.)

- Increase in Access Grievances

- Medication fills and appointment availability grievances had the largest increases due in part to the misunderstanding of the pharmacy approval process and appointment availability for specialists.
- GARS worked jointly with the Pharmacy, Utilization Management, Provider Relations and Quality Improvement departments to address the issues on these complaints.

Medi-Cal Summary (cont.)

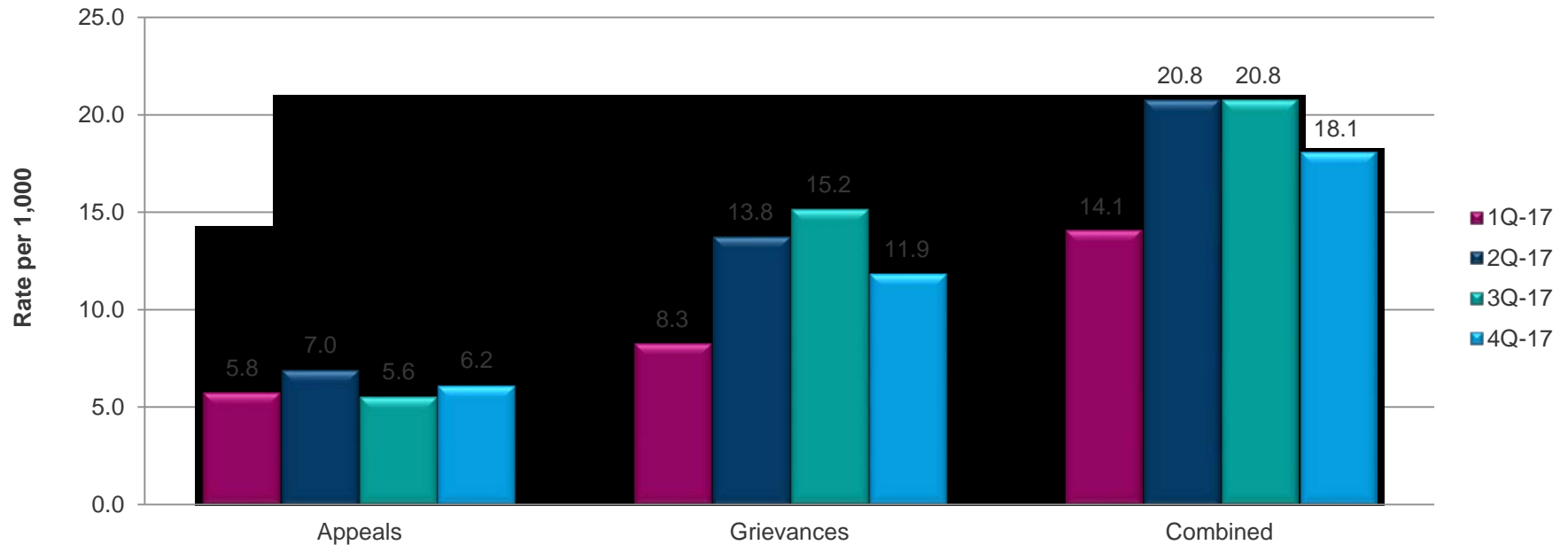
- Increase in Billing Grievances

- 18 percent of billing issues are related to emergency room services. Of these, 60 percent are services received out of area, state or country.
- COD and CCN member billing continues to increase due to the biller not having insurance information or being unaware of state and federal regulations prohibiting billing.
- GARS continues to educate providers and refer those who refuse to cease billing to Compliance for further action.

