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

WEDNESDAY, OCTOBER 9, 2024
3:00 P.M.

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

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
José Mayorga, M.D., Chair
Maura Byron
Catherine Green

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL KENNADAY LEAVITT	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo	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 materials are available for review at CalOptima Health, 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 Health website at www.caloptima.org.

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at: https://us06web.zoom.us/webinar/register/WN_HaTS3Xz7Tnau9iUxdtTDgw and Join the Meeting.
Webinar ID: **891 5339 4453**
Passcode: **101283** -- Webinar instructions are provided below.

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CALL TO ORDER
Pledge of Allegiance
Establish Quorum

MANAGEMENT REPORTS
1. Medi-Cal Regulatory Audits Update

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
2. Approve Minutes of the June 12, 2024 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

REPORT/DISCUSSION ITEMS
3. Recommend that the Board of Directors Approve Modifications to CalOptima Policy AA.1207b and AA.1207c: Performance-based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology and Performance-based Community Health Center Auto-Assignment Allocation Methodology 2027 Auto Assignment Methodology

4. Recommend that the Board of Directors Approve CalOptima Health Measurement Year 2025 Medi-Cal and OneCare Pay-for-Value Programs

5. Recommend that the Board of Directors Approve Recommendations for the Chair and Vice Chair Appointments to the Whole-Child Model Family Advisory Committee

ADVISORY COMMITTEE UPDATES
6. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

7. Whole-Child Model Family Advisory Committee Updates

INFORMATION ITEMS
8. Overview of Quality Improvement

9. Update on Quality Improvement Program

10. Healthcare Effectiveness Data and Information Set (HEDIS) Measurement Year 2023 Results

11. Quality Improvement Grant Program

12. Behavioral Health Mental Health Incentive Program Update

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

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TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee on October 9, 2024 at 3:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_HaTS3Xz7Tnau9iUxdtTDgw

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. .
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Passcode: **101283**

Or One tap mobile:
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Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 346 248 7799 or +1 719 359 4580 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 or +1 646 931 3860 or +1 689 278 1000 or +1 301 715 8592 or +1 305 224 1968 or +1 309 205 3325 or +1 312 626 6799 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 646 558 8656

Webinar ID: **891 5339 4453**

Passcode: **101283**
International numbers available: **https://us06web.zoom.us/u/kdfBf0mtff**

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Medi-Cal Regulatory Audits Update

Quality Assurance Committee Meeting

October 9, 2024

John Tanner, Chief Compliance Officer

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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2023 Department of Healthcare Services (DHCS) Focused Audit

- Conducted February/March 2023
- Areas of focus
  - Transportation
    - Non-Emergency Medical Transportation (NEMT)
    - Non-Medical Transportation (NMT)
  - Behavioral Health (BH)
    - Specialty Mental Health Services (SMHS)
    - Non-Specialty Mental Health Services (NSMHS)
    - Substance Use Disorder Services (SUDS)

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CalOptima Health

2023 DHCS Focused Audit (continued)

- 8/30/24 Final Audit Report received
  - Transportation – no findings
  - Behavioral Health – 2 findings

2.1 Follow up for Referred Substance Use Disorder (SUD) Treatment

- DHCS Finding #1: The Plan did not make good faith efforts to confirm whether members received SUD services for treatments referred to the County.

2.2 SUDS Follow-up to Understand Barriers and Make Adjustments

- DHCS Finding #2: The Plan did not have a process in place to follow-up with members to understand barriers and make subsequent adjustments to referrals for which the member did not receive the referred treatment.

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CalOptima Health

2023 DHCS Focused Audit (continued)

- 9/6/24 DHCS formally requested a Corrective Action Plan (CAP)
- 10/7/24 CAP due to DHCS

- **Next Steps: ON-TRACK**
  - BH Leadership has implemented desktop procedures, trained staff, and implemented monthly monitoring to prevent re-occurrence
  - CAP remediation is complete as of July 2024
  - CalOptima Health to submit CAP to DHCS by 10/7/24

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CalOptima Health

2024 DHCS Routine Medical Audit

- Conducted March 2024
- Scope/audit areas
  - Utilization Management
  - Case management and coordination of care
  - Availability and accessibility
  - Member's rights
  - Quality management
  - Administrative and organizational capacity

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CalOptima Health

2024 DHCS Routine Medical Audit - Findings

- Key information
  - Audit period: 2/1/23 – 2/29/24
  - 10 findings across 4 audit categories

