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

WEDNESDAY, MAY 19, 2021
3:00 P.M.

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

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

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Richard Sanchez	Gary Crockett	Sharon Dwiers

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

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

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

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

1) **Listen to the live audio at +1 (631) 992-3221 Access Code: 230-234-663 or**
2) **Participate via Webinar at** https://attendee.gotowebinar.com/register/2378242966303979022 **rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

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

CONSENT CALENDAR
1. Approve Minutes of the February 25, 2021 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS
2. Consider Recommending the Continued Use of the Methodology Previously Approved for the Distribution of OneCare Connect Quality Withhold Payments to Contracted Health Networks in Demonstration Years 2 Through 5 for Distribution of Such Payment for Demonstration Years 6 Through 8.

3. Consider Recommending Authorization of a Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetics

INFORMATION ITEMS
4. Pay for Value Program Overview

5. PACE Member Advisory Committee Update

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee May 19, 2021 3:00 PM PDT at:

   https://attendee.gotowebinar.com/register/2378242966303979022

2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.

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

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

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

   TO USE YOUR COMPUTER'S AUDIO:

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   TO USE YOUR TELEPHONE:

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   United States: (631) 992-3221

   Access Code: 230-234-663

   Audio PIN: Shown after joining the webinar

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 25, 2021

A Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on February 25, 2021 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

At 3:05 p.m., Chair Mary Giammona, M.D., announced that Director Tran was running late, and that staff could provide informational updates until he arrived. Sharon Dwiers led the Pledge of Allegiance.

PUBLIC COMMENTS

There were no requests for public comment.

MANAGEMENT REPORTS

1. Chief Medical Officer Update

Emily Fonda, M.D., Interim Chief Medical Officer, reviewed the latest COVID-19 numbers, and reported a snapshot of CalOptima's population at the beginning of the year until the end of December 2020. CalOptima membership totals 806,334; first quarter of 2021 membership is at 818,000, 12,100 are experiencing homelessness of our members and 4148 are confined to long-term care facilities. In addition, close to 2001 members or more have one or more medical conditions that placed them at high risk if they contract a COVID infection. Dr. Fonda also provided information on vaccination efforts to date.

INFORMATION ITEMS

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

Elizabeth Lee, Director, CalOptima PACE, noted that the Program of All-Inclusive Care for the Elderly Member Advisory Committee (PMAC) report is provided in the meeting materials and asked if there were any questions. Ms. Lee also noted that most of the members of the PMAC are PACE members, and they have transitioned to virtual meetings since the pandemic.

10. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Committee Report
b. Program of All-Inclusive Care for the Elderly Report
c. Member Trend Report

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Chair Giammona asked that staff report both raw or absolute grievance counts and per 1,000-members when there is an increase in grievances in future reports.

CALL TO ORDER

A quorum of the Board of Directors' Quality Assurance Committee was achieved at 3:39 p.m.

Members Present: Mary Giammona, M.D., Chair; Trieu Tran, M.D. (via teleconference)

Members Absent: None

Others Present: Richard Sanchez, Chief Executive Officer; Gary Crockett, Chief Counsel, Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D., Interim Chief Medical Officer; Sharon Dwiers, Clerk of the Board

CONSENT CALENDAR

2. Approve the Minutes of the December 10, 2020 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee

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

REPORTS

Recommended Actions for Agenda Items 3 and 4 were each read into the record and were approved in one motion and vote.

3. Receive and File 2020 CalOptima Quality Improvement Program Evaluation

Esther Okajima, Director, Quality Improvement presented a review of the 2020 Quality Improvement (QI) Program evaluation accomplishments, including: CalOptima receiving recognition by the Department of Health Care Services (DHCS) as the highest performing Medicaid plan in California; CalOptima meeting all DHCS Managed Care Accountability Set (MCAS) measures required to achieve Minimum Performance Level (MPL) in measurement year (MY) 2019; CalOptima completing successful incentive outreach to members in MY 2019 to obtain preventive care, which resulted in improvements for HEDIS, including well-child visits, postpartum care, breast and cervical cancer screening; and CalOptima demonstrating the highest Adverse Childhood Experiences (ACE) screening rate among Managed Care Plans (MCPs). In addition, CalOptima recognized and rewarded outstanding performance of Health Networks and CalOptima Community Network through the comprehensive Board-approved Pay for Value (P4V) performance measurement program; CalOptima extended its Homeless Health Initiative, which included Clinical Field Team (CFT) and Community Health Center (CHC) efforts; CalOptima also implemented a Post-acute Infection Prevention Quality Initiative (PIPQI), as well as participated in the Orange County Nursing Home Infection Program, both of which reduce the spread of COVID-19 and other bacterial, fungal and viral infections; and CalOptima responded to the COVID-19 pandemic. Ms. Okajima also highlighted opportunities for improvement that were identified as part of the 2020 Quality Program and made the following recommendations: develop a comprehensive COVID-19 mitigation strategy;

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continue member health rewards incentive programs specifically for preventive screenings; and expand member incentives to promote COVID-19 vaccine acceptance.

4. Consider Recommending Board of Directors Approval of the 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan

Ms. Okajima provided an overview of the proposed 2021 Quality Improvement (QI) Program and 2021 Quality Improvement Work Plan. She noted that much of the 2021 QI Program is based on the 2020 QI Plan Evaluation and that many of the goals for 2021 revolve around COVID-19. These include: aiming for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during the pandemic; improve members' ability to access primary and specialty care for routine appointments and achieve Accredited rating from the National Committee of Quality Assurance (NCQA) and maintain a NCQA overall rating of 4.0.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended Board of Directors approval of the 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan. (Motion carried 2-0-0)***

The recommended Actions for Agenda Items 5 and 6 were approved in a single motion and vote.

5. Receive and File 2020 CalOptima Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation

Miles Masatsugu, M.D., Medical Director, presented a review of the 2020 Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan Evaluation accomplishments during 2020 which included the following: swiftly responding to the COVID-19 pandemic by implementing "PACE without Walls", redesigning the triage and clinical workflow to respond to the pandemic, 98% pneumococcal immunization rate, and 83% influenza immunization.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors Receive and File the 2020 Program of All-Inclusive Care for the Elderly Quality Improvement Plan Annual Evaluation. (Motion carried 2-0)***

6. Consider Recommending Board of Directors Approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Dr. Masatsugu provided an overview of the proposed 2021 CalOptima PACE Quality Improvement Plan, which includes the following goals: improve quality of care for participants, ensure the safety of clinical care, ensure appropriate access and availability, ensure appropriate use of resources, improve participant experience, and additional focus on COVID-19.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended Board of Directors approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan. (Motion carried 2-0)***

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7. Consider Recommending Board of Directors Approval of the 2020 CalOptima Utilization Management Program Evaluation and the 2021 CalOptima Utilization Management Program Description

Tracy Hitzeman, Executive Director, Clinical Operations, reviewed the 2020 CalOptima Utilization Management (UM) Program Evaluation accomplishments including: adding a Custom DME Specialist – Physical Therapist who provides in-home assessments for members needing custom DME; and Monitoring nurses to ensure compliance with internal monitoring activities and identification of opportunities for improvement. In addition, CalOptima implemented auto authorization rules for select initial specialty consults, developed enhanced tools and templates to standardize review processes and reinforce UM principles, and enhanced over and underutilization monitoring as corporate-wide initiative. Ms. Hitzeman also provided an overview of the proposed 2021 Utilization Management Program Description. Updates to the program are based on results from the prior year's evaluation and include a COVID-19 focus.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended Board of Directors approval of the 2020 Utilization Management Program Evaluation and the 2021 Utilization Management Program Description. (Motion carried 2-0)***

8. Consider Recommending Board of Directors Approval of Modifications to Quality Improvement Policies

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors approve modifications to the following CalOptima policies pursuant to CalOptima's annual review process: GG.1603: Medical Records Maintenance; GG.1611: Potential Quality Issue Review Process; GG.1615: Corrective Action Plan for Practitioners; and GG.1658: Suspend, Restrict or Terminate Practitioner Participation in CalOptima's Network. (Motion carried 2-0)***

COMMITTEE MEMBER COMMENTS

The Committee members thanked staff for their work.

ADJOURNMENT

Hearing no further business, Chair Giammona adjourned the meeting at 4:49 p.m.

_____
Sharon Dwiers
Clerk of the Board

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 19, 2021
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

2. Consider Recommending the Continued Use of the Methodology Previously Approved for the Distribution of OneCare Connect Quality Withhold Payments to Contracted Health Networks in Demonstration Years 2 Through 5 for Distribution of Such Payment for Demonstration Years 6 Through 8.

Contacts

Emily Fonda, MD, MMM, Chief Medical Officer, (714) 246-8487
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Action

Recommend Board of Directors' approval of the continued use of the methodology previously approved for the distribution of OneCare Connect quality withhold payments to contracted Health Networks (including the CalOptima Community Network (CCN)) in Demonstration Years (DY) 2-5 (Calendar Years 2016-2019) for the distribution of such payment for DY 6-8 (Calendar Years 2020-2022).

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.

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 (calendar year 2015), 2% for Year Two (calendar year 2016), 3% for Years Three, Four, and Five (calendar years 2017-2019) and 4% for Years Six, Seven, and Eight (calendar years 2020 - 2022). 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 June 7, 2018, the CalOptima Board of Directors approved the methodology and disbursement of the DY 2-5 (CY2016 – CY2019) quality withhold that was received from DHCS and CMS and distributed to the health networks. Additional Board action is required for the methodology and distribution of earned quality withhold dollars for DY 6-8.

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Discussion

CalOptima began participation 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 2-8) 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 four percent (4%) in Years Six, Seven, and Eight. 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 withholds 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%

Quality Withhold Distribution Methodology:

To determine the payment allocation to the Health Networks, staff score each measure and determine HN allocation for payment according to the methodology in the tables below. After each measure is scored by comparing performance against established benchmarks, the health network is assigned quality points based on their performance. These points are added up and a weighted factor is determined for overall performance so that higher performing networks earn a higher share of the allocation. This methodology is similar to how CMS assesses health plan performance nationwide. The final step of payment allocation also considers the HN financial model type (HMO, PHC or SRG) to determine any payments that may be required to affiliated hospitals under the PHC model.

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Health Network Scoring

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

Health Network Measure Performance Points

- 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

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

Health Network (HN) Allocation = HN Weighted % of Allocation

- **Allocation** = Withhold funds received from CMS
- **HN Weighted Allocation** = HN CMS Revenue * HN Quality Points
- **HN Weighted %** = HN Weighted Allocation / Sum of HN Weighted Allocation

P (professional) = 34.40% * HN Allocation
H (hospital) = 50.90% * HN Allocation

- **HMO: Health Networks are paid for Provider and Hospital.**
- **PHC: Hospital is paid directly by CalOptima.**
- **SRG: Money contributed to SRG pool.**

Distribution of Earned Withhold Funds to the Health Networks

CalOptima's contracts with the health networks provide 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 health networks do not have full accountability for every measure. There are measures for which CalOptima has direct responsibility, while CalOptima shares responsibility with the delegated health networks on some measures.

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- The methodology that staff is proposing for DY 6-8 is unchanged from DY 2-5. The methodology 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). 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.
- 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.

Fiscal Impact

The recommended action is budget neutral to CalOptima. Distributions to health networks, including CCN, will not exceed the amount of Medicare quality withhold funds earned back by CalOptima. There is 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

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Attachments

1. CalOptima Board Action dated June 7, 2018, Consider Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to Participating Health Networks
2. CMC Extension DY6-8 DRAFT dated March 12, 2019 which stipulates the quality withhold for Demonstration Years 6-8 as 4%.
3. Presentation: OCC Quality Withhold Methodology DY6-8

/s/ Richard Sanchez *05/12/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider 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

Approve 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

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

Health Network Measure Performance Points

- 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

- Benchmark is set by Cal MediConnect.
- Points based on CalOptima's rate for measure
  - 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 Consortiums (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
Board of Directors' Quality Assurance Committee

Attachment
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 *5/30/2018*
Authorized Signature **Date**

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)

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- 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 amout 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 networks's POP is 35%, the network's capitation will be 35% x $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 — *07/31/2015*
Authorized Signature — **Date**

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March 12, 2019

Dear CMC plans,

Please find below draft contract language regarding the draft extension provisions in the California 3-way contract. This language is not final, and is subject to change based on CMS and DHCS clearance processes. Plans will have the opportunity to comment on this and other 3-way contract language via the usual process of updating the contract. We anticipate the MMP comment period to occur later this spring.

Please don't hesitate to reach out to Gretchen.nye1@cms.hhs.gov if you have any questions related to the below language.

1. Experience Rebate/One-Sided Risk Corridor Draft Contract Language (new section 4.4)

4.4. One-Sided Risk Corridors will be established for Demonstration Years 6-8

4.4.1 General Provisions

4.4.1.1 The Demonstration will utilize a one-sided risk corridor for Demonstration Years 6 through 8. The one-sided risk corridor is designed to limit the profits received by Cal MediConnect MMPs to a reasonable percentage of total revenue.

4.4.1.2 Calculation of Gains and Losses: The risk sharing arrangement described in this section of the Contract may result in payment by the Contractor to the State and CMS.

4.4.1.2.1 All payments made by the Contractor to the State and CMS will be calculated and determined jointly by the State and CMS.

4.4.1.2.2 All calculations, determined jointly by the State and CMS, will be based on the Contractor's reporting of Actual and Adjusted Non-Service Expenditures and Actual and Adjusted Service Expenditures, as required in Section 4.4.3. All financial reporting will be subject to review and/or audit at the State's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.4.1.2.3 CMS and the State will perform a final settlement of the payments made by the Contractor to CMS and the State, as described in Section 4.4.3.

4.4.1.3 Allowable Expenditures

4.4.1.3.1 CMS and the State shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the State's rate development template) submitted by the Contractor (as required by Section 4.4.3 and Section 2.17-2.19 of this Contract). CMS and the State reserve the right to audit Actual Non-Service Expenditure and Adjusted Non-Service Expenditure data.

4.4.1.3.2 CMS, the State, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the

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Contractor, CMS, the State and the Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the State, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the State will jointly have the final decision on the resolution of any differences in the expenditure data reported.

4.4.1.3.3 The State and CMS reserve the right to adjust expenditures for services that are reimbursed at more than ten percent (10%) above the median reimbursement rate of all plans within a region. For the purposes of the risk corridor, the Regions are defined as the Northern Counties Region (San Mateo and Santa Clara Counties) and the Southern Counties Region (Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties). The State and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or the State for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.4.2 One-Sided Risk Corridor Parameters

4.4.2.1 The Demonstration will utilize a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), intergovernmental transfers, and as if all Contractors had received the full quality withhold payment.

4.4.2.1.1 Risk Corridor Share: The Medicare and Medicaid contributions to risk corridor payments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.4.2.1.2.

4.4.2.1.2 Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures, with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.

4.4.2.1.3 Up-Side Risk Corridor Payment/Recoupment: For gains, the following bands apply:

4.4.2.1.3.1 First Band: The Contractor will retain all of the gains that are equal to or less than three percent (3%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

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4.4.2.1.3.2 Second Band: DHCS/CMS and the Contractor will share that portion of the gains that is over three percent (3%) and less than or equal to five percent (5%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with eighty percent (80%) retained by the Contractor and twenty percent (20%) paid to DHCS/CMS.