Interventions

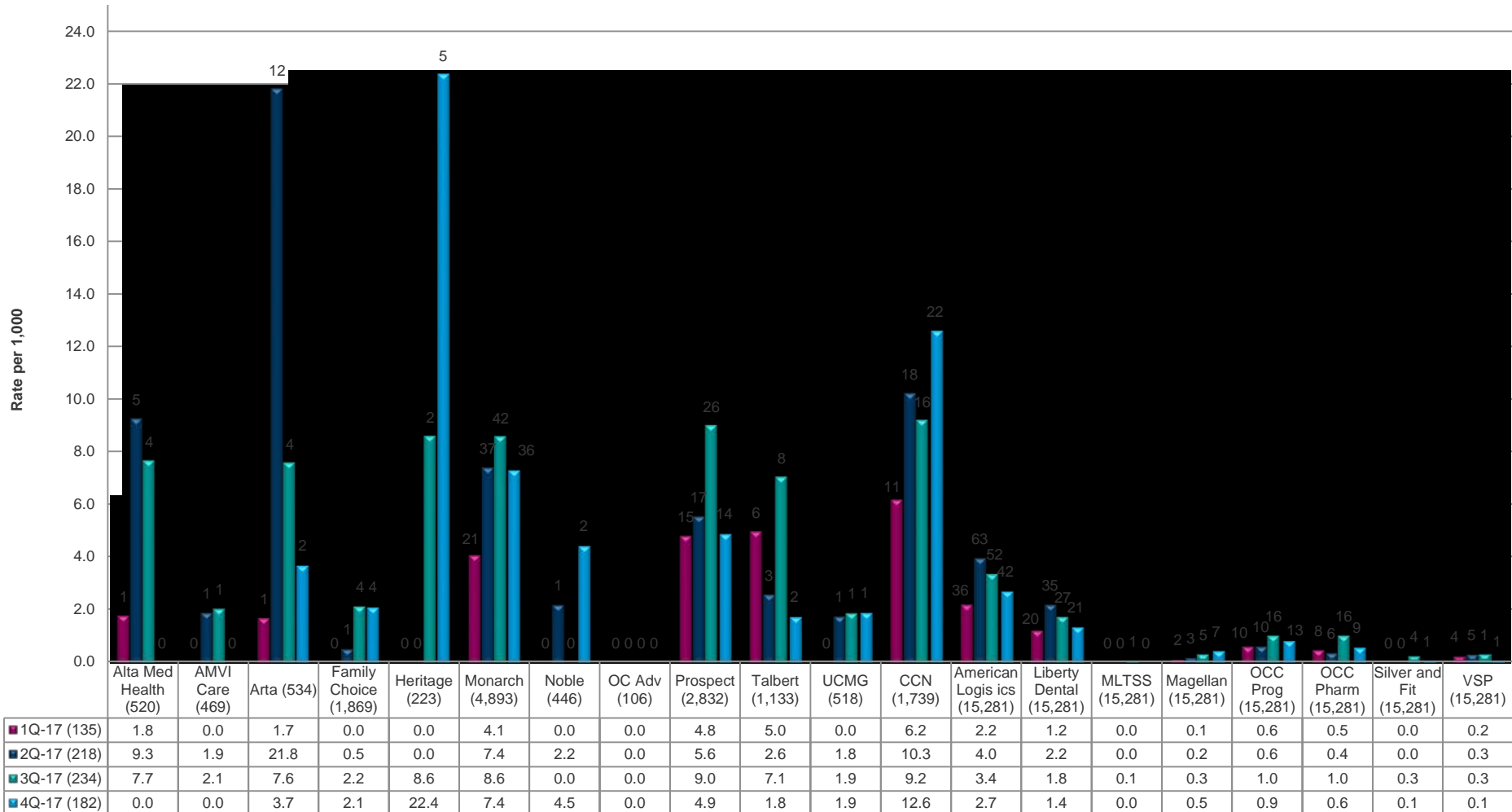
- The area of Access, Authorization Process and Delay in Service has been identified as an outlier.
 - A multidepartmental workgroup was created to improve internal resources, the referral authorization process and the integrity of the provider data in an effort to improve access to care and reduce delays in service.