Audit Area	Finding
Utilization Management (UM)	**3 Findings**
Case Management and Coordination of Care	**2 Findings**
Access and Availability of Care	**4 Findings**
Members' Rights	**1 Finding**
Quality Management	No Findings
Administrative and Organizational Capacity	No Findings

- 8/22/24 DHCS formally requested a CAP
- 9/23/24 CAP submitted to DHCS
- Monthly CAP updates due to DHCS until all CAP actions have been implemented
- Final CAP deliverable is scheduled to be completed by January 2025

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CalOptima Health

2024 DHCS Routine Medical Audit - Details

Category	Section	DHCS Finding	Remediation
Category 1 – Utilization Management	1.2.1 Prior Authorizations	The Plan did not ensure consistent application of its UM written criteria for adjudicating Gender Affirming Care (GAC)-related PA requests.	Reviewed and confirmed policies were appropriate and retrained Medical Directors to ensure appropriate criteria is applied.
	1.2.2 Notice of Action Letters	The Plan did not send PA NOA letters to members and providers within the required timeframes outlined in APL 21-011.	Staff has undergone training; desktops were updated, and a monitoring/oversight report will be implemented in Q3 2024.
	1.3.1 Member's Right to File a Grievance	The Plan did not inform members of the right to file a grievance after denial of a request for expedited resolution of an appeal.	Grievances, Appeals and Resolutions (GARS) policy was updated to reflect the requirement. Member letters were revised, and staff training was conducted.
Category 2 – Case Management and Coordination of Care	2.1.1 Anticipatory Guidance	The Plan did not ensure the provision of oral or written blood lead anticipatory guidance to the parents or guardians of a child member starting at the age of 6 months and up to 72 months	Health Network and provider education was completed. Future milestones include oversight/monitoring through record review, member education, and continued provider education.
	2.1.2 Provision of Blood Lead Screening of Young Children	The Plan did not ensure that the network providers ordered or followed up with the BLS test results for child members at 12 months, 24 months, and up to 72 months of age.	Health Network and provider education was completed. Future milestones include oversight/monitoring through record review, member education, and continued provider education.

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CalOptima Health

2024 DHCS Routine Medical Audit - Details

Category	Section	DHCS Finding	Remediation
Category 3 – Access and Availability of Care	3.1.1 Appointment Wait Time Standards	The Plan did not ensure primary and specialty providers complied with appointment wait time standards.	Developed and revised staff resources including flowcharts, checklist, and templates. Staff training conducted.
	3.2.1 Physician Certification Statement Forms	The Plan did not ensure that the health care professional signature on the PCS forms can be legibly identified.	Updated the Physician Certification Services (PCS) form to require a printed name alongside the signature. Internal staff and Health Network training underway.
	3.2.2 Transportation Minors Consent Forms	The Plan did not ensure a procedure to verify minor consent letters are collected prior to arranging NEMT and NMT services.	CalOptima Health contracted with a new transportation broker as of 4/1/24. Implemented process with current vendor to ensure compliance. Instituted monthly monitoring to ensure ongoing compliance.
	3.2.3 Medi-Cal Enrollment of Non-Medical Transportation Providers	The Plan did not ensure all NMT individual transportation providers are enrolled in the Medi-Cal program.	CalOptima Health contracted with a new transportation broker as of 4/1/24. The current transportation vendor has an established process to ensure compliance; CalOptima Health monitors monthly to ensure ongoing compliance.
Category 4 – Member's Rights	4.1.1 Grievance and Appeals Written Record	The Plan's governing body (Board of Directors) did not review the grievance and appeals written records.	Policy was updated to include the review of grievance and appeals written records by the governing body. Reporting to various committees has begun.

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MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

June 12, 2024

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee (Committee) was held on June 12, 2024, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Trieu Tran called the meeting to order at 3:02 p.m., and Director Byron led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; Maura Byron; José Mayorga, M.D.

(All Committee members in attendance participated in person except Director Mayorga, who participated remotely under Just Cause, using his first of two uses for calendar year 2024 as permitted by AB 2449.)

Members Absent: None.

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Troy Szabo, Outside General Counsel, Kennaday Leavitt; Linda Lee, Executive Director, Quality Improvement; Monica Macias, Director, PACE; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

None.

PUBLIC COMMENTS

There were no public comments.