4.4.2.1.3.3 Third Band: DHCS/CMS and the Contractor will share that portion of the gains that is over five percent (5%) and less than or equal to seven percent (7%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with sixty percent (60%) retained by the Contractor and forty percent (40%) paid to DHCS/CMS.

4.4.2.1.3.4 Fourth Band: DHCS/CMS and the Contractor will share that portion of the gains that is over seven percent (7%) and less than or equal to nine percent (9%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with forty percent (40%) retained by the Contractor and sixty percent (60%) paid to DHCS/CMS.

4.4.2.1.3.5 Fifth Band: DHCS/CMS and the Contractor will share that portion of the gains that is over nine percent (9%) and less than or equal to twelve percent (12%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with twenty percent (20%) retained by the Contractor and eighty percent (80%) paid to DHCS/CMS.

4.4.2.1.3.6 Sixth Band: DHCS/CMS will recoup the entire portion of the gains that exceeds twelve percent (12%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

Figure 4-4 Demonstration Years 6-8 Risk Sharing Corridor Table (for illustrative purposes only)

Risk Corridor Band	Incremental Gain[1]	% Contractor Gain Sharing	% State & CMS Gain Sharing	% CMS Gain Sharing	% State Gain Sharing
Gain Band 1	Gains ≤ 3%	100%	0%	0%	0%
Gain Band 2	Gains >3% and ≤5%	80%	20%	(20%) * (Medicare A/B Percent of Rate)	(20%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains >5% and ≤7%	60%	40%	(40%) * (Medicare A/B Percent of Rate)	(40%)*(Medi-Cal Percent of Rate)
Gain Band 4	Gains >7% and ≤9%	40%	60%	(60%) * (Medicare A/B Percent of Rate)	(60%)*(Medi-Cal Percent of Rate)
Gain Band 5	Gains >9% and ≤12%	20%	80%	(80%) * (Medicare A/B Percent of Rate)	(80%)*(Medi-Cal Percent of Rate)

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Risk Corridor Band	Incremental Gain[1]	% Contractor Gain Sharing	% State & CMS Gain Sharing	% CMS Gain Sharing	% State Gain Sharing
Gain Band 6	Gains >12%	0%	100%	(100%) * (Medicare A/B Percent of Rate)	(100%)*(Medi-Cal Percent of Rate)

[1] Gain reflected on an incremental basis. Gains in Gain Bands 6 still results in risk sharing reconciliation for the gain in Gain Bands 2-5.

4.4.3 Risk Sharing Settlement

4.4.3.1 CMS and the State shall determine final settlement of payments made by the Contractor to CMS and the State.

4.4.3.2 Data Submission. The Contractor shall submit to DHCS and CMS, in the form and manner prescribed by DHCS and CMS, the necessary data to calculate and verify the final settlement after the end of each applicable Demonstration Year.

2. Quality Withhold Draft Contract Language (Section 4.8.1.3 is updated)

4.8.1.3 The quality withhold will increase to two percent 2% in Demonstration Year 2, three percent 3% for Demonstration Years 3-5 and 4% for Demonstration years 6-8. **See Figure 4.6.**

3. Disenrollment Penalty Draft Contract Language (new section 4.10)

4.10 Medicare A/B Disenrollment Penalty

4.10.1 Beginning in Demonstration Year 5 (CY 2019) CMS will implement a retrospective financial penalty in the Medicare A/B component of the capitation rate for Contractors with high disenrollment rates. This penalty is intended to address selection bias that may be impacting Medicare costs for the Cal MediConnect demonstration and to align incentives for plans to improve quality for all enrollees.

4.10.2 Performance will be evaluated annually using the existing Medicare Part C measure entitled “Members Choosing to Leave Plan.” For DYs 5 and 6, CMS intends to maintain the benchmark at the median Contractor performance from measurement year 2017. For DYs 7 and 8, CMS will set the benchmark at the median Contractor performance from the most recent measurement year. Contractors with rates above the benchmark will be subject to the penalty on a sliding scale, starting at 1% and up to 2%. Additional detail regarding the methodology will be provided in separate technical guidance.

4.10.3 Based on Contractor performance, CMS will recoup the Medicare A/B penalty retroactively, once performance for the applicable Demonstration Year has been determined.

4. Contract Term (Section 5.8.1 is updated)

5.8 Contract Term.

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5.8.1 This Contract shall be in effect starting from the date on which all parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2022, so long as the Contractor has not provided CMS and the State with a notice of intention not to renew, and CMS/State have not provided the Contractor with a notice of intention not to terminate, pursuant to 42 C.F.R. § 422.506 or Section 5.5 above This contract will terminate, or its effectuation will be delayed, unless the State receives all necessary approvals from CMS, including but not limited to § 1115(a) demonstration authority, and unless the Contractor is deemed ready to participate in the MMCO demonstration, as provided for in Section 2.2.1.3 of this Contract. Funds must not be expended or awarded until the State has received all necessary approvals from CMS. No payments will be made nor Medicaid federal Medical assistance payment (FMAP) funds drawn for any services provided or costs incurred prior to the later of the approval date for any necessary § 1115(a) authority, the Readiness Review approval, or the effective date of this Contract.

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OneCare Connect

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OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

OCC Quality Withhold Current Distribution Strategy

Quality Assurance Committee Meeting

May 19, 2021

Emily Fonda, M.D., MMM, Chief Medical Officer

Marie Jeannis, Executive Director, Quality & Population Health Management

Purpose

- Request Board approval to continue the use of current Board approved process for allocating Quality Withhold funds to participating Health Networks for the remainder of the OneCare Connect program (measurement years 2020-2022).
- The current process has been in place since 2015
  - Supports successful implementation of the distribution of the quality withhold dollars.
- The slides that follow describe the Quality Withhold distribution methodology.

OCC Quality Withhold (OCC QW) Overview

- CMS Quality Withhold
  - For the remainder of the OCC QW program, (CY 2020-2022) the quality withhold is 4%

- 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

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 point if CalOptima does not pass measure

Health Network Measure Performance Points

- NCQA National Medicaid HEDIS Percentiles
- CMS Star Cut Points
- Minimum denominator of 1% 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.

Health Network Points per Measure Example

Health Network	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%	
	Denom	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% 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

Health Network Allocation Calculation

Health Network (HN) Allocation = HN Weighted % of Allocation

- **Allocation =** Withhold funds received from CMS
- **HN Weighted Allocation =** HN CMS Revenue * 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

(Quality Points) * (DY CMS Revenue) = (Weighted Allocation)
1 * $3,000 = 3,000

(HN Weighted Allocation) / (Total Weighted Allocation) = (Weighted %)
3,000 / 10,000 = 30%

(Weighted %) * (Amount Received from CMS) = (Health Network Allocation)
30% * $100 = $30

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% * HN Allocation

H (hospital) = 50.90% * HN Allocation

- HMO: Health Networks are paid for Provider and Hospital.
- PHC: Hospital is paid directly by CalOptima.
- SRG: Money contributed to SRG pool.

CalOptima's Mission

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


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Medi-Cal
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OneCare (HMO SNP)
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OneCare Connect
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PACE
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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 19, 2021
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

3. Consider Recommending Authorization of a Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetics

Contacts

Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Actions

Recommend that the Board of Directors:

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to implement a two-year pilot Multidisciplinary Approach to Improving Care in Poorly Controlled Diabetics, hereinafter referred to as "the diabetes mellitus (DM) program," for CalOptima Community Network (CCN) Medi-Cal members;
2. Authorize the allocation of Intergovernmental Transfer (IGT) 10 funds in an amount not to exceed $3.6 million for program expenses for the DM program;
3. Authorize funding for staffing resources and program design expenses for the DM program prior to CalOptima's receipt of IGT 10 funds from the State of California; and
4. Authorize the CEO, with the assistance of Legal Counsel, to execute a contract with a selected vendor through the Request for Proposal process to provide fresh produce delivery services.

Background

Diabetes is a disease caused by too much sugar in the blood that requires a primary care provider's (PCP's) comprehensive care. When diabetes is not managed, it can damage vital organs and lead to various complications. According to the Centers for Disease Control and Prevention's 2017 data[1], diabetes is the most expensive chronic condition in the United States, and the total annual cost spent on diabetes was $327 billion.

The high cost of diabetes is not just our nation's story; CalOptima is also seeing the high cost of diabetes for our CCN Medi-Cal members. Based on claims data from July 2019 through June 2020, CalOptima observed that approximately $247 million was spent on diabetic care (refer to Attachment 1). In addition to the enormous total cost, the average annual cost per diabetic member was $20,334, which is approximately four times higher than non-diabetic member's average annual cost.

Food insecurity is "a lack of consistent access to enough food for an active, healthy life and it's an issue that touches people of all ages with all types of diabetes[2]." According to American Diabetes Association, diabetics with food insecurity have a higher risk of developing complications. Diabetes is a complex and challenging disease for members, as well as for their families and society at large. To reduce the risk of complications of diabetes, members need to learn about this complex disease and incorporate a variety of self-management behaviors into their daily lives. In order to better assist this population and facilitate PCP care, CalOptima staff proposes to offer a multidisciplinary approach to assist managing CCN Medi-Cal

[1] https://www.cdc.gov/chronicdisease/programs-impact/pop/diabetes.htm
[2] https://www.diabetes.org/healthy-living/recipes-nutrition/food-insecurity-diabetes

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members with poorly controlled diabetes and their complex treatment regimens. The anticipated start date for the DM program is September 1, 2021. The goals of this new DM program are: 1) lower HbA1c level to avoid complications; 2) reduce emergency department (ED) visits; 3) reduce hospitalization rates; 4) reduce costs for diabetic medications; 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx. This new DM program is proposed in CalOptima's 2021 Quality Improvement (QI) Program. Through the QI Program, CalOptima aims to continuously improve the structure, processes, and outcomes of its health care delivery system to serve our members.

Discussion

Pharmacist Involvement and Intervention

Literature shows that pharmacists involved in diabetes care and management play a pivotal role in helping members achieve healthier lifestyle goals. This active participation in diabetes care and management requires that the CalOptima pharmacist's role extends to include individual member outreach and provider consultations. CalOptima staff believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. With this new DM program, CalOptima proposes to hire two Clinical Pharmacists to provide various interventions to optimize medical management. The estimated salary and benefit expenses for the two-year pilot period is $854,968.

Health Coach/Registered Dietician Intervention

CalOptima's Population Health Management department's Health Coaches have been providing chronic condition management and coaching for members. With the new multidisciplinary approach, CalOptima proposes to hire two Health Coaches to provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. The estimated salary and benefit expenses for the two-year pilot period is $509,342.

Member Health Rewards Program

Subjected to Department of Health Care Services (DHCS) approval, staff proposes supporting member engagement and compliance by providing members with member health rewards (non- monetary incentives). The non-monetary incentives will be provided as gift cards subjected to DHCS approval.

Based on claims data, staff identified poorly controlled diabetic CCN Medi-Cal members as follows:

- Total diabetic members: 12,200
    - Known poorly controlled (HbA1c > 9%): 985 (almost 9% of total diabetics)
        - Potentially poorly controlled: 564
    - Adequate control (HbA1c <9%): 4,945
    - No HbA1c test (in past 12 months): 6,270

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To encourage all CCN Medi-Cal members with diabetes to regularly monitor their blood sugar levels, staff recommends providing $25 non-monetary health rewards (e.g., gift cards) for those who complete their HbA1c test on an annual basis (eligible once a calendar year).

For those members with poorly controlled HbA1c levels, staff recommends providing $50 health rewards for reducing HbA1c levels by full 1 percentage point, for example, from HbA1c 10 to 9. (eligible twice a year, totaling up to $100). For the 6,270 members who have not had HbA1c test, there is a possibility that 9% (564) of this population may be identified as poorly controlled based on the trends.

Lastly, staff proposes offering $25 health rewards for those members with adequately maintained HbA1c levels for one year (HbA1c less than 9%).

Staff assumes a predicted participation rate of 40%. The total estimated cost for implementing these Health Rewards Programs for a two-year period is $491,900.

Description	**Amount**
$25 Non-monetary health rewards for HbA1c test completion	$122,000
$50 Health reward to improve HbA1c control by 1%	$62,000
$25 Health reward to maintain adequate control	$49,450
Annual Total	$233,450
Provider/member educational expenses	$25,000
Two-year pilot total	**$491,900**

Provider Incentives

For providers, staff plans to promote the existing Board-approved Pay for Value (P4V) CCN Program. The program was approved by the Board of Directors on February 6, 2020 and is currently approved through calendar year 2021 and encourages CCN providers to provide timely preventive health care services, deliver excellent outcomes, and achieve and maintain high levels of member satisfaction. In addition to the P4V program, in order to have successful provider buy-ins, staff proposes providing additional incentives for a year participation in the DM program. The additional incentives would not require provider contract amendments.

Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

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To be eligible for these additional rewards:

- Year 1: $150
    - PCP to schedule appointment and see member
    - Order HbA1c lab test
    - PCP to have an consultation with CalOptima pharmacist to review the medication review tool list along with pharmacy recommendations and consider making changes
        - CalOptima Pharmacy documentation of PCP participation
- Year 2: $200
    - If a PCP manages to lower an eligible member's HbA1c <= 8%, the PCP would be eligible to receive an additional $200 (one time per member per year).

Staff assumes a predicted participation rate of 40%. The total estimated cost for implementing provider incentives for a two-year period is $217,000.

Description	**Amount**
Year 1 Provider Incentives	$93,000
Year 2 Provider Incentives	$124,000
Two-year pilot total	**$217,000**

Fresh Produce Delivery Program

Along with physician activity, nutrition and attention to food insecurity are important parts of a healthy lifestyle when managing diabetes. Following a healthy meal plan can help members keep their blood sugar in their target range. However, fresh produce is not a covered Medi-Cal benefit. Therefore, staff proposes including a fresh produce delivery into this new multidisciplinary DM program to support an appropriate meal plan, based on a recommended American Diabetes Association diet, for our CCN Medi-Cal poorly controlled diabetic members.

In order to qualify for food delivery, members must meet the following requirements:

- Have an appointment with their PCP and have HbA1c lab test
- Lab results indicates that HbA1C > 9
- Have consultation with CalOptima Pharmacist
- Have consultation with CalOptima Registered Dietician

Qualified members with poorly controlled diabetes will receive fresh produce delivered to their homes twice per month following engagement in the program.

Staff assumes a predicted participation rate of 40%. The total estimated annual cost for implementing the fresh produce delivery program is $729,120, or $1,458,240 for the two-year period.

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Evaluation Goals
During the two-year pilot intervention, staff proposes to review members' progress on a semiannual basis and study the following annually:

Hospitalization rates	Member satisfaction (survey)
% reduction in members with HbA1c > 9	Provider satisfaction (survey)
Rate of medication adherence	Review pharmaceutical cost savings
Participation rate	ED visits/rates

To measure member and provider satisfaction, staff proposes conducting a before-and-after survey. The estimated mailing cost for conducting a before-and-after survey is $4,000.