OneCare Connect Member Complaints



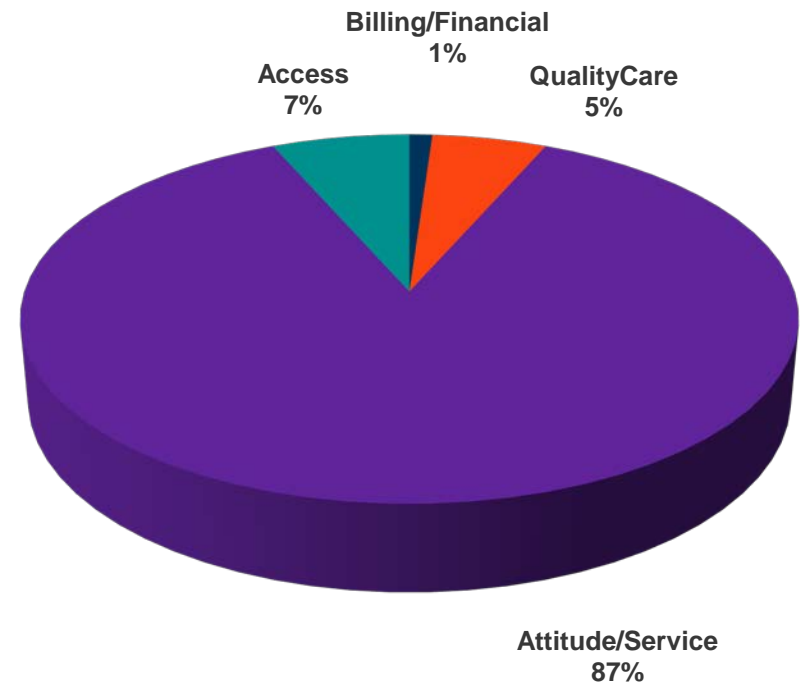
	Total Complaints	Appeals	Grievances	Membership
1Q-2017	230	95	135	16,297
2Q-2017	328	110	218	15,810
3Q-2017	320	86	234	15,348
4Q-2017	277	95	182	15,281

OneCare Connect Grievances Quarterly/1,000



OneCare Connect Grievances by Category

- 182 grievances filed by 144 unique members in Q4 2017
 - 158 grievances (87 percent) were related to QOS
 - 10 grievances (5 percent) were related to QOC
 - The percentage by categories represents the historic trend.
- The QI department continues to review for QOC issues.



Common QOS and QOC Concerns

QOS:

- Rudeness
- Delay in service
 - Referral/test results/DME
- Transportation vendor
 - Late pickup/no show
 - Poor customer service

QOC:

- Question treatment
 - Inadequate care provided
 - Dissatisfied with diagnosis provided