CONSENT CALENDAR

1. Approve the Minutes of the March 13, 2024, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

Action: ***On motion of Director Byron, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 3-0-0)***

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REPORT/DISCUSSION ITEMS

2. Recommend that the Board of Directors Approve the Revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan

Linda Lee, Executive Director, Quality Improvement, highlighted the revisions to CalOptima Health's 2024 Quality Improvement and Health Equity Program (QIHEP) and Work Plan. Ms. Lee noted that the program and annual work plan was previously approved by the Committee in March 2024, and noted that the revisions being brought before the Committee today are regulatory in nature and will help align CalOptima Health with contractual requirements as directed by the Department of Health Care Services (DHCS). Ms. Lee reviewed the changes to the agency's QIHEP and Work Plan, which included changing the name of the Population Health Management Program to the Equity and Community Health Program. She noted that CalOptima Health also changed its department name from Population Health Management Department to Equity and Community Health Department. Ms. Lee added that this highlights DHCS' priorities around identifying health disparities and working to ensure health equity amongst California members and the broader community that CalOptima Health serves in Orange County.

Ms. Lee reviewed other changes, which included adding a Cultural and Linguistic Appropriate Services (CLAS) Program to align cultural and linguistic services to quality improvement. Ms. Lee note that going forward, for Health Equity Accreditation, cultural and linguistic services are tightly integrated with quality improvement efforts. This is also a DHCS and National Committee for Quality Assurance (NCQA) requirement.

Ms. Lee reported that the revised documents are the Quality Improvement (QI) Program Description, the Work Plan, and the new CLAS Program. Ms. Lee noted that CalOptima Health has involved the community and members through its Member Advisory Committee (MAC). The MAC will review opportunities for CLAS. CalOptima Health has specified CLAS goals; one of the goals, which is new to CalOptima Health, is to implement a process to collect sexual orientation and gender identifying data. Ms. Lee added that collecting this data is an integral part of health equity accreditation, so staff is working towards ensuring that its systems can house this data and that there is a way for members to self-identify and report this information in the system.

Ms. Lee responded to Committee members' comments and questions.

Action: ***On motion of Director Mayorga, seconded and carried, the Committee recommended that the Board of Directors approve the revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan. (Motion carried 3-0-0)***

3. Recommend that the Board of Directors Approve CalOptima Health's Calendar Year 2025 Member Health Rewards

Ms. Lee reviewed the proposal for the Calendar Year (CY) 2025 Member Health Rewards Program, which would start January 1, 2025, through December 31, 2025. The main change for CY 2025 Member Health Rewards is the alignment of the incentive amounts, so that all incentives have the same amount. Ms. Lee also noted that CalOptima Health is changing the blood lead testing from attestation-based rewards to passive rewarding and reducing the postpartum care amount from $50 to $25 to align it with the rest of the incentives. She added that the fiscal impact is estimated based on a

15% response rate. This is tracking with what the 2023-2024 experience has been so far. For Medi-Cal, the estimated cost for the CY 2025 Member Health Rewards Program is $4.87 million, which will be funded by the CalOptima Health Fiscal Year (FY) 2024-25 Operating Budget and unearned funds from the Measurement Year 2023 Medi-Cal Pay for Value Performance program. For OneCare, the estimated cost is $660,000, which will be funded by the proposed FY 2024-25 Operating Budget and expenses for the period of July 1, 2025, through December 31, 2025, will be included in the FY 2025-26 Operating Budget.

Ms. Lee and Yunkyung Kim, Chief Operating Officer, responded to Committee members' comments and questions.

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors 1.) Approve CalOptima Health's Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare. (Motion carried 3-0-0)***

4. Recommend Appointments to the CalOptima Health Whole-Child Model Family Advisory Committee

Ms. Kim introduced this item noting that CalOptima Health is extremely fortunate to have a Whole-Child Model Family Advisory Committee (WCM FAC). She noted that as the former Chair, Director Byron is very familiar with the WCM FAC.

Director Byron asked for more information on the consumer advocate recommendation, Jennifer Heavner.

Cheryl Simmons, Staff to the Advisory Committees, responded to Director Byron's question noting that Jennifer Heavner is currently an authorized family member, but her son is aging out of the California Children's Services (CCS) program. Ms. Simmons noted that Ms. Heavner has been advocating for her son for 21 years and she would like to continue to advocate on behalf of other children that are in the program.

Ms. Simmons responded to Committee members' comments and questions.

Director Byron emphasized how incredibly important the WCM FAC is, and noted that sometimes it gets overlooked. She also noted that the WCM FAC has gone through a lot of transitions, and now it is not under the Brown Act. She noted that the WCM FAC is a committee that meets virtually, which is very important because many of the members that sit on the committee do not have the ability to meet in person because they are taking care of their loved ones. Director Byron added that she appreciates the fact that CalOptima Health has a WCM FAC, and she is very proud of where the committee started and where it is going.