IGT Status
CalOptima staff recommends the Board of Directors' authorization for up to $3.6 million through allocation of IGT 10 funds. It is anticipated that CalOptima's share of IGT 10 funds will be approximately $65.6 million ($42.9 million in spring 2021 and $22.7 million in fall 2021). Due to timing issues, staff requests the Board of Directors Quality Assurance Committee to recommend that the Board of Directors authorize the CEO to allocate $3,535,450 for this new DM program prior to CalOptima's receipt of the IGT 10 funds from the Department of Health Care Services, if not yet received.

As of May 6, 2021, the CalOptima Board of Directors has already allocated $36,421,145 of IGT 10 funds, leaving approximately $29,178,885 million unallocated. Of this unallocated amount, staff is requesting allocation of $3,535,450. More information on IGT 10 is attached.

Fiscal Impact
The recommended action to allocate up to $3.6 million in IGT 10 funds to fund the DM Program for CCN Medi-Cal members has no net fiscal impact to future CalOptima operating budgets. Staff anticipates any cash expended for the program will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted, one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendations
The recommended actions will support CalOptima's efforts to assist members with poorly controlled diabetes achieve healthier lifestyles and avoid complications.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Cost Comparison Diabetic vs. Non-Diabetic Members
2. Intergovernmental Transfers (IGT) 10 Summary
3. PowerPoint Presentation

/s/ Richard Sanchez *05/12/2021*
Authorized Signature **Date**

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Cost Comparison - Diabetic vs. Non-Diabetic Members

From: 2019-07 Through: 2020-06 For CCN - MC

	Distinct Members		Total Amount Paid		Avg Cost Per Member		% of Population Utilizing Services	
	Diabetic	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**
Grand Total	12,200	69,426	$247,898,668	$370,585,854	$20,320	$5,338	100.0%	100.0%
LTC	340	298	$28,569,377	$25,269,785	$84,028	$84,798	2.8%	0.4%
Inpatient	2,087	6,082	$73,209,011	$97,481,773	$35,079	$16,028	17.1%	8.8%
Hospice	144	273	$1,875,977	$2,465,905	$13,028	$9,033	1.2%	0.4%
Outpatient	7,036	28,775	$41,171,497	$51,745,653	$5,852	$1,798	57.7%	41.4%
Pharmacy	11,821	55,186	$56,199,373	$88,097,684	$4,754	$1,596	96.9%	79.5%
Professional	11,609	64,740	$46,873,433	$105,525,053	$4,038	$1,630	95.2%	93.3%

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Diabetic with HbA1c > 9

*Latest from last 12 months

Total	12,200
HbA1c > 9	985
HbA1c <= 9	4,945
No HbA1c Result	6,270

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Intergovernmental Transfers (IGT) 10 Summary

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities, which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in ten Voluntary Rate Range IGT transactions. Funds from IGTs 1 through 9 have been received. IGT 10 funds are expected to be received from DHCS in two installments in 2021.

For the DHCS approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs. It is estimated that CalOptima's share of IGT 10 funds will be approximately $65.6 million ($42.9 million in Spring 2021 and $22.7 million in Fall 2021). As of May 6, 2021, the CalOptima Board of Directors has allocated $36.4 million of IGT 10 funds, leaving estimated $29.2 million unallocated as follows:

Date	Initiative	Amount
	Total Anticipated (est.)	**$65.6 million**
1/7/2021	Orange County COVID-19 Nursing Home Prevention Program Grant Extension and Expansion	$1.2 million
1/7/2021	COVID-19 Vaccination Member Incentive Program for Calendar Year 2021- Member Incentive	$35.0 million
3/4/2021	COVID-19 Vaccination Member Incentive Program for Calendar Year 2021- Staffing	$221,145
	Total Allocated	**$36,421,145**
	Unallocated (est.)	**$29,178,885**
	Total Allocation Recommendation Requested at the May 2021 Quality Assurance Committee Meeting	**$3,535,450**

It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS in the year received and thus will have an impact on medical loss ratio (MLR) and administrative loss ratio (ALR), in that year. Similarly, amounts will have an impact on MLR and ALR in the year the funds are spent. To the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's ALR.

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A Multidisciplinary Approach to Improving Care in Poorly Controlled Diabetics

Board of Directors Quality Assurance Committee
May 19, 2021

Emily Fonda, M.D., MMM
Chief Medical Officer

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Diabetes: Background/National Cost

- Seventh leading cause of death in California[1]
- Total annual cost of diabetes: $327 billion[2]
  - $1 out of every $4 in US health care costs is spent on caring for people with diabetes
  - $237 billion is spent each year on direct medical costs and another $90 billion on reduced productivity
  - The total economic cost of diabetes rose 60% from 2007 to 2017
  - 48% to 64% of lifetime medical costs for diabetics are due to complications, such as heart disease and stroke

[1] https://www.cdc.gov/nchs/pressroom/states/california/california.htm

[2] https://www.cdc.gov/chronicdisease/programs-impact/pop/diabetes.htm

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Diabetes: CalOptima's Cost

- Total annual cost of Medi-Cal CalOptima Community Network (CCN) diabetes is more than $247 million

	Distinct Members		Total Amount Paid	
	Diabetic	Non-Diabetic	Diabetic	Non-Diabetic
Grand Total	12,200	69,426	$247,898,668	$370,585,854
LTC	340	298	$28,569,377	$25,269,785
Inpatient	2,087	6,082	$73,209,011	$97,481,773
Hospice	144	273	$1,875,977	$2,465,905
Outpatient	7,036	28,775	$41,171,497	$51,745,653
Pharmacy	11,821	55,186	$56,199,373	$88,097,684
Professional	11,609	64,740	$46,873,433	$105,525,053

  - Average cost per member comparison:
    - Diabetic member: $20,320
    - Non-diabetic member: $5,338
    - Diabetic cost is almost four times higher than non-diabetic cost

Based on July 2019 – June 2020 claims/encounter data

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How Do We Improve Care in CalOptima's Diabetic Members?

- Implement a multidisciplinary approach to care for Medi-Cal CCN members with diabetes:
  - Poorly controlled diabetics (HbA1C > 9 %)
- Assist primary care providers' (PCPs') efforts by offering:
  - Pharmacist/Health Coach/Registered Dietician individual support and interventions
  - Member health rewards
  - Provider incentives
  - Fresh produce delivery program
- Goals:
  - Reduce HbA1c levels to <= 8% to avoid complications
  - Reduce utilization and medication costs
  - Improve member and provider satisfaction
  - Optimize medication management by smoothing the Medi-Cal pharmacy (Medi-Cal Rx) transition
- Two-year pilot cost: $3.6 million (estimated)

Reference from "ADA"

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Pharmacist Intervention

- Beyond the traditional pharmacist's role
- Monitoring of a member's medication list:
  - Individual member outreach
  - Avoid readmission from medication noncompliance
  - Prevent drug duplication
  - Notate drug interactions
  - Highlight medication review tools
  - Recommend adherence to medications, including insulin
  - Promote timely refills
- Collaboration with the multidisciplinary team

Health Coach/Registered Dietician Intervention

- Provide CCN-specific assessment and care planning
- Conduct motivational interviewing
- Participate in Interdisciplinary Care Team meetings, as applicable
- Create member education materials
- Identify other acute needs and connect members to case management, as appropriate
- Refer members to other community resources based on needs

Member Health Rewards

- Support member engagement and compliance
- Recommend providing non-monetary health rewards for all diabetics based on goals:
  - 12,200 members identified with diabetes
    - $25 for completing their HbA1c test on an annual basis
  - 1,549 members with poorly controlled HbA1c level (>9%)
    - 985 known members, 564 potential members
    - $50 for reducing HbA1c level by 1%
      - Eligible twice a year (up to $100)
  - Members with adequately maintained HbA1c level for one year (<=9%)
    - $25 for maintaining their HbA1c level at less than 9% for one year

Provider Incentives

- Motivate providers to deliver excellent outcomes
- Promote the existing Board-approved Pay for Value (P4V) CCN Program
- Recommend incentives as follows:
  - For known or potentially poorly controlled diabetics
  - Year 1: $150 per member for participating in the program
  - Year 2: $200 per member if a PCP manages to lower an eligible member's HbA1c level <= 8%

Fresh Produce Delivery Program

- Diabetic populations are affected by Social Determinants of Health, such as food insecurity
- Food insecurity is “a lack of consistent access to enough food for an active, healthy life and it’s an issue that touches people of all ages with all types of diabetes[1]”
- According to American Diabetes Association, diabetics with food insecurity have a higher risk of developing complications
- Recommend providing fresh produce to members with poorly controlled diabetes
  - Delivered to their homes twice per month
  - Following engagement in the program
- Estimated budget:
  - Farm Fresh To You Mixed Fruit and Veggie Boxes (“More Box” is $49.00 per box)
  - For HbA1c > 9% diabetic members (1,549)
  - $1,458,240 (based on 40% predicted participation rate)

[1] https://www.diabetes.org/healthy-living/recipes-nutrition/food-insecurity-diabetes

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Next Steps

- Obtain the Board's approval to allocate IGT 10 funds
- Collaborate with stakeholder/community partners
- Implement the program
- Track and trend to identify opportunities for improvement
- Report outcomes to the Board
- Outcome measures:

Hospitalization rates	Member satisfaction (before/after survey)
ED visits/rates	Provider satisfaction (before/after survey)
Rate of med adherence	Review pharmaceutical cost savings
% reduction in members with HbA1c > 9	Participation rate

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

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Pay for Value (P4V) Program Introduction

Quality Assurance Committee
May 19, 2021

Kelly Rex-Kimmet, MSW, MBA
Director, Quality Analytics

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MY2021 Pay for Value (P4V) Overview

- CalOptima has implemented a comprehensive Health Network P4V Performance Program to recognize outstanding performance and support ongoing improvement that will strengthen CalOptima's mission of providing access to quality health care.
- P4V is designed to provide quality-related incentives for all participating health networks (HNs) for the MediCal and OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) programs.
  - CalOptima Community Network (CCN) is treated like all other health networks

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MY 2020 and MY 2021 HNQR Methodology for Medi-Cal

- National Committee for Quality Assurance (NCQA) HNQR methodology adopted for MY 2020 and MY2021
  - Each HN is assessed a quality score between 1 and 5.
  - Score is based on HN performance on the list of DHCS Minimum Performance Level (MPL) Medicaid measures on a 1–5 scale (5 is the highest).
  - HEDIS measures are weighted 1.0.
  - Member Experience measures: CAHPS are weighted 1.5.
  - Measures having small denominator (HEDIS <30; CAHPS <100) will be assigned “NA” and the measure will not be used in the calculation.

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MY 2020 and MY2021 P4V Scoring and Payment

Health Network Quality Rating	Percent of $5 PMPM Payment Earned
≥ 4.5	100%
≥ 4.0	80%
≥ 3.5	60%
≥ 3.0	40%
≥ 2.5	20%
< 2.5	0%

PMPM = Per Member Per Month

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Medi-Cal P4V Measures for MY 2021

- Medi-Cal P4V measures utilize the HEDIS measures required by DHCS to meet a minimum performance level (MPL)
- 18 P4V Measures for Medi-Cal including:
  - 3 Children's Health (HEDIS)
  - 5 Women's Health (HEDIS)
  - 2 Acute and Chronic Disease Management (HEDIS)
  - 8 Member Satisfaction (CAHPS)

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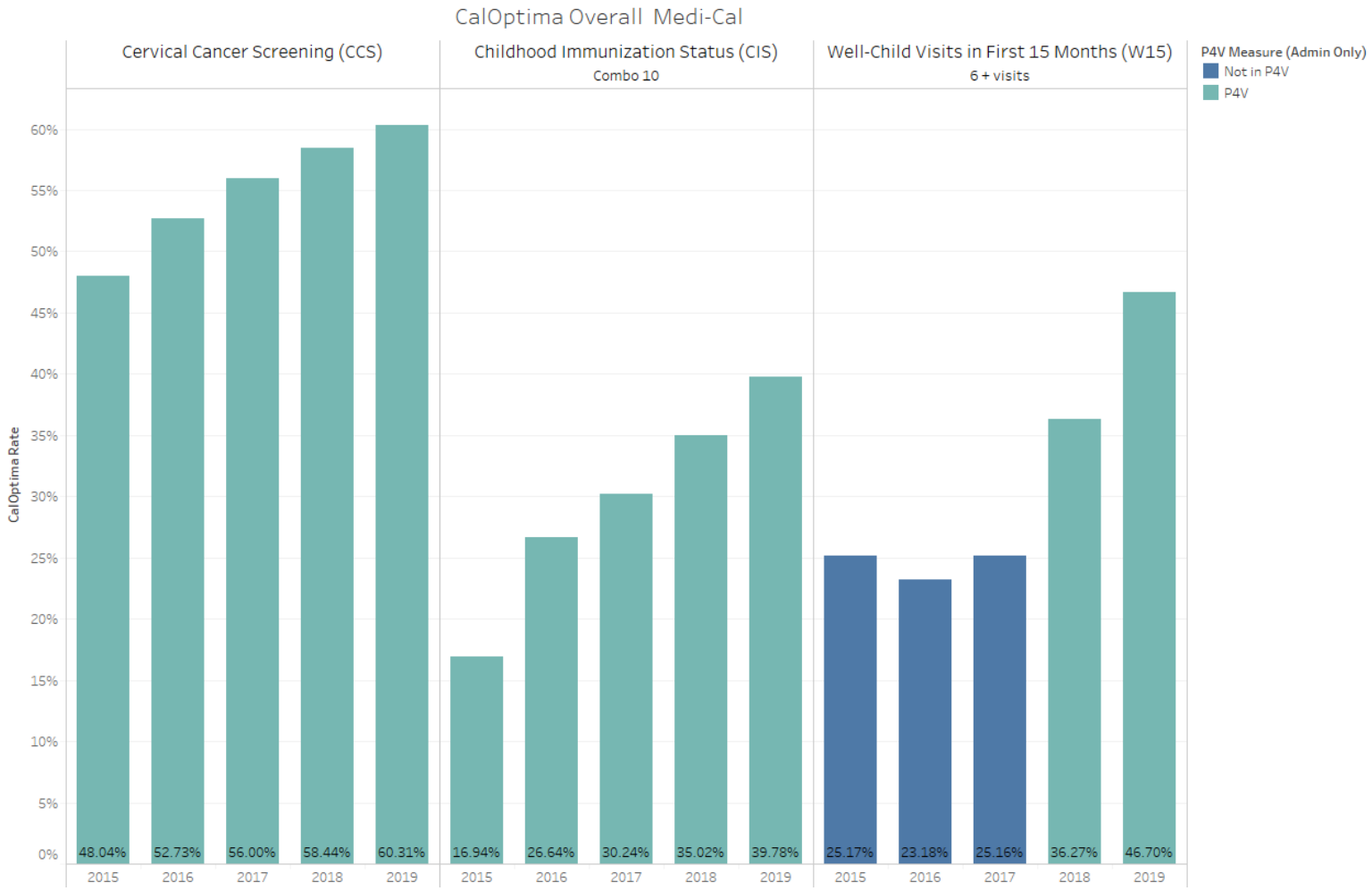
Measure Improvements with P4V