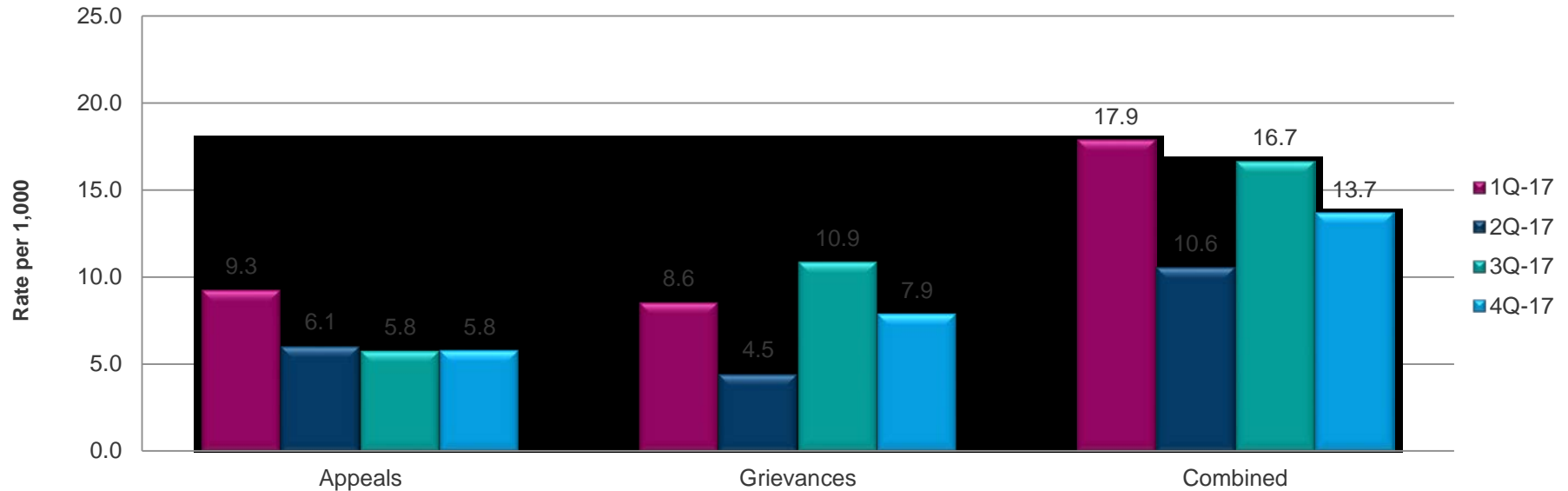
OneCare Connect Summary

- Although 24 members filed multiple grievances, Q4 had a 22 percent decrease in grievances from Q3 2017.
- American Logistics and LIBERTY Dental continue to trend down in grievances since Q2 2017.

Interventions

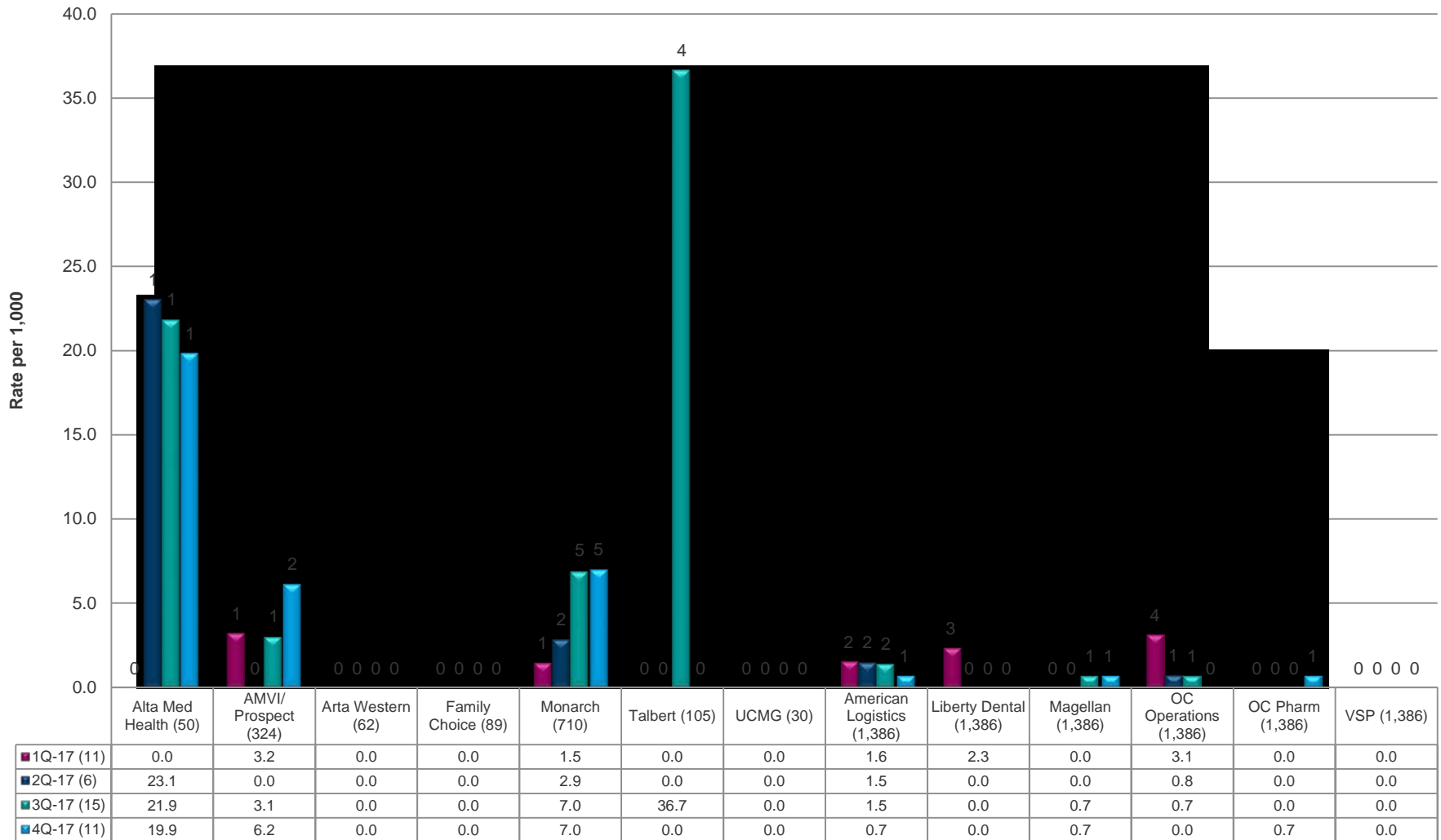
- Ongoing discussions with the transportation vendor, American Logistics, about member dissatisfaction has improved the service for our members.
- Education to LIBERTY Dental providers about the supplemental benefit package has decreased member grievances.