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors approve the Whole-Child Model Family Advisory Committee's recommendations and in turn recommend that the Board of Directors approve those recommendations as follows: 1.) Reappoint the following individuals to each serve a two-year term on the Whole-Child Family Advisory Committee, effective upon Board of Directors***

approval: a.) Jessica Putterman as an Authorized Family Member Representative for a term ending June 30, 2026; b.) Kristen Rogers as an Authorized Family Member Representative for a term ending June 30, 2026; and c.) Erika Jewell as a Community Based Organization Representative for a term ending June 30, 2026. 2.) Newly appoint the following individuals to each serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board of Directors approval: a.) Jody Bullard as an Authorized Family Member Representative for a term ending June 30, 2026; and b.) Jennifer Heavener as a Consumer Advocate Representative for a term ending June 30, 2026. (Motion carried 3-0-0)

ADVISORY COMMITTEE UPDATES

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

Chair Tran noted that the update for the PACE Member Advisory Committee is in the meeting materials and the Committee accepted Agenda Item 5 as presented.

6. Whole-Child Model Family Advisory Committee Report

Kristen Rogers, Chair, WCM FAC, provided an update on the activities of the WCM FAC. Ms. Rogers thanked the Committee for recommending approval of the WCM FAC members, which included herself as one of the members. She added that the next WCM FAC is scheduled for June 18, 2024, at 9:30 a.m., at which the committee will be approving its quarterly schedule for the next fiscal year. Ms. Rogers reported that in addition to the Chief Executive Officer, Chief Operating Officer, and Chief Medical Officer updates, the committee will receive an update on the OneCare program, and a Quality Improvement Update from Linda Lee.

INFORMATION ITEMS

7. Update on Quality Improvement Programs

Ms. Lee provided an update on several key initiatives, which have been presented to the Committee in the past. She noted that she will provide updates on credentialing, CalOptima Health NCQA Health Plan Accreditation Survey, the NCQA Health Equity Accreditation Survey, and other key quality initiatives.

Credentialing Update

Ms. Lee noted that as she had previously reported to the Committee, there were opportunities for improvement of CalOptima Health's credentialing processes. Since the last update, staff contracted with a Credentialing Verification Organization (CVO) in March 2024 and held a kick-off meeting in April 2024. Ms. Lee noted that as part of the CVO implementation process, staff is attending weekly implementation meetings with the vendor, preparing documents, creating workflows and protocols for data exchange. Currently, staff expects to go live with the vendor by end of June 2024. Ms. Lee added that the vendor will assume most of CalOptima Health's credentialing services, which will improve credentialing turnaround times. CalOptima Health will monitor post go-live transmission for 30 days, after which time, internal auditor staff will continuously monitor to ensure the vendor is meeting contract requirements.

NCQA Health Plan Accreditation

Ms. Lee provided an update on CalOptima Health's Health Plan Accreditation, noting that it has been accredited by NCQA since 2012. The current Health Plan Accreditation is a re-survey for the agency

and is a 24-month look-back period, from April 30, 2022, to April 30, 2023, and from April 30, 2023, to April 30, 2024. Ms. Lee reported that staff has submitted all documents to NCQA. Ms. Lee also noted that CalOptima Health is prepared and added that the file review includes delegated network files for areas that CalOptima Health delegates to its health networks. She reported that the results will not be available until around August.

NCQA Health Equity Accreditation

Ms. Lee updated the Committee on the new DHCS requirement of NCQA Health Equity Accreditation. By way of background, DHCS will require all managed care plans to achieve Health Equity Accreditation by January 1, 2026. CalOptima Health's goal is to be accredited ahead of that date and is targeting quarter three of 2025. Ms. Lee noted that staff has engaged its NCQA consultant and completed a readiness assessment. The consultant has created a gap analysis and work plan, and staff is working towards remediating that work plan. Ms. Lee provided additional details on what Health Equity Accreditation standards cover, which included six areas: (1) organizational readiness, diverse staff, and promoting diversity among staff; (2) collection of race/ethnicity, gender identity, and sexual orientation data; (3) access and availability of language services; (4) practitioner network cultural responsiveness; (5) culturally and linguistically appropriate services program; and (6) reducing health care disparities. Ms. Lee added that CalOptima Health has already started including these requirements in the revised 2024 QIHEP and Work Plan. She also shared the project timeline for obtaining NCQA Health Equity Accreditation, noting that CalOptima Health's survey submission date is tentatively in June 2025.