CCS was included as a P4V measure in 2010; CIS Combo 10 was included as a P4V measure in 2015

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OneCare Connect (OCC) P4V Measures for MY2021

- Clinical Measures (HEDIS)
  - Breast Cancer Screening (BCS)
  - Colorectal Cancer Screening (COL)
  - Comprehensive Diabetes Care HbA1c Poor Control (CDC)
  - Plan All-Cause Readmissions 65+ (PCR)
  - Medication Adherence for Diabetics (MAD)
- Member Satisfaction Measures (CAHPS)
  - Annual Flu Vaccine
  - Getting Appointments and Care Quickly
  - Getting Care Quickly
  - Rating of Healthcare Quality

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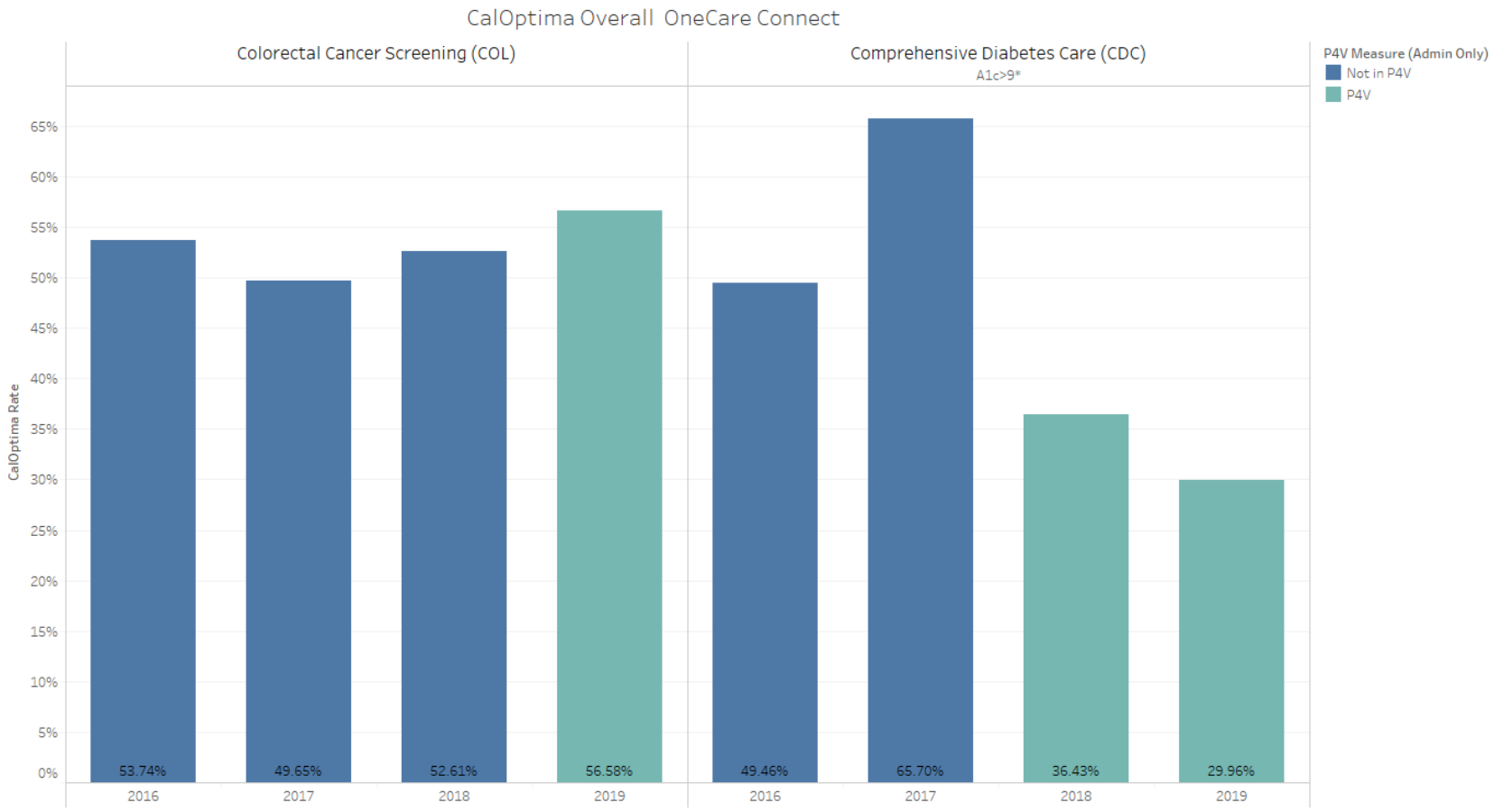
OCC P4V 2016–2019: COL and CDC



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Next Steps

- Restructure OCC measure set, payment and scoring methodology to align the program with the sunset of the OCC program.
- Include at least one health equity measure for both P4V programs.
- Present proposed revisions to P4V programs at future QAC meeting.

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Board of Directors' Quality Assurance Committee Meeting
May 19, 2021

PACE Member Advisory Committee (PMAC) Update

Committee Overview
The PACE Member Advisory Committee meets quarterly to share information and engage PACE participants in a discussion on recommendations to inform CalOptima PACE leadership on the PACE care delivery system. The committee is comprised of primarily PACE participants.

PMAC Meeting March 17, 2021

Updates from the Director
Director Elizabeth Lee thanked PMAC members for joining the third virtual committee meeting. Members were updated on the current status of the program. The PACE Center continues to be closed to visitors but remains open Monday through Friday for clinic and skilled rehabilitation appointments. Wellness kits are delivered to participant residences 1–2 times per month. Elizabeth shared her departure date from PACE and introduced Monica Macias as the Interim PACE Director.

COVID-19 Updates
Eva Elser, QI Manager provided updates related to COVID-19 numbers and status. She shared that Orange County moved to the red tier, which is less restrictive allowing more indoor activities at a reduced capacity. Even though we have changed tiers, restrictions continue to be in place. Eva also shared that as a PACE program, we continue to wait for the county's direction on when to fully re-open. In addition, PACE currently has 308 participants who have been fully vaccinated.

PMAC Member Forum

- A participant shared her wish that COVID-19 will end soon so that she can come back to the day center and resume her regular routine. She is very happy with the care she receives.
- Another participant shared his hope to get back to the life he had before COVID-19.
- A participant expressed having some issues getting his call answered at the front desk reception area. It appears that phone just continues to ring.
- Elizabeth Lee thanked our PMAC participants for sharing and will address the issue with the front desk. This topic will be added to our next PMAC meeting agenda.

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Board of Directors' Quality Assurance Committee Meeting
May 19, 2021

Quality Improvement Committee First Quarter 2021 Report

Summary

- Quality Improvement Committee (QIC) met on January 12, 2021, February 16, 2021, and March 13, 2021.
- The following subcommittees reported to QIC in Quarter 1 (Q1):
  - Whole-Child Model Clinical Advisory Committee (WCM CAC)
  - Utilization Management Committee (UMC)
  - Credentialing and Peer Review Committee (CPRC)
  - Member Experience Committee (MEMX)
  - Grievance & Appeals Resolution Services Committee (GARS)
- Accepted and filed the following programs:
  - 2020 Quality Improvement Program Evaluation
  - 2021 Quality Improvement Program and Work Plan
  - 2020 Utilization Management Program Evaluation
  - 2021 Utilization Management Program
- Accepted and filed minutes from the following committees and subcommittees:
  - WCM CAC meeting minutes: August 18, 2020, and September 22, 2020, Ad Hoc
  - UMC meeting minutes: November 19, 2020
  - BMSC meeting minutes: July 29, 2020, August 26, 2020, and September 30, 2020
  - MEMX meeting minutes: December 10, 2020, and February 9, 2021
  - GARS meeting minutes: December 2, 2020
  - 2020 Quality Improvement (QI) Work Plan Q4

QIC Quarter 1 Highlights

- **Quality Program Highlights**
  - 2020 Quality Improvement Evaluation and 2021 Quality Improvement Program and Work Plan were presented and approved at January QIC. These documents were presented and approved at the February QAC.
  - 2020 Utilization Management Evaluation and 2021 Utilization Management Program were presented and approved at February QIC. These documents were presented and approved at the February QAC.
  - **CMO Update** — Dr. Fonda provided CalOptima updates to committee each month. She presented the COVID-19 vaccine outreach strategy that detailed plans to partner with the OC Health Care Agency (HCA) and community partners in the distribution of vaccines as well as gift cards to members who receive the vaccine. Dr. Fonda shared that CalOptima aims to address member health disparities and Social Determinants of Health (SDoH). As

identified in the 2018 CalOptima Member Needs Assessments, the top three issues that need to be addressed are food insecurity, housing needs and transportation. Dr. Fonda provided updates on telehealth visits, as well as the Orange County nursing home COVID infection prevention program, and Homeless Health Initiative (which will provide quick service restaurant gift cards to promote vaccinations for individuals experiencing homelessness). In March, Dr. Fonda provided an update on the Equity Vaccine Pilot Program (EVPP) with Dr. Clayton Chau at HCA to increase vaccine confidence and the use of the Othena scheduling application. She also shared success with getting PACE members vaccinated and PACE events. Vaccine numbers continue to increase as eligibility increases. Dr. Jose Mayorga of UCI commented that UCI has vaccinated one dose to 65% of members in their network.

- **Medicare Attestation Program** was presented by Chris Punzalan. It is a new initiative for providers contracted with CalOptima Community Network (CCN) for OneCare Connect (OCC) members aiming to improve member engagement with providers with a minimum of one annual PCP visit to address chronic conditions and review preventive care. Providers will receive a payment of $150 per member, per PCP group, per year. Providers must attest via form with supporting medical records to the completion of a qualified face-to-face visit with their assigned members, and address conditions and screenings identified.
- **HEDIS MY 2020** was presented by Kelly Rex-Kimmet that MY 2020 rates and audits are in progress. After preliminary analysis for all lines of business, five Department of Health Care Services (DHCS) Minimum Performance Level (MPL) measures have been identified at risk, with some rates adversely impacted by the pandemic. It is unclear if DHCS will penalize plans who do not meet MPL.
- **Pay for Value (P4V) —** payments for 2019 performance have been completed and sent out. The 2020 P4V program implements new methodology and Health Network Quality Rating (HNQR). For health networks (HN) that receive a quality score between 1.0–5.0 (higher is better), P4V incentive payments will be earned based on HNQ4. HNs that do not achieve a minimum 2.5 HNQR will receive a corrective action plan. There were four measures removed from MY 2020 MCAS MPL list. The 2021 prospective rate reports will begin April 1, 2021.
- **OCC Quality Withhold Program** — CalOptima achieved 100% of OCC Quality Withhold dollars earned for MY 2019, due to exceptional circumstances, which is expected to be applied to MY 2020 per Centers for Medicare & Medicaid Services (CMS), if plans submit full audited HEDIS results for OCC.

- **UMC**
  - UM report was presented to QI committee by Mike Shook, which included data presented at the November 19, 2021 committee, such as Q3 2020 membership and operational performance as well as outcome measures. Operational performance for medical authorizations identified two HNs that fell below goal, as well as one HN not meeting turnaround time. A Corrective Action Plan (CAP) was issued, and the HNs will be monitored and reported next quarter.

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- Behavioral Health Integration presented Q3 2020 trends related to applied behavior analysis (ABA) services, with no unusual patterns or trends. OC/OCC outpatient services and medication management area is slightly higher. The Q3 2020 raw number utilization had a slight drop from previous months. BHI is monitoring this closely.

- **Behavioral Health Integration (BHI)**
  - Dr. Poon presented a report related to behavioral health provider participation in Interdisciplinary Care Teams (ICT). In 2020, the participation rate was at 32%, while in 2019, the rate was 42%. While the COVID-19 pandemic lowered participation rates in Q2 and Q3, staff found that many providers were not aware of the concept of BH provider participation in ICTs. As a follow up, there will be email messaging to BH providers to emphasize the importance of BH provider attendance, as well as an invitation and participation form to BH providers. Staff will start this process and analyze the data to determine impact.
  - Natalie Zavala presented BH workgroup measures, Follow-up Care for Children with Prescribed ADHD Medication (ADD) as well as Follow-up After Hospitalization for Mental Illness within 7 or 30 days after discharge (FUH). Both measures continue to be a challenge, and there is opportunity for more targeted interventions.
- **Population Health Management (PHM)**
  - Member Health Rewards RFP was released to help with member gift card distribution and member engagement strategy. New blood lead screening requirements from DHCS were communicated to the HNs, and updates for measure changes and focus for 2021 were shared. Improvement projects for MC, OC, OCC, along with the Quality Improvement Program Effectiveness (QIPE) and Plan Performance Monitoring and Evaluation (PPME) were presented, with goals meeting target.
  - **Post-Acute Infection Prevention Quality Incentive (PIPQI)** is currently on hold due to COVID-19. However, PIPQI nurses continue to monitor compliance with facilities via phone and outreach. Facilities are submitting their product purchase invoices and health acquired infection (HAI) scores. The average HAI score for Q3 2020 was 4.59%. UCI is providing additional support to nursing facilities through the Orange County Nursing Facility COVID-19 Prevention Training (OC NH COVID-19 Prevention Training Program). The primary objective during Q4 2020 and Q1 2021 is getting the staff and residents vaccinated.
- **GARS**
  - **MC Member Grievances** — Quality of Service (QOS) continues to be the highest grievance category. Monitoring complaints for appointment availability and telephone accessibility that have seen increases since previous quarter. MC Behavioral Health Grievances have increased slightly over Q3 for QOS mainly for lack of follow up, medication related, unhappy with overall service provided and treatment delays.
  - **OCC Member Grievances** saw a slight increase from previous quarter. The top category complaint was access and appointment availability. OCC Behavioral Health Grievances

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decreased from the beginning of 2020. Complaints were related to medication, as well as telephone accessibility.

- OC member and behavioral grievance volume remains low.