OneCare Member Complaints



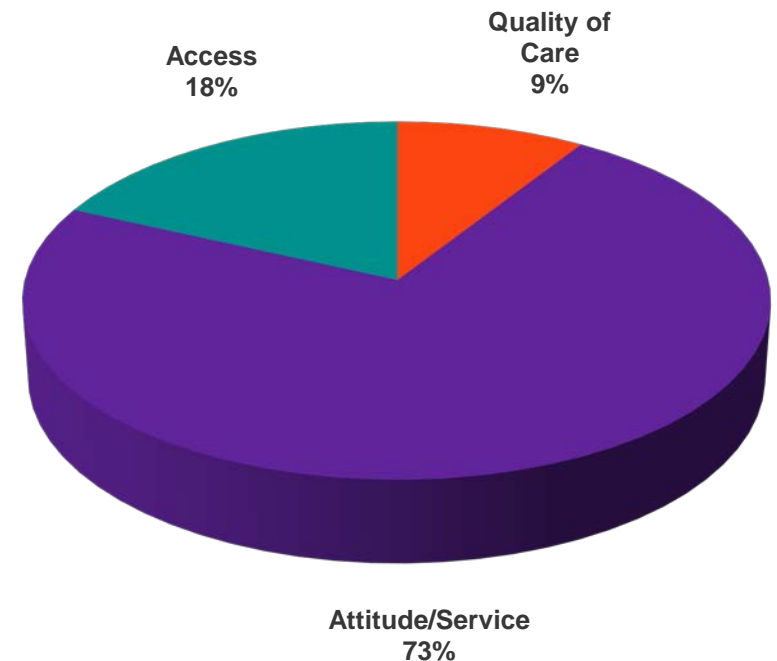
	Total Complaints	Appeals	Grievances	Membership
1Q-2017	23	12	11	1,285
2Q-2017	14	8	6	1,320
3Q-2017	23	8	15	1,373
4Q-2017	19	8	11	1,341

OneCare Grievances Quarterly/1,000



OneCare Grievances by Category

- 11 grievances filed by 10 unique members in Q4 2017
 - Eight grievances (73 percent) were related to QOS
 - One grievance (9 percent) was related to QOC
 - The percentage by categories represents the historic trend.
- The QI department continues to review for QOC issues.



Common QOS and QOC Concerns

QOS:

- Delay in service/referrals
- Provider service/treatment

QOC:

- Question treatment

OneCare Summary

- Grievances decreased from 15 in Q3 to 11 in Q4 2017.
- GARS continues to review for trends.
- QOC concerns were escalated to the QI department for further review.

CalOptima's Mission

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



CalOptima

Better. Together.



Medi-Cal

CalOptima

Better. Together.



OneCare (HMO SNP)

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Better. Together.



OneCare Connect

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Better. Together.



PACE

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