Quality Initiatives

Ms. Lee provided an update on CalOptima Health's quality initiatives that are federally and state mandated Performance Improvement Projects (PIP). For Medi-Cal, the first DHCS mandated performance improvement initiative is on well infant visits for the first 15 months of life. This initiative addresses disparities for Black or African American members. Ms. Lee noted that CalOptima Health has a very low number of members that fit into this population, with only 153 members. Nevertheless, that population shows a disparity. In measurement year 2022, the baseline rate was about 35% for that population, compared to the 46% overall rate among all other members in the age cohort, which is an 11% difference. Ms. Lee noted that staff has conducted education campaigns, sent reminders, is coordinating appointments, and offering gifts cards. Ms. Lee also noted that staff has identified other racial populations that might have disparities, so CalOptima Health is reaching out to those populations as well.

The next PIP area falls under the Plan-Do-Study-Act (PDSA) Project for the age group of 15 to 30 months of life and similar initiatives. Ms. Lee noted that CalOptima Health has found that members who received two call attempts had similar rates of compliance as members who received three call attempts and a birthday card reminder, and as a result, staff can minimize the outreach and costs associated with this and conduct two call attempts and a post birthday card reminder. Ms. Lee reported that staff conducts rapid cycle studies to inform what initiatives CalOptima Health should undertake and whether the initiatives are having the desired impact.

Ms. Lee also reported that the agency has a behavioral health non-clinical PIP, which is mandated by DHCS. The purpose of the PIP is to increase enrollment of CalOptima Health Medi-Cal only members into care management, complex case management, or enhanced care management for members diagnosed with Specialty Mental Health/Substance Use Disorder to achieve better health

outcomes, reduce emergency visits, and reduced health care costs. Staff has collected baseline data and created the initial report. The first draft of the PIP was submitted to DHCS and they have reviewed and accepted the proposed PIP. Ms. Lee reported that the quality interventions due to this initiative include the following: text messaging campaigns; member health rewards; member outreach; member newsletter; automation via CalOptima Health provider portal; and provider communication, including tip sheets and best practice letters. Ms. Lee reminded the Committee that CalOptima Health has a Behavioral Health Pay for Value program, which is aligned with these efforts.

Ms. Lee reported on the blood lead screening initiative, which is an area that has hovered around the minimum performance level year after year. To date, staff has added an incentive for blood lead screening incentive, initiated text campaigns, and a live call campaign to address gaps for members who have not yet had a blood lead screen.

Ms. Lee reported on the OneCare Chronic Care Improvement Program (CCIP). This initiative focuses on members with diabetes on two fronts. The first is medication adherence for diabetes to ensure that members stay compliant and in control of their HbA1c levels. The second is identifying members who have an emerging risk for poor HbA1c control, this would be eligible members with diabetes whose HbA1c test result is below 8.0% but tested between 8.0% and 9.0% in their most recent test. Ms. Lee reported that CalOptima Health is tracking these results and when HbA1c levels rise it conducts outreach via telephone by a health coach to identify solutions, which could include general diabetes health education, blood sugar management, nutrition and exercise, and preventive care reminders.

Ms. Lee responded to Committee members' comments and questions.

Director Byron noted that currently, most people do not pick up the phone and said it may be advantageous to outreach to members via text and enlist providers and hospitals to help educate members on the importance of screenings for infants and children.

Ms. Lee thanked Director Byron for her comments and suggestions and noted that CalOptima Health will continue looking for avenues to reach members to ensure the best health outcomes for all CalOptima Health members.

Director Mayorga commented that he has read the PACE Member Advisory Committee update and the metrics within that report. He suggested that staff may want to consider connecting with other PACE providers within the county to exchange best practices on how to improve the care of this vulnerable population, from a performance perspective. He noted that staff could report out the results at a future Committee meeting.

Director Mayorga also requested a report on member grievances, particularly around access to care.

Ms. Kim responded to Director Mayorga's comments and suggestions regarding the PACE best practices and committed to bringing an update on the findings at a future Committee meeting. Ms. Kim also thanked Director Mayorga for requesting a report on member grievances, noting that this information is included in the meeting materials; but the Committee has not always had the opportunity to dig into the details. Ms. Kim noted that the Committee can expect a report on member

grievances for CalOptima Health's direct network, its delegated network, and the delivery system as a whole at the next Committee meeting.

The following items were accepted as presented.