- **Whole-Child Model — Clinical Advisory Committee (WCM CAC)**
  - Dr. Nguyen presented a summary of WCM CAC meeting held on November 17, 2020. Pharmacy gave an update on the transition of Medi-Cal Rx to Magellan, which was postponed to April 1, 2021. The committee continues to discuss resolution of newborn Medi-Cal and California Children's Services (CCS) NICU eligibility issues, and conversations with the state are ongoing. There are new CCS numbered letters that are timely because it speaks to experimental and investigational services for WCM members.
- **Member Experience Subcommittee (MEMX)**
  - Marsha Choo presented OC and OCC Plan and HN CAHPS (Consumer Assessment of Healthcare Providers and Systems) results. OC CAHPS results for MY 2017–19 have generally gone up except for Coordination of Care and Getting Needed Care. OCC CAHPS have generally gone up with a dip in Getting Needed Care and Getting Care Quickly. OC and OCC Plan CAHPS have mostly increased or stayed the same. Access-related measures Getting Needed Care and Getting Care Quickly, and Care Coordination decreased from previous year and have the lowest scores. In 2021, CMS increased the importance of CAHPS measures by increasing the weight from double (2X) to quadruple weighting (4X), and to be 32% of the overall Star Rating. Plans to continue with initiatives in the QI Work Plan to improve member experience, as well as share results with HNs. HNs with low CAHPS and Health Network Rating below 2.5 were issued Plan-Do-Study-Act (PDSA) forms. CalOptima continues to work with HNs on their PDSAs to improve member experience.
  - DHCS Medical Audit CAP has closed. The 2020 Timely Access survey began fielding in November 2020, and CalOptima fielded an in-office wait time survey in January 2021 to members who recently had a visit. CalOptima received DHCS approval for member texting campaign for COVID-19 related information. The Telephone Consumer Protection Act (TCPA) project continues to obtain member consents. Virtual care strategies are in process, including 24/7 e-visits RFP which has selected a vendor (Teledoc).
- **Credentialing and Peer Review Committee (CPRC)**
  - Laura Guest presented an update on CPRC. Staff continues to monitor initial and recredentialing files for the plan. Timeliness of recredentialing monitoring indicate we are 98% timely (recredentialing files within 36 months), plan wide. Monitoring of exclusion and preclusion activity was reported to the committee. PQI team implemented a new process as a result of the 2020 DHCS medical audit. The new process has shifted the medical director response to Quality of Care grievances, prior to becoming a Potential Quality Issue. This is resulting in a significant decrease in PQI cases that are being opened. Facility Site Reviews continue to be on hold due to Executive Order APL 20-011 in response to COVID-19. Staff will resume on-site visits once fully vaccinated. Nursing facility on-site visits were also put on hold, due to APL 20-004. Virtual audits were

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performed since August. Nursing facilities incident reports had dropped significantly in 2020 due to COVID-19.

Attachments

2020 Quality Improvement Work Plan Q4

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2020 QI Work Plan Element Description	Goals	Planned Activities	**Staff Responsible**	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT						
2020 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2020 QI Program and Workplan by March 2020	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Betsy Ha	Approved: QIC 1/14/20; QAC 2/19/20; BOD 3/5/20		
2019 QI Program Evaluation	Complete Evaluation 2019 QI Program by January 2020	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Betsy Ha	Approved: QIC 1/14/20; QAC 2/19/20; BOD 3/5/20		
2020 UM Program	Obtain Board Approval of 2020 UM Program by June 2020	UM Program will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Mike Shook	2020 UM Program approved: QIC 4/21/20		
2019 UM Program Evaluation	Complete Evaluation of 2019 UM Program by March 2020	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Mike Shook	2019 UM Evaluation approved: QIC 4/21/20		
Population Health Management Strategy	Review and implement strategy in 2020	Review and adopt on an annual basis	Pshyra Jones	Population Health Management Strategy was written in May of 2019, and presented at QIC in August of 2019. The annual review of the strategy is in progress, and will be presented at QIC 8/11/2020.		
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee, as well as Nursing Facility and CBAS quality oversight annual results.	Miles Masastugu, MD/ Esther Okajima/L. Guest	CPRC update on Q4 activity will be presented to QIC in March 2021. The Credentialing activity, on-going monitoring and timeliness of recredentialing for the Plan will be presented, as well PQI data. There was a shift in process for Quality of Care grievances and PQI which took place during Q4, in response to 2020 DHCS CAP. The result of the change is a significant decrease in volume for PQI's. COVID-19 continues to impact the oversight for nursing facilities and CBAS. In Q2 and Q3 of 2020, the staff began a virtual process for oversight of the nursing facilities for CHDP reviews completed in Q4 2019 and Q1 2020. FSR/PARS returned to the field in Q3 even though DHCS APL 20-011 remains in effect. However at the end of December, due to COVID-19 surge, all on-site activity was suspended.	In 2021, CPRC will continue to report: 1. Initial and recredentialing activity and timeliness 2. Ongoing monitoring 3. PQI trending for Q4 2020 4. FSR/PARS progress and results	
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Mike Shook	UMC presented 2020 2nd Quarter and Annual Trends (Aug 27, 2020). QIC accepted and filed UMC 8/27/20 meeting minutes. Update to QIC included: Member Summary ending June 2020, 2Q 2020 Operational Performace, 2Q 2020 Utilization Outcomes, WCM -NICU & PICU July 2019-June 2020, In-patient and DME July 2019-June 2020 Update, WCM Members Inpatient and ED Metrics Medical Rollup, Over/Under Utlization Monitoring highlights from 6.15.20 Stakeholder meeting, BMSC, Pharmacy, BHI.	In 2021, UMC is scheduled to present to QIC on January 12, 2021, and will continue to provider quarterly updates on utilization and outcome measures impacting member care.	
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Kelly Rex-Kimmet/Marsha Choo	In Q4, MEMX Committee has reviewed/discussed the following in Quarter 4 (meetings on 10/8/20 and 12/10/20): • Executive Committee recommendation to request that AOC/Compliance issue CAPs to AMVI CARE and Family Choice. AOC/Compliance approved that PDSA to be issued by QA to 4 HNs with low performing CAHPS scores. • Reviewed Behavioral Health 2020 Member Experience Survey Results • Updates on the workplan/projects including Member Portal and Outreach Update, Virutal Care Strategy (i.e. Member Texting campaigns, PACE Telehealth Solution (VSEE), eConsult, BH Virutal Visits, 24/7 After Hours Urgent Care). • Discussion on PHM Preventive Care Services including Outreach Call Campaign and Telephone Consumer Protection Act (TCPA) • DHCS Medical Audit CAP Updates including Timely Access Provider Letters and GARS PQI Workflow • COVID Impact/Challenges • Review and approve 2021 Member Experience Workplan	In 2021, MEMX will continue to assess annual CAHP results as well as review member complaints to identify member dissatisfaction in areas of Access, Appointment Availability, Care Coordination, and Customer Services.	

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Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	T.T. Nguyen, MD	Update to QIC on 10/13/20 was as follows: WCM had a regular meeting on 8/18/20 and an AdHoc meeting on 9/22/20 to address some confusion on NICU Transfer of babies while under mom's CIN for the first 30 days. While CalOptima does not have control of the Medi-Cal eligibility of newborns, they are in discussion with state about challenging scenarios. Found no inappropriate denials in the four areas of improvement identified by USCF's WCM CCS survey: Transportation, Prior-Authorization, Non-Medical transportation and Access to care and Coordination in Case Management, nonetheless, CalOptima is working on strategies to enhance services in these areas. Continue collaboration with CHOC and the State on formulary for medications used by CCS specialists. CCS 04-0520 NL was shared with the Committee. WCM CAC Charter was updated and approved.	In 2021, WCM CAC is scheduled to give update to QIC on January 12, 2021 and will continue to meet quarterly to review WCM CAC statistics related to utilization, care coordination, member services, and GARS, to improve the quality of care provided to CCS members..	
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of resolution of Grievances and Appeals for members and providers in a timely manner.		Identify grievance trends by provider and refer to Provider Relations for education or other recommendations.	Ana Aranda	GARS presented to QIC on 12/08/20 their report of Q3 2020 Member Appeals, Member Grievances, Provider Appeals; Grievances by Category, BH and lines of business; Trends with 2Q/3Q comparison . QIC accepted and filed GARS 08/26/20 Meeting Minutes.	In 2021, GARS committee will continue to: 1) Monitor the availability of providers to ensure adequate access to care. 2) Educate members on how to contact CalOptima and get care they need 3) Trend grievance data with the Quality Improvement department and shared with Provider Relations leadership for further action.	
PACE QIC - Quarterly review and update of PACE QIC activities		The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC, and summarized quarterly at QIC	Miles Masatsugu, MD	PACE took the 7/21/2020 and 8/25/2020 PACE Minutes to QIC to receive and file.	In 2021, PACE will reporting directly to QAC, and updates will be brought directly to QAC.	
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2020	Monitor and report to QIC	Kelly Rex-Kimmet/ Sandeep Mital	Consistent with the guidance first provided on April 1, 2019, affected MMPs will receive the full quality withhold payment from CMS and the state for CY 2020, provided that the MMP fully reports all applicable quality withhold measures	Due to the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), CalOptima was not required to report Healthcare Effectiveness Data and Information Set (HEDIS) measures covering the CY 2019 measurement year. CalOptima automatically received a "met" designation for these measures in the quality withhold analysis. Overall we ended up with "having met" 7 of the 8 measures (CBP being suspended) and CalOptima received 100% of the Quality Withhold dollars for MY2019. We will continue to monitor our performance across all of the OCC Quality Withhold measures for CY2021.	
Quality Program updates (Health Network Quality Rating, MCAS, P4V)	Achieve 50th percentile on all MCAS measures in 2020	**Varies per measure**. Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Kelly Rex-Kimmet/ Paul Jiang	HEDIS reporting for MY2020 is underway. Preliminary results for five DHCS MCAS measures are identified as potentially at risk for not achieving the minimum performance level (50th percentile based on NCQA national Medicaid benchmarks). The five at risk measures are: 1. Breast Cancer Screening 2. A1C Control 3. Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic RX 4. Metabolic Monitoring for Children and Adolescents on Antipsychotics 5. Prenatal Care	Continue to monitor MY2020 results on these measures as HEDIS production moves forward. Some measures are hybrid and may benefit from chart review findings. There is also some claims lag which will be added before final results are generated and reported.	

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Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIPs:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County; 2) Improving well-care visits for children in the 15 months of life (W15) **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% **OCC QIP:** Improving Status Use (SPD) **OCC PIP:** Member with ICP with documented discussions of care goals - Concluded 4/2020. **PPME (OC):** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC):** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents	Helen Syn/ Mimi Cheung/Sloane Petrillo/ Cathy Osborn	**PPME (OC):** HRA outreach completion: Annual: OCT-100%; NOV-100%; DEC-100%; Initial: OCT-100%; NOV-100%; DEC: In progress; OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% **QIPE (OCC):** HRA outreach completion: Annual: OCT-99%, NOV-100%, DEC-100%; Initial: OCT 100%, NOV-100%, DEC-100% ICP 90-day completion Q4 83%; HN MOC oversight: Annual: OCT-96.3%, NOV-97%, DEC-98%; Initial: OCT-93.2%, NOV-94.7%, DEC-95.7% OCC QIP: Improving Statins Use for Patients with Diabetes **MC PIP:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County 2) Improving well-care visits for children in the 15 months of life (W15) **Medi-Cal PDSA:** Improve Cervical Cancer Screening for Medi-Cal members **COVID-19 PIP:** COVID-19 activities	In 2021, Continue with implementing all improvement projects: **PPME (OC):** Continue outreach timely using existing call list **QIPE (OCC):** Continue current outreach strategy using existing call list, work with individual networks to support process improvement and updated training **MC PIPs -** (Both submissions for Module 1 due: March, 2021) 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County 2) Improving well-care visits for children in the 15 months of life (W15) **Medi-Cal PDSA:** Improve Cervical Cancer Screening for Medi-Cal members. Revise PDSA and submit February 2021. **OCC QIP** – Improving Statins Use for Patients with Diabetes - implementation in process **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% - implementation in process **COVID-19 PIP:** In process	
II. QUALITY OF CLINICAL CARE- ADULT WELLNESS						
Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	**HEDIS 2020 Goal:** MC 76.07%; OC 95.66%; OCC 93.70%	1) Continue Homeless Clinical Access Program (HCAP) program. This program started in late 2019 and will be available for members in 2020 2) Support health networks and provider offices with targeted outreach (i.e. CalOptima Day activities) 3) Implement the Health Equity PIP to improve access to acute/preventive care services for homeless members. 4) Track the number of homeless members accessing preventive care services at Homeless clinic events, and help transition members back to PCP	Pshyra Jones/ Jasmine Awadallah/ Helen Syn/ Mimi Cheung	HCAP program continued with barriers due to the COVID-19 pandemic. Counts were adjusted to include telehealth visits instated during the COVID-19 pandemic. **2020 November Prospective Rate (PR):** MC: 64.32% OC: 90.17% OCC: 88.33% Measure is performing lower than same time last year for all LOBs (MC, OC, OCC)	Due to the COVID-19 pandemic, the quality measures are impacted as members are not accessing timely health care services. Continue to monitor measure and adjust according to CDC recommendations. In 2021, this measure was incorporate as part of MC PIP to improve access to Acute and Preventive Care services to members experiencing homelessness in OC.	
Cervical Cancer Screening (CCS)	**HEDIS 2020 Goal:** MC 63.99%	1) Implement $25 member incentive program for completing a CCS. 2) Targeted outreach campaigns to promote cervical cancer screenings 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach (IVR, call campaigns, etc.)	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Targeted mailing to CCS population initially delayed due to COVID-19 pandemic was dropped Sep 15-18 to 66,362 female Medi-Cal members due for a cervical cancer screening 21-64 years old. the mailing included the CCS incentive form and COVID-19 general disclaimer. 2) # of CCS 2020 member incentives processed as of 1/28/21: 1130 3**) 2020 November Prospective Rate (PR):** MC: 55.40% Measure is performing lower than same time last year however, we have achieved the 50th percentile (MPL). Rate is negatively impacted by the COVID-19 pandemic. Many members are not going in for preventive care visits.	In 2021, initiatives associated with cancer screenings were combined with other screening measures.Ongoing outreach via HNs and coordination of joint quality initiatives, and CalOptima health rewards will continue.	
Colorectal Cancer Screening (COL)	**HEDIS 2020 Goal:** OC 73%; OCC 73%	1) Implement new member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy)	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) # of COL 2020 member incentives processed as of 1/28/21: 28 **2) No-Cost Colorectal Cancer Screening for People 50 and Older article** was printed in Aug Q3 OCC Newsletter, with information on the colorectal cancer screening incentive. 3**) 2020 November Prospective Rate (PR):** OC: 47.94% OCC: 52.98% Measure is performing lower than same time last year for both OC/OCC and is currently below the 50th percentile. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going in for preventive care visits	In 2021, initiatives associated with cancer screenings were combined with other screening measures.Ongoing outreach via HNs and coordination of joint quality initiatives, and CalOptima health rewards will continue.	

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Breast Cancer Screening (BCS)	**HEDIS 2020 Goal:** MC 63.98%; OC 76%; OCC 66%	1) Implement $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted outreach campaigns to promote breast cancer screenings. Track the number of calls listened to from targeted outreach campaigns (i.e. IVR or direct phone outreach) 5) Track the number of mammograms scheduled through targeted call campaigns.	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Targeted mailing to BCS population initially delayed due to COVID-19 pandemic was dropped Sep 18-21 to **17,862 female Medi-Cal members** due for a breast cancer screening 50-74 years old and to **1,362 OC/OCC members**. The mailing included the BCS incentive form and COVID-19 general disclaimer. 2) # of BCS Medi-Cal 2020 member incentives processed as of1/28/21: 661 # of BCS OC/OCC 2020 member incentives processed as of 1/28/21: 67 3) **2020 November Prospective Rate (PR):** MC:56.93%; L OC: 64.30%; L OCC: 59.28%: L Measure is performing lower than same time last year all LOBs.We have achieved the 50th percentile for MC (MPL) and below the 50th for OC and OCC populations. Measure is performing lower than same time last year. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going in for preventive care visits	In 2021, initiatives associated with cancer screenings were combined with other screening measures.Ongoing outreach via HNs and coordination of joint quality initiatives, and CalOptima health rewards will continue.	
III. QUALITY OF CLINICAL CARE - BEHAVIORAL HEALTH						
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS 2020 Goal:** 30-Days: OC: NA; OCC: 56% 7-Days: OC: NA; OCC: 18.20%	1) Visit top 3 hospitals in the first quarter. 2) Outreach to members post discharge to coordinate follow-up appointments. 3) Track the number of members that have a follow up appointment at discharge.	Edwin Poon	HEDIS Prospective Rates Q1: 30-Day 13.79%, 7-Day 6.90% Q2: 30-Day 32.73%, 7-Day 7.27% Q3: 30-Day 34.31%, 7-Day 10.78% Q4 (November): 30-Day 33.59%; 7-Day 10.16% 1) Continued outreach to members post-discharge to coordinate follow-up appointments. Experienced some difficulty reaching members post-discharge due to invalid phone numbers or no answer; BHI CM staff requesting most recent phone # at time of d/c. Some mbrs's are unaware of f/u appointment; reminder calls have helped. 2) Continued to complete the Psychiatric Transition Summary Form to confirm follow-up visits scheduled. Mbr's without an assigned BH provider are only given a list of providers by facility and directed to make own appointment. Noticed a better success rate if already linked to BH provider. 3) Continued weekly BHI clinical rounds meeting with MD, MCM's and PCC to discuss concurrent reviews and internal coordination interventions. 4) CalOptima continues to work with OC HCA regarding provider credentialing issues to ensure that County claims are being processed through CalOptima to capture all data. 5) FUH CORE report developed.	This measure continues to be a challenge in meeting the goal. In 2021: 1) Team will establish tracking method to identify members that did not attend follow-up appointment within 7 days of discharge. 2)TCM team will continue to conduct post discharge outreach.	
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 55.50%	1) Develop CORE report and track the numbers of members that filled Rx and their providers. 2) Coordination for members and providers through outreach and assistance with appointment setting and reminders. 2)Track the number of members that have a follow up appointment scheduled.	Edwin Poon	HEDIS Prospective Rates Q1: 47%; Q2: 42%; Q3: 34.68%; Q4 (November): 34.98% 1) Pharmacy related intervention continued (i.e., 30-day limit for the initial fill of ADHD medication to encourage members to follow up with the prescriber within 30 days continues). This intervention will discontinue due to the new pharmacy benefit carve out beginning 4/1/2021. 2) Created report to track/trend providers with high non-compliance. 3) Sent letters to high non-compliant providers in December.	This measure continues to be a challenge in meeting the goal. In 2021, team will: 1) Track/trend report of providers with high non-compliance. 2) Update and distribute member and provider educational materials for ADD.	

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IV. QUALITY OF CLINICAL CARE - CHRONIC CONDITIONS						
Statin Therapy for People with Cardiovascular Disease (SPC) and Statin Therapy for People with Diabetes (SPD)	**HEDIS 2020 Goal:** SPC - Therapy MC 77.57%; OC 79%; OCC 79% SPD - Therapy MC 70.19%; OC 74.13%; OCC 74.13%	1) Quarterly faxes to Provider offices with lists of members missing an appropriate statin (SPD: any potency statin; SPC: moderate to high potency statin) or members who fall below adherence thresholds (PDC< 80%). (Rx) 2) SPD targeted mailings to members based on list provided from Pharmacy Provider outreach. (PHM) 3) Conduct IVR outreach calls to targeted members. (PHM) 4) Track the number of new members starting appropriate statins medications from targeted outreach list. 5) Track the number of members who were adherent to appropriate statins using calculated PDC rates.	Nicki Ghazanfarpour, Pharm.D./ Helen Syn	**Pharmacy Management:** 1. Provider fax interventions completed by Pharmacy Dept for SPD: 527; Successful: 484; Failed: 43 (faxes); 6,595 (members) Total Mbr Count: MCAL: 5,807; OCC: 700; OC: 88 2. Provider fax interventions completed by Pharmacy Dept for SPC: 236; Successful: 230; Failed: 6 (faxes); 559 (members) Total Mbr Count: MCAL: 419; OCC: 3; OC: 2 These rates are based on November 2020 prospective rates **SPC:** MC: Adherence Total: 75.23% Therapy Total: 80.15% OC: Adherence Total: 76.92% Therapy Total: 70.91% OCC: Adherence Total: 78.93% Therapy Total: 80.43% **SPD:** MC: Adherence Total: 70.10% Therapy Total: 70.65% OC: Adherence Total: 78.82% Therapy Total: 73.91% OCC: Adherence Total: 78.39% Therapy Total: 79.48% Measure is performing better same time last year for MC, OC and OCC. **PHM:** 1) What is a Statin Mailing (By LOB, MC, OC & OCC) - Sent for mailing in Dec 2020, dropped on 1/8/21 OCC 278 (117 En, 128 Sp, 33 V); MC 1,961 (853En, 768 Sp, 340V)	Pharmacy: Continue quarterly faxes and tracking. SPC measure will not be on the 2021 Workplan. However, it will still be monitored and tracked via DUR requirements for MC. The SPD measure will be monitored as part of the OCC QIP improvement project.	
Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	**HEDIS 2020 Goal:** MC 77.93%; OC N/A; OCC N/A	1) Quarterly faxes to Provider offices for members missing persistent beta blocker use for a total of 6 months post-ASCVD date. 2) Track the number of members who are persistently using beta blockers 6 months post-ASCVD date.	Nicki Ghazanfarpour, Pharm.D.	Provider fax interventions completed by Pharmacy Dept for PBH: 126; Successful: 122; Failed: 4 (faxes); 232 (members) Total Mbr Count: MCAL: 225; OCC: 5; OC: 1	Pharmacy: Continue quarterly faxes and tracking. This measure will not be on the 2021 Workplan, however under-utilization will continue to be reported at P&T.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing	**HEDIS 2020 Goal:** MC: HbA1c Testing: 89.78% OC: HbA1c Testing: 93% OCC: HbA1c Testing: 93%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out	Pshyra Jones/ Helen Syn/ Mimi Cheung	**1)** Targeted mailing to CDC-Eye Exam and A1C population initially delayed due to COVID-19 pandemic was dropped Sep 10 to **20,532 Medi-Cal members with diabetes, 260 OC members with diabetes and 2,569 OCC members with diabetes**. The mailing included the A1C Test and Eye Exam incentive forms, an information flier on health coaching, Questions to Ask Your Doctor about Diabetes Medicine informational sheet and a COVID-19 general disclaimer. **CDC A1c Testing:** 2) # of A1c Testing - 2020 member incentives processed as **of 1/28/21: 888** **3) 2020 November Prospective Rate (PR) A1c Testing:** MC: 78.66%; L OC: 82.86%; L OCC: 82.69%; L Measure is performing lower than same time last year all LOBs. Rate is currently below the 50th percentile for all LOBs. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going in for routine health care visits.	In 2021, Diabetes initiatives will expand to include multi-disciplinary involvement to address A1C testing and control from member understanding, vision and medical provider engagement, pharmacy MTM management and lab and test data bridging.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS 2020 Goal:** MC: Eye Exam: 64.72% OC: Eye Exam: 78% OCC: Eye Exam: 78%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization	Pshyra Jones/ Helen Syn/ Mimi Cheung	**1)** Targeted mailing to CDC-Eye Exam and A1C population initially delayed due to COVID-19 pandemic was dropped Sep 10 to 20,532 Medi-Cal members with diabetes, 260 OC members with diabetes and 2,569 OCC members with diabetes. The mailing included the A1C Test and Eye Exam incentive forms, an information flier on health coaching, Questions to Ask Your Doctor about Diabetes Medicine informational sheet and a COVID-19 general disclaimer. **2)** The Diabetes Eye Exam incentive for 2021 was redesigned to include the question for attestation whether Eye Exam results have been share with PCP from vision specialist to promote communication between specialist and primary care providers. **CDC Eye Exam:** 3) # of Eye Exam - 2020 member incentives processed by **as of1/28/21: 747** **4) 2020 November Prospective Rate (PR) - Eye Exam:** MC: 48.97%; L OC: 56.51%; L OCC: 61.10%; L Measure is performing lower than same time last year all LOBs and currently below the 50th percentile. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going in for routine health care visits.	In 2021, Diabetes initiatives will expand to include multi-disciplinary involvement to address A1C testing and control from member understanding, vision and medical provider engagement, pharmacy MTM management and lab and test data bridging.	

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Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Good Control (<8.0%)	**HEDIS 2020 Goal:** MC: HbA1c Control (<8.0%): 60.77% OC: HbA1c Control (<8.0%): 71.97% OCC: HbA1c Control (<8.0%): 71.97%	1) Targeted outreach to members in "emerging risk" category (8.0-9.0) 2) Track the number of completed calls to emerging risk members identified	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Targeted mailing to CDC-Eye Exam and A1C population initially delayed due to COVID-19 pandemic was dropped Sep 10 to **20,532 Medi-Cal members with diabetes, 260 OC members with diabetes and 2,569 OCC members with diabetes**. The mailing included the A1C Test and Eye Exam incentive forms, an information flier on health coaching, Questions to Ask Your Doctor about Diabetes Medicine informational sheet and a COVID-19 general disclaimer. 2)Health coaches continue outreach to members who moved recently from <8% to >8% based on recent lab data to identify the cause for the increase and support efforts to reduce it with behavior modification and/or better medication adherence. **3) 2020 November Prospective Rate (PR): (A1c >8; Adequate Control - (PR):** MC: 38.18%; B OC: 50.48%; B OCC: 49.86%; B Measure is performing better across all LOBS than same time last year, however currently below the 50th percentile for all LOBs.	This measure is part of the OCC CCIP, and will be monitored under program oversight in 2021.	
V. QUALITY OF CLINICAL CARE - MATERNAL CHILD HEALTH						
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	**HEDIS 2020 Goal:** Prenatal MC 86.37% Postpartum MC 68.36%	1) Implement $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments	Ann Mino	79 postpartum incentives were approved for Q4. For calendar year 2020 there was 420 total approved postpartum incentives. 350 member Bright Steps postpartum assessments were completed in Q4. For 2020, there was over 1,200 postpartum assessments completed with members through the Bright Steps program.	In 2021: Continue to track Bright Steps completed postpartum assessments and postpartum incentives. Provider mailing to encourage notification of pregnant members to CalOptima/Bright Steps, to complete a postpartum visit with members and reminder of CalOptima postpartum incentive to Medi-Cal members. Continue to promote Bright Steps and the postpartum incentive through the CalOptima website, provider offices, and member mailings.	
VI. QUALITY OF CLINICAL CARE - PEDIATRIC /ADOLESCENT WELLNESS						
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 44.82%; OC 58.82%; OCC 50.39%	Educate providers and members on importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. Track number of educational events on depression screening and treatment.	Edwin Poon	HEDIS Prospective Rates Q1: MC 34.33%, OC 50.00%, OCC: 47.06% Q2: MC 38.78%, OC 46.15%, OCC 52.94% Q3: MC 43.27%, OC 71.43%, OCC 58.90% Q4 (November): MC 44.46%, OC 71.43%, OCC: 59.15% 1) Updated educational brochure on depression and the importance of treatment compliance. 2) Unable to distribute brochure to provider offices due to issues related to COVID-19 (i.e. temporary closure of provider offices; provider relation staff not conducting in-person visits; members attending appointments via telehealth). 3) No educational events occurred due to COVID-19.	In 2021: 1) Send providers digital version of the depression brochure to share and discuss with members during telehealth visit. 2) Educate members on depression and the importance of screening and follow up visits via member newsletters and other social media.	
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS 2020 Goal:** **MC: NA**	1) Develop way to load PHQ scores from Guiding Care to HEDIS software. Develop way to capture information (i.e., PHQ scores and scheduled f/u appts) from provider offices. 2) Educate providers on depression screening tools and importance of screening. 3) Educate providers and members on importance of follow up appointments via newsletters/ outreach. 4) Track depression screening scores completed by internal staff in GC. 5) Track number of educational events for depression screening and treatment, and increase # compared to last year.	Edwin Poon	HEDIS Prospective Rates Q1: N/A; Q2: N/A; Q3: N/A; Q4: N/A 1) Data collection continues to be a major challenge due to the lack of mechanisms for capturing provider data. Meetings to address barriers around the data collection (access to data and loading of data) are ongoing and continued throughout this quarter. Strategies are being explored on collaborating with Health Networks to collect provider data (i.e. start with one Health Network focusing on a group with a smaller population). 2) Developing a HEDIS reporting tip sheet to be made available as a resource to providers via company website. 3) Updated depression brochure to educate members and support providers. 4) Unable to distribute brochure to provider offices due to issues related to COVID-19 (i.e. temporary closure of provider offices; provider relation staff not conducting in-person visits; members attending appointments via telehealth). 4) No educational events occurred due to COVID-19.	In 2021: 1) Finalize and post to website HEDIS reporting tip sheet to educate providers on requirements. 2) Continue to educate providers and members on depression screening via newsletters and other social media. 3) Idenitify Health Network to begin collaboration of data collection.	

2020 QI Work Plan Element Description	Goals	Planned Activities	**Staff Responsible**	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Well-Care Visits in first 15 months of life (W15)	**HEDIS 2020 Goal:** MC 65.83%	1) Implement CalOptima Days targeting the W15 population only and track the number of members who engaged in W15 CalOptima Day events. 2) Implement **Member** incentive program for completing 1-3 and 4-6 well-child visits in the first 15 months of life and Track the number of W15 incentives paid out to members 3) Implement **Provider** incentive program for the W15 measures; members must complete 1-3 and 4-6 visits. Track the number of W15 incentives paid out to providers.	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) # of W15 1-3 and 4-6 visit 2020 member incentives processed as of1/28/21: 979 **2) 2020 November Prospective Rate (PR):** (W15 all 6 visits) MC: 27.57% Measure is performing lower than same time last year. Measure is currently below the 50th percentile. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going into their PCP's office timely.	Measure to retire for MY 2020-2021, this measure in 2021 will be called W30- Well-Care Visits in the First 30 Months of Life(W30)	
Adolescent Well-Care Visits (AWC)	**HEDIS 2020 Goal:** MC 60.34%	1) Implement $25 member incentive program for adolescents 12-17 years old and Track the number of AWC incentives paid out to members. 2) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents and Track the number of participants for targeted adolescent "back-to-school" events.	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) # of AWC 2020 member incentives processed of 1/28/21: 11,143 2**) 2020 November Prospective Rate (PR):** **MC:33.14%** Measure is performing lower than same time last year. Measure is currently below the 50th percentile. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going in for preventive care visits	Measure to retire for MY 2020-2021, this measure in 2021 will now be called WCV (Child and Adolescent Well-Care Visits)	
Children and Adolescents' Access to Primary Care Practitioners (CAP)	**HEDIS 2020 Goal:** **MC:** 12-24 Months 95.62% 25 months-6 years: 87.87% 7-11 years: 92.33% 12-19 years: 90.21%	1) Targeted outreach campaigns (IVR, call campaigns, etc.) 2) Also see other measure activities: [W15, AWC, IMA, CIS activities] 3) Track number of members who have an office visit after targeted outreach campaigns (i.e. IVR/Text messaging) 4) CAP measures is impacted by the following measures: W15, AWC, IMA, CIS and it's activities.	Pshyra Jones/ Helen Syn/ Mimi Cheung	**Child Access to Primary Care (CAP)** **2020 November Prospective Rate (PR) Medi-Cal:** 1. Age 12 - 24 months: 88.71% 2. Age 25 months - 6 years: 72.51% 3. Age 7- 11 years: 87.40% 4. Age 12 - 19 years: 85.37% Measure is performing lower than same time last year for all submeasures. Measure is performing lower than same time last year. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going into their PCP's office timely.	Measure to retire for MY 2020-2021, this measure is was retired by NCQA.	