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

COMMITTEE MEMBER COMMENTS
The Committee members thanked staff for the work that went into preparing for the meeting.

ADJOURNMENT
Hearing no further business, Chair Tran adjourned the meeting at 4:10 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: October 9, 2024

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CalOptima Health Board Action Agenda Referral

Action To Be Taken October 9, 2024
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

3. Recommend that the Board of Directors Approve Modifications to CalOptima Policy AA.1207b and AA.1207c: Performance-based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology and Performance-based Community Health Center Auto-Assignment Allocation Methodology

Contact

Linda Lee, Executive Director, Quality Improvement, 657-900-1069

Recommended Actions

Recommend that the Board of Directors approve recommended modifications to policy AA.1207b: Performance-based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology and AA.1207c: Performance-based Community Health Center Auto-Assignment Allocation Methodology.

Background

Since 2006, CalOptima Health has utilized an auto assignment methodology to assign members to Health Networks and primary care providers when members do not choose a provider upon enrollment. The auto assignment methodology mimics selection criteria that members use when self-selecting, such as geography, previous provider assignment, member family link, and provider quality. CalOptima Health's auto assignment methodology and process are outlined in the following three policies:

- AA.1207a CalOptima Health Auto-Assignment.
- AA.1207b Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology.
- AA.1207c Performance-based Community Health Center Auto-Assignment Allocation Methodology.

Discussion

Staff regularly review agency policies and procedures to ensure that they are up-to-date and aligned with federal and state health care program requirements, contractual obligations, laws, and CalOptima Health operations.

CalOptima Health implements an auto-assignment process as a proxy for member selection when members do not actively choose a Health Network and primary care practitioner. The auto-assignment process utilizes factors that mimic selection criteria that a member may use when self-selecting. These factors include geographic distance between the member's location and provider's office, previous affiliation with a provider, linkage between a provider and other eligible family members, and provider quality performance.

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Staff has reviewed the auto assignment methodology and recommends changes to align CalOptima Health's auto assignment quality score with the California Department of Health Care Services auto assignment quality score, update the quality measures based on CalOptima Health priorities, and create a method for new providers to participate in auto assignment before a quality score can be calculated.

Below is a description of the impacted policies, followed by a summary of recommended substantive changes to the policy, which are reflected in the attached redlines. The list does not include non-substantive changes that may also be reflected in the redline (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

Policy AA.1207b revisions update the quality metrics and scoring used to allocate auto-assignment for Health Networks. These changes were shared and discussed with the health networks at Health Network Forums, Community Clinic Forum, Quality Forum, and the Quality Improvement and Health Equity Committee.

Policy Section	**Changes to Policy AA.1207b: Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology**
Page: 1 Policy Section: II.B.1.a Lines: 28-32	Added new language defining an updated auto assignment quality score.
Page: 2 Policy Section: II.F.1 Lines: 31-37	Updated language that describes new methodology for assigning an auto assignment quality score to new Health Networks.
Page: 3-4 Procedure Sections: III.C-I Lines: 11-28, 1-17	Added new language defining the procedure for calculating the auto assignment quality score, including the quality measures that will be used.

Policy AA.1207c revisions update the quality metrics and scoring used to allocate auto-assignment for Community Health Centers. These changes were shared and discussed with the health networks at Health Network Forums, Community Clinic Forum, Quality Forum, and the Quality Improvement and Health Equity Committee.

Policy Section	**Changes to Policy AA.1207c: Performance-based Community Health Center Auto-Assignment Allocation Methodology**

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Pages: 1-3 Policy Sections: II.B-D.1.2. E-F Lines: 12-41	Added new language defining an updated auto assignment quality score.
Page: 3 Policy Sections: II.G-K. Lines: 15-26	Updated language that describes new methodology for assigning an auto assignment quality score to new Health Networks.
Pages: 3-4 Procedure Sections: III.A-I Lines: 30-37, 1-34	Added new language defining the procedure for calculating the auto assignment quality score, including the quality measures that will be used.

Fiscal Impact

The recommended action to approve changes to policies AA.1207b and AA.1207c is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable laws, regulations, rules, and accreditation standards, CalOptima Health staff recommends that the Quality Assurance Committee recommend that the Board of Directors approve and adopt the revised policies. The updated policies will supersede prior versions.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. AA.1207b Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology
2. AA.1207c Performance-based Community Health Center Auto-Assignment Allocation Methodology
3. Presentation: Changes to Auto-Assignment Quality Metrics and Scoring

/s/ Michael Hunn *10/04/2024*
Authorized Signature **Date**

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Policy:	AA.1207b
Title:	**Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's methodology for determining a Health Network and CalOptima Health's Community Network's (CHCN) Assignment allocations according to performance-based indicators.