2020 QI Work Plan Element Description	Goals	Planned Activities	**Staff Responsible**	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VII. QUALITY OF SERVICE						
Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Needed Care	Improve Member Experience for **Getting Needed Care** from 25th to 50th percentile AND Improve Member Experience for **Getting Care Quickly** from 25th to 50th percentile	1) Continue Provider Data Initiative 2) Update the CalOptima Website (Provider Directory) so that providers and services are easily accessible to members. 3) To have HN meet Time and Distance Standards 4) To have HN have at least 1 urgent care enter int he provider directory.	Marsha Choo	• Customer Service continues to conduct outbound calls to OC/OCC high risk members to inform members of additional care delivery options such as telehealth and the nurse advice line and practical advice on stay safe during the COVID-19 pandemic. • Member Portal new enhancement and features on 10/24/20 include member ability select Spanish and Vietnamese languages, personal representatives can now register members under 18, and implementation of provider data rules. • Network Operations working to review taxonomis for accuracy and a PM has been added to focus on the Cactus HN Credentialing Project. • CalOptima passed all monthly quality check metrics and reviewed the records that were flagged as questionable for a data quality. PDMS continues to monitor for data quality and accuracy. •mPulse interface file and opt-out file testing in progress. COVID-19/Flu member texting campaigns cancelled for early 2021. Requirement to obtain DHCS approval for campaigns would delay the project until after the flu season. PHM to finalize and submit texting policy to DHCS and plan for future campaigns. • PDSAs issued to 4 HNs with low performing CAHPS scores.	THis meausre was modified to add specificty to the planned activities for 2021. CAHPS will still be reported, but the measures related to improving CAHPS will be added to 2021 Workplan. • CS continues to conduct outbound calls to high risk members. •Portal Release 6 is tentatively scheduled for end of Jan 2021 to Mid February 2021. Primary feature launch is collecting member consent for telephone, text communications per TCPA and continuing development of automated face-to-face interpreter requests and approvals •Complete implementation for mPulse. Finalize and submit required information to DHCS. • CalOptima to review PDSAs, provide feedback and request resubmission if needed.	
Review of Timely Access - Increase appointment availability	Improve Timely Access for **Compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists** from current rate to 80%	1) Contract with Telehealth vendor and initiate telehealth services for identified specialties. **(Pace Telehealth, BH Virtual Care Visit, After-hour Telehealth)** 2) PCP Overcapacity Monitoring and closing of panels	Marsha Choo	• 24/7 After Hours Urgent Care RFI issued, RFP to be issued by end of December and select vendor by Feb 8, 2021. Goal is to submit COBAR for vendor approval at March Board mtg. • PACE inital pilot went live 10/19. Complete, full roll-out to ALL PACE Clinical Teams. •Bright Heart, continue contractating with and onboarding of BH and Specialist providers/groups that offer Virtual Care visits and services. • eConsult RFP has been issued and vendor selection is targeted for Q1 2021. • Timely access notification and education letters to non-compliant letters mailed in Q4. Many providers have contracted CalOptima to express their dissatisfaction with the provider letter, particularly during a national health emergency. • Annual Timely Access Survey began fielding in Q4, 2020 with a hydrid mystery shopper and direct call methodology to a sample of providers. • PDSAs issued to all HNs to improve Timely Access.	In 2021: •Finalize 24/7 evisit SOW and issue RFP •Refine eConsult program design. Continue finalizaing program details and workflows. Re-visit vendor proposals in light of finalized program. • Contracted survey vendor to provide CalOptima with preliminary compliance rates for Timely Access including provider level detail for outreach. • CalOptima to review PDSAs, provide feedback and request resubmission if needed.	
VIII. SAFETY OF CLINICAL CARE						
Plan All-Cause Readmissions (PCR)	**HEDIS 2020 Goal:** OC 8%; OCC 8%	1) Track # of Members receiving health coaching 2) Track # of member with a hospital admission versus unplanned readmission	Helen Syn/ Jocelyn Johnson	**2020 November Prospective Rate (PR)** MC: 8.28%; B OC: 9.09%; B OCC: 11.41%; L Measure is performing better than same time last year for MC and OC and lower for OCC. Achieved CMS 3-Star for OC and 2-Star for OCC. **OCC CHF Transition of Care Q4 2020: Between October 1st, 2020 through December 31st, 2020** **Total Referrals Received: 5** 2 out of 5 members received health coaching and none of them were re-admitted to the hospital within 30 days 3 out 5 members were released to a SNF/LTC	This measure is an NCQA Measure, it will be monitored by Utilization Management Dept and will have specific (UM) planned activites for 2021	
Opioids Utilization	Optimal utilization of opioid analgesics.	Interventions: a. Quantity limits b. Duration limits c. Prior Authorization criteria d. Prescriber Report Cards e. Pharmacy Home f. Prescriber Restriction	Kris Gericke	Goal: Average Morphine Milligram Equivalent (MME)/Member <15.5 1Q19: 13.9 1Q20: 12.0 2Q20: 11.4 3Q20: 10.9 4Q20: 9.8	Goal met. Measure removed from 2021 Work plan, however continue interventions and monitoring through UMC in 2021.	

2020 QI Work Plan Element Description	Goals	Planned Activities	**Staff Responsible**	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.*)	Red - At Risk Yellow - Concern Green - On Target
Post-Acute Infection Prevention Quality Incentive (PIPQI), aka as SHIELD OC	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	Cathy Osborn	1. Twenty-six nursing facilities participating 2. Due to COVID-19 on-site visits are suspended; CalOptima nurses are doing phone outreach instead to monitor and offer support to participating facilities. Some facilities are struggling with staffing, which makes phone contact challenging at times. For example, if our primary contact is the Director of Staff Development and he/she is absent, they does not seem to be a back-up contact assigned for the purposes of PIPQI. 3. Nineteen (19) of 26 facilities regularly reporting HAI scores. Average score in Q3 is 4.59%.	UCI continues to provide additional support through the OC Nnursing Home COVID-19 Prevention Training. CalOptima PIPQI nurses continue to provide educational videos and phone/email consultation/support. will gather HAI scores (for PIPQI and non-PIPQI facilities) and product purchase invoices.	

Board of Directors' Quality Assurance Committee (QAC) Meeting
May 19, 2021

Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
First Quarter 2021 Meeting Summaries

January 26, 2021: PACE Quality Improvement Committee (PQIC) Ad Hoc Meeting and PACE Infection Control Subcommittee Summary

- All PQIC members present.
- Infection Control Subcommittee: PACE's Response to COVID-19:
    - On January 23, 2021, and January 28, 2021, PACE held COVID-19 vaccination clinics where 277 participants received their first dose of the COVID vaccine.
    - Participants' primary care providers (PCPs) are reaching out to participants who are expressing vaccine hesitancy. The benefits of the vaccine are communicated by the PCP.
- Presentation of the PACE 2020 Work Plan Evaluation Accomplishments:
    - Rapid response to the COVID-19 pandemic through the implementation of "PACE without Walls"
    - Redesigned the triage and clinical workflows to respond to the pandemic.
    - Implemented Virtual Care through a telehealth platform.
    - Low percentage of participants residing in long-term care
    - Pneumococcal immunization rate of 98%
    - Influenza immunization rate of 93%
    - Ninety-fifth (95th) percentile in the quality of diabetes care
    - Medication reconciliation rate of 99%
    - Transportation on-time performance of 98%
    - Overall participant satisfaction score of 88%, exceeding the national PACE average
    - Met 21 of 26 PACE Quality Work Plan goals.
- Discussion Points of the 2020 Work Plan Evaluation:
    - We did not meet our goals in the areas of Advance Health Care Planning (Physician's Orders for Life-sustaining Treatment); use of opioids at high dosages; hospital utilization and PACE enrollment.
    - PACE membership decreased due to pandemic.
    - Met target goals in the areas of comprehensive diabetes care and potential drug/disease interactions.
    - Inpatient utilization increased trend correlated as the pandemic increased in severity.

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    - ER utilization decreased as participants were less likely to go to the ER due to the pandemic. The decrease in ER utilization can also be attributed to the redesign of the PACE triage system, telehealth and daily wellness calls.
    - Participant Satisfaction Survey had accurate measurement of domains, including social worker, rehabilitation and recreational therapy were difficult to obtain due to a decrease in participant visits during the pandemic.
- Discussion points for improvement opportunities for 2021:
    - Addition of COVID-19 vaccine adherence to Quality Initiatives.
    - Continue to monitor participants receiving opioids.
    - Continue expansion of the PACE telehealth program.
    - Continue to examine strategies in reopening the PACE Day Center.
    - Continue to build on decreased ER utilization.
    - Continue to increase the number of PACE core specialists.
    - Refine "PACE without Walls" to improve participant experience.
- Presentation of the PACE 2021 Work Plan
    - Addition of three new quality goals: COVID-19 immunization rates; advanced care planning; engagement in telehealth
    - Two goals modified: Monitoring of falls within the participant home; reducing opioids at high dosage.

February 23, 2021, PACE Quality Improvement Committee (PQIC) Meeting and PACE Infection Control Subcommittee Summary

- All PQIC members present.
- Infection Control Subcommittee: PACE's response to COVID-19:
    - More than 2,600 wellness calls made to participants in January 2021.
    - Two COVID-19 vaccine clinics held at PACE in January, vaccinating 277 participants with their first dose.
    - Scheduled additional COVID-19 vaccine clinic in February 2021 to provide the second vaccine dose.
    - Continued tracking of COVID vaccine eligibility and reaching out to participants to provide a vaccination appointment.
    - Continued drive-through COVID-19 testing.
    - Continued providing essential skilled and non-skilled services at PACE that included physical/occupational therapy, shower assists and escort services.
    - Continued implementation of the telehealth platform. In January 2021, 62 telehealth visits occurred.
    - Continued COVID-19 updates during weekly leadership meetings and monthly all-staff meetings.

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    - Secured contract for monoclonal antibody infusion for COVID-positive participants.
- Membership: We are below our goal for the 4th quarter of 2020. This, however, is to be expected in view of the pandemic.
- Immunizations: The pneumococcal vaccination rate at the end of quarter 4 in 2020 rests at 98%. Our influenza vaccination rate is at 93%.
- Falls Without Injury:
    - We observed a downward trend in quarter 4 of 2020.
    - Most falls occur as a result of not using assistive devices.
    - The PACE rehabilitation department is examining trends and providing participant/caregiver education.
    - The PACE Falls Committee continued to provide intervention to participants to prevent future falls.
- Grievances:
    - A total of eight grievances were submitted in quarter 4 of 2020. Grievance resolutions were to the satisfaction of the participant.
- Quality Incidents with Root Cause Analysis:
    - Eight quality incidents were reported: Seven falls with injury and one burn with a root cause analysis being conducted for each incident.
- Quality Initiative: COVID-19 Vaccines
    - Quality initiative focuses on vaccine education, outreach and vaccine distribution with a goal of 80% of participants fully vaccinated.
    - Vaccine hesitancy reported by 9% of participants. PACE PCPs reached out to these participants communicating the benefits of the vaccine and answering participant questions and concerns. After discussion with their PCP, 17% of these participants agreed to the vaccine.
- Quality Initiative: Telehealth Engagement
    - Successfully implemented a telehealth platform in November 2020.
    - PACE providers and participants were trained in navigating the telehealth platform.
- Introduction of three new PACE Desk References:
    - PACE Transportation Services
    - PACE Scheduling of Service Request Process Requisitions
    - PACE Specialty Authorization Process

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Member Trend Report: 4th Quarter 2020

Quality Assurance Committee

May 19, 2021

Ana Aranda, Director, Grievance and Appeals Resolution Services

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Overview

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

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Definitions

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

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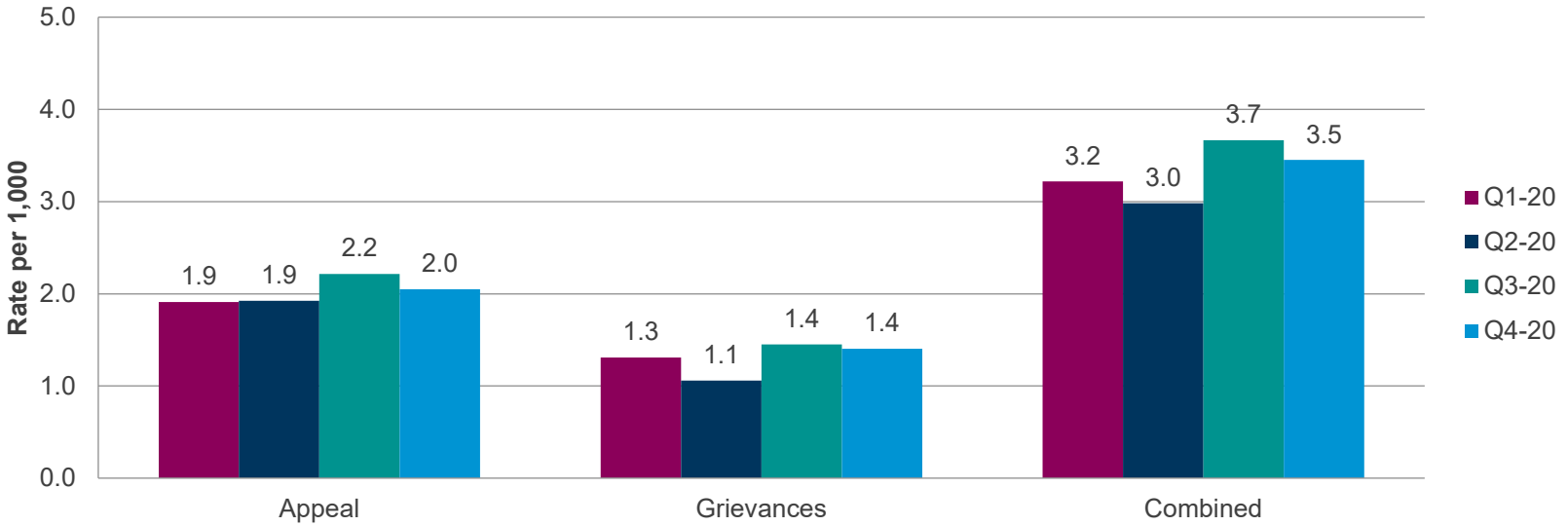
Medi-Cal Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2020	3,090	334	2,756	701,662
Q2-2020	2,653	348	2,305	725,939
Q3-2020	3,724	424	3,300	759,192
Q4-2020	3,694	404	3,290	782,283