II. POLICY

A. ~~CalOptima Health shall Auto-Assign a Health Network Eligible Member who has not selected a Health Network, or CHCN, to a Health Network, or CHCN, in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.~~CalOptima Health shall Auto-Assign a Health Network Eligible Member who has not selected a Health Network, or CHCN, to a Health Network, or CHCN, utilizing performance-based indicators and in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

~~B. CalOptima Health shall assign eligible Members not Auto-Assigned under CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment based on a Health Network's, or CHCN's, performance-based Auto-Assignment allocation.~~

~~C.~~B. CalOptima Health shall determine a Health Network's, or CHCN's, performance-based Auto-Assignment allocation according to indicators listed in the Health Network/CHCN Performance-based Auto-Assignment Allocation Table.

~~1.~~ CalOptima Health shall calculate a Health Network's, (including CHCN's), performance-based Auto-Assignment allocation as follows:

~~2.~~1.

a. CalOptima Health shall calculate an ~~Health Network Quality Rating~~ Auto Assignment Quality Score (~~HNQR~~AAQS) (scored between zero (~~1~~0) ~~–~~and ten (~~5~~10)) for each Health Network. A higher score indicates better performance. ~~-~~The scores are ranked to determine the order of the Auto-Assignment allocation run.~~The HNQR utilizes industry standard scoring developed by the National Committee for Quality Assurance to derive health plan~~

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~~quality performance scores. This methodology also aligns with CalOptima Health's Board of Directors approved Pay for Value program scoring methodology.~~

~~2. Health networks that do not achieve a HNQR of at least 2.5 will be suspended from Auto-Assignment until the next measurement period. Health Networks that do not achieve a HNQR of at least 2.5 will be notified and required to complete an improvement plan that details their plans to raise their performance to expected minimum performance levels.~~

b. Annually, each Health Network will be provided with documentation of how their ~~HNQR~~ AAQS score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the ~~HNQR~~AAQS.

~~D.~~C. CHCN, and each individual Health Network, shall be given a ~~HNQR~~ AAQS score from zero (~~1.0~~0) to ten (~~5.0~~10) based on their performance during the measurement period. CalOptima Health shall utilize the Health Network, or CHCN, ~~HNQR~~AAQS, in numerical sequence, (highest to lowest) as the processing order for Auto-Assignment~~s~~.

~~E.~~D. In the event that CHCN's, or a Health Network's, Auto-Assignment is suspended for any reason, CalOptima Health shall distribute that Health Network's, or CHCN's, allocation of Auto-Assigned Members amongst the remaining eligible Health Networks, or CHCN, in a manner that is proportional to each individual Health Network's, or CHCN's, Performance-based Auto-Assignment allocation.

~~F.~~E. CalOptima Health shall score a Health Network for an indicator as long as the Health Network maintains a Contract for Health Care Services for the entire measurement year and is contracted with CalOptima Health at the time of measurement calculation.

~~G.~~F. Performance-based Auto-Assignment allocation for a new Health Network, or CHCN:

1. A new Health Network, for purposes of Auto-Assignment, is considered a Health Network with less than one (1) full measurement year of data during the measurement period. Prior to one (1) full measurement year, a new Health Network will receive three (3.0) points per measure used in the AAQS. ~~New health networks will not be eligible for Auto-Assignment until the following year w~~When a full year of data is available and ~~and~~ an ~~HNQR~~ AAQS can be calculated, ~~with evidence of minimum performance level~~ then the new Health Network shall receive an AAQS based on performance. ~~achievement calculated by CalOptima Health staff.~~

2. In the event of a declaration of a "extreme and uncontrollable event" declared by DHCS (such as the previous declarations for regional wild-fires and flooding which adversely impacted ability to collect data and calculate quality scores), there will be no penalties to scores and each HN will ~~achieve at least a 2.5 HNQR~~ receive the better of the current or prior year AAQS.

~~H.~~G. CalOptima Health shall evaluate the performance-based Auto-Assignment allocation methodology for Health Networks and CHCN annually, or upon:

1. Addition, or termination, of a Health Network;

2. A material change; or

3. Change in indicators.

~~I.~~H. CalOptima Health shall notify Health Networks of any changes in the performance-based Auto-Assignment allocation methodology~~,~~ or ~~indicators~~measures prior to the measurement period.