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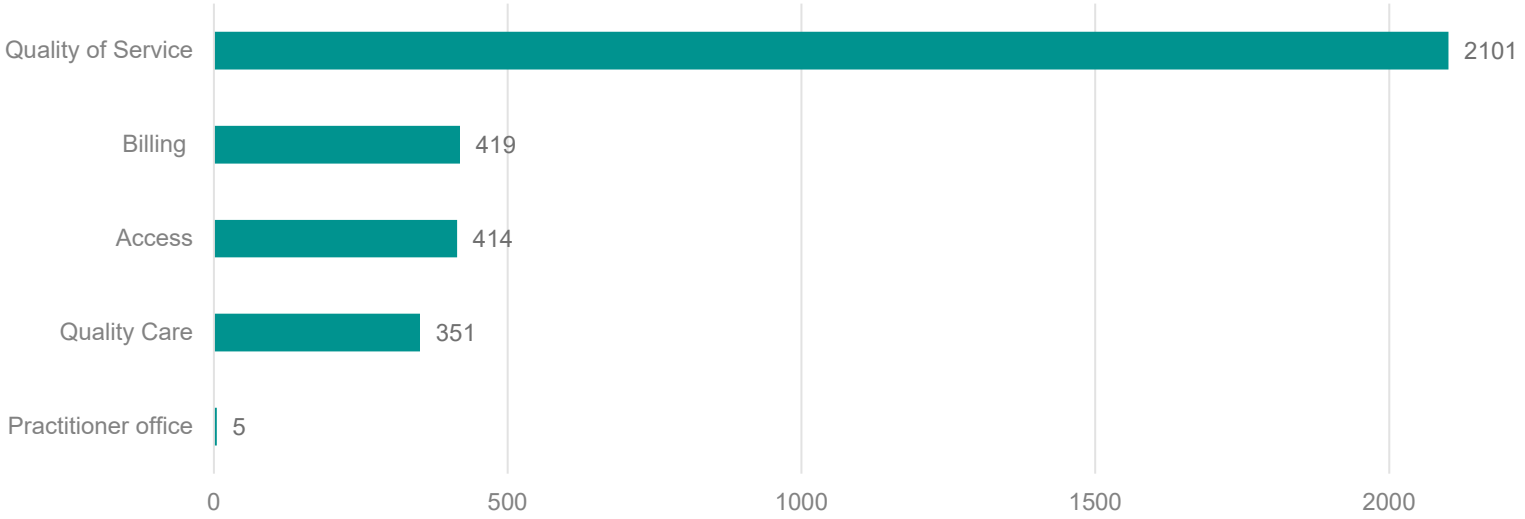
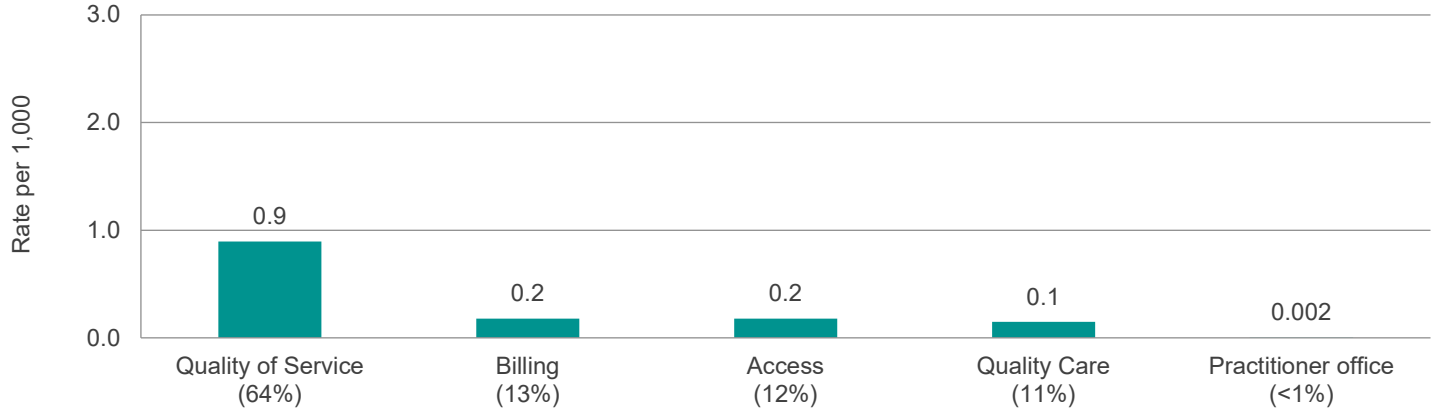
Medi-Cal Grievances by Category





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Medi-Cal Summary

- Grievances decreased by <1% from Q3 2020 to Q4 2020.
  - Quality of care grievances decreased by 12%.
  - Access grievances decreased by 10%.
  - Quality of service grievances increased by 3%.
  - Billing grievances increased by 2%.

- Non-medical transportation grievances decreased by 19% from Q3 2020 to Q4 2020.
  - Utilization of rides increased by <1%

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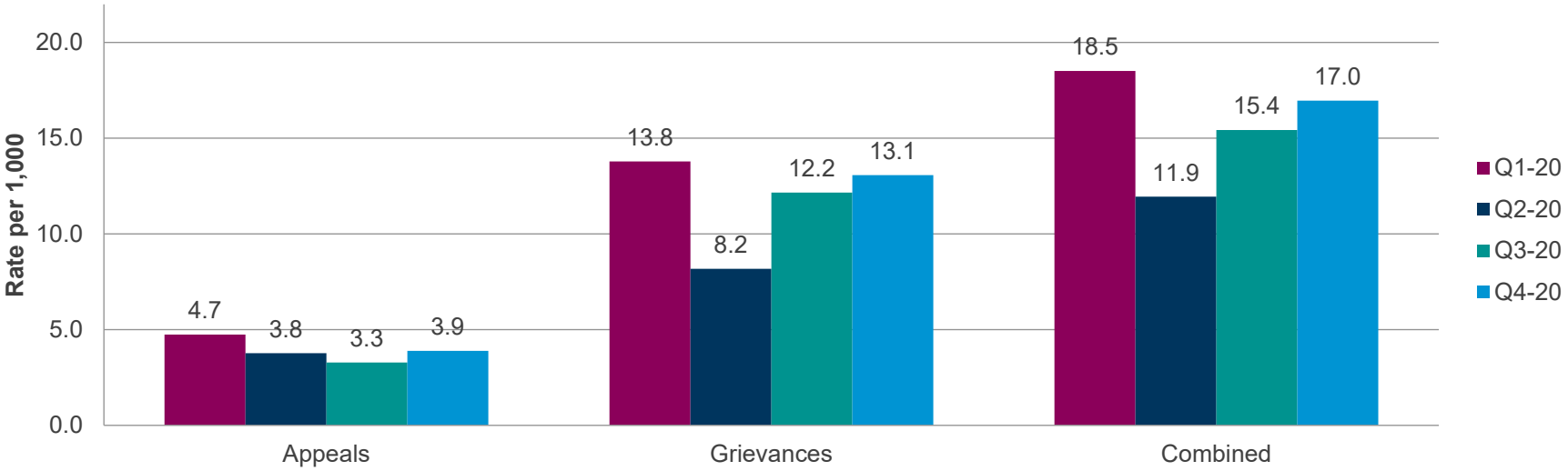
OneCare Connect Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2020	262	67	195	14,148
Q2-2020	171	54	117	14,318
Q3-2020	226	48	178	14,642
Q4-2020	253	58	195	14,912

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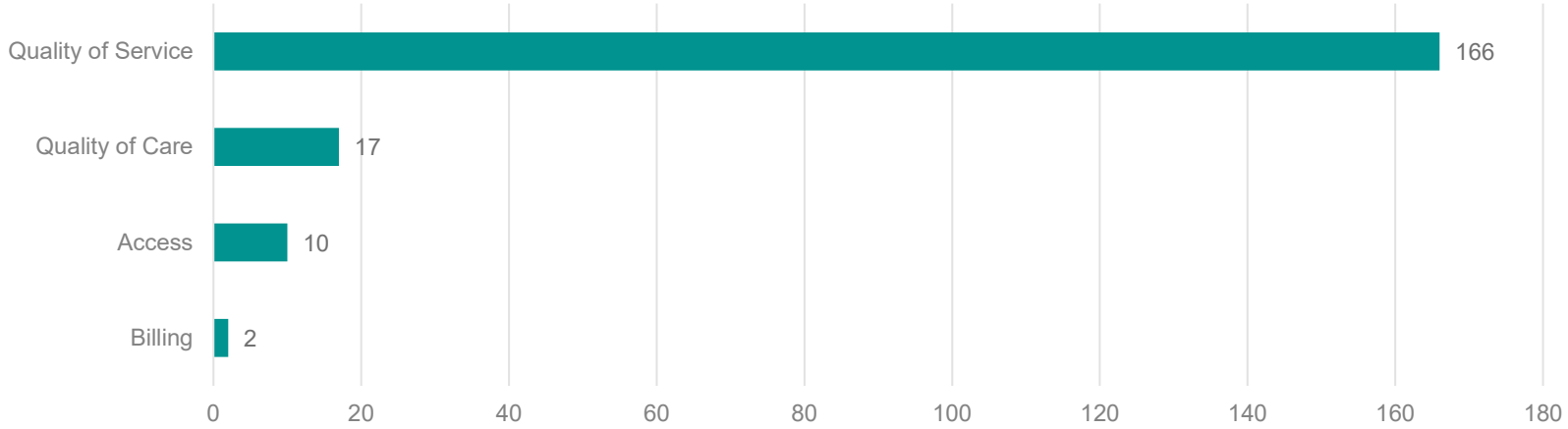
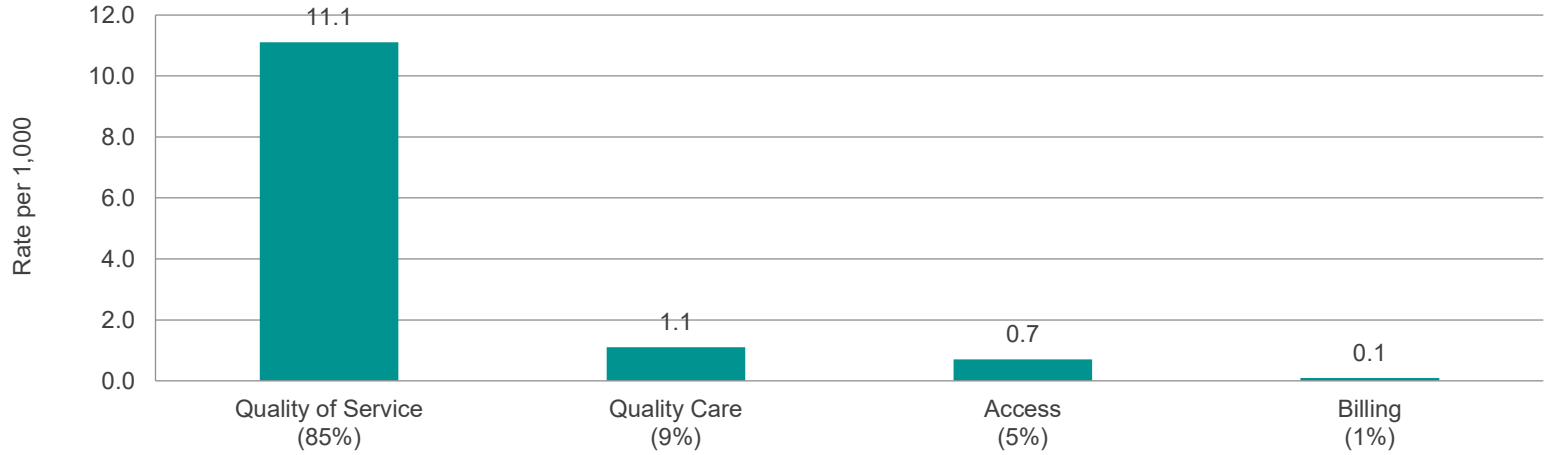
OneCare Connect Grievances by Category





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OneCare Connect Summary

- Grievances increased by 10% from Q3 2020 to Q4 2020.
  - Billing grievances decreased by 60%
  - Quality of care grievances increased by 70%
  - Access grievances increased by 43%
  - Quality of service grievances increased by 6%

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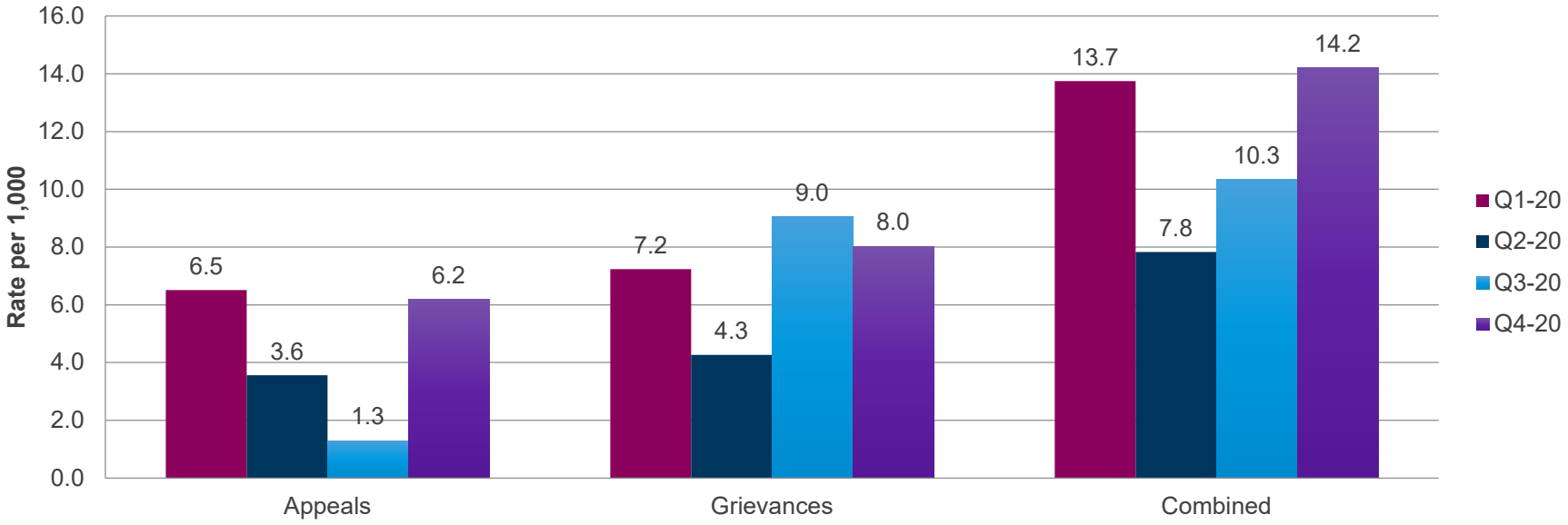
OneCare Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2020	19	9	10	1,382
Q2-2020	11	5	6	1,406
Q3-2020	16	2	14	1,548
Q4-2020	23	10	13	1,619

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OneCare Summary

- Grievances decreased slightly from Q3 to Q4 2020
- Grievances were for the following:
  - ✓ Access to PCP/Specialists
  - ✓ CalOptima staff/services
  - ✓ Provider services/demeanor
  - ✓ Non-Medical Transportation

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Our Mission

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

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