III. PROCEDURE

A. CalOptima Health shall ~~measure~~ calculate each ~~indicator~~ measure annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following ~~the~~ measurement.

C. The AAQS shall be based on the following eleven (11) measures weighted equally:

Measure	Category
Adult Access to Preventive and Ambulatory Care Visits	HEDIS
Child and Adolescent Well-Care Visits	HEDIS
Childhood Immunization Status- Combination 10	HEDIS
Immunizations for Adolescents- Combination 2	HEDIS
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	HEDIS
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	HEDIS
Prenatal and Postpartum Care: Postpartum Care	HEDIS
Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS
Cervical Cancer Screening	HEDIS
Getting Care Quickly	CAHPS
Getting Needed Care	CAHPS

D. Healthcare Effectiveness Data and Information Set (HEDIS) performance rates shall be calculated for each Health Network, including CHCN, using administrative data (claims and encounter data). The minimum denominator to report a performance rate shall be thirty (30) M~~m~~embers.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance rates will be calculated based on M~~m~~ember satisfaction surveys fielded by CalOptima Health for each Health Network, including CHCN, according to CalOptima Health P~~p~~olicy GG.1637: Assessing Member Experience.

F. Points will be allocated for each measure based on comparison to the most recent National Committee for Quality Assurance (NCQA) National Medicaid percentiles available at the time of measurement. Point allocation shall be as follows:

Points Earned for Individual Measures	
NCQA Percentile	**Points**
At or above the 75th percentile	10
At or above the 66.67th percentile, below the 75th percentile	8
At or above the 50th percentile, below the 66.67th percentile	6
At or above the 33.33rd percentile, below the 50th percentile	4
At or above the 25th percentile, below the 33.33rd percentile	2
Below the 25th percentile	0

G. A new Health Network, prior to the ability to report performance rates as described in Section II.G.1. ~~above~~of this Policy, shall receive three (3) points per measure.

H. The AAQS is calculated based on the sum of points for each measure divided by the number of reportable measures. The maximum possible AAQS is ten (10) points. Health Networks must report a minimum of three (3) HEDIS measures to generate an AAQS and to participate in Auto Assignment.

I. CalOptima shall calculate eligible and participating Health Network's (including CHCN's) performance-based Auto-Assignment allocation as follows:

1. For each Health Network, derive a score relative to the sum of all AAQS scores for all eligible and participating Health Networks;

2. For each Health Network, calculate the final allocation percentage by multiplying the relative score with the percent of the total Health Network Auto-Assignment in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
C. CalOptima Health Policy GG.1637: Assessing Member Experience

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/14/1995	Regular Meeting of the CalOptima Board of Directors
01/23/1996	Regular Meeting of the CalOptima Board of Directors
12/04/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
10/06/2022	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2009	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2011	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	07/01/2013	AA.1207b	Performance-based Health Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	12/01/2014	AA.1207b	Performance-based Health Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2016	AA.1207b	Performance-based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2017	AA.1207b	Performance-based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207b	Performance-Based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	10/06/2022	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2024	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	05/01/2024	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	TBD	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal

IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Health Member who does not select a Primary Care Provider (PCP) and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health, Health Network or CalOptima Health Community Network (CHCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

Policy:	AA.1207b
Title:	**Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's methodology for determining a Health Network and CalOptima Health's Community Network's (CHCN) Assignment allocations according to performance-based indicators.

II. POLICY

A. CalOptima Health shall Auto-Assign a Health Network Eligible Member who has not selected a Health Network, or CHCN, to a Health Network, or CHCN, utilizing performance-based indicators and in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

B. CalOptima Health shall determine a Health Network's, or CHCN's, performance-based Auto-Assignment allocation according to indicators listed in the Health Network/CHCN Performance-based Auto-Assignment Allocation Table.

1. CalOptima Health shall calculate a Health Network's, (including CHCN's), performance-based Auto-Assignment allocation as follows:

a. CalOptima Health shall calculate an Auto Assignment Quality Score (AAQS) (scored between zero (0) and ten (10)) for each Health Network. A higher score indicates better performance. The scores are ranked to determine the order of the Auto-Assignment allocation run.

b. Annually, each Health Network will be provided with documentation of how their AAQS score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the AAQS.

C. CHCN, and each individual Health Network, shall be given a AAQS score from zero (0) to ten (10) based on their performance during the measurement period. CalOptima Health shall utilize the Health Network, or CHCN, AAQS, in numerical sequence, (highest to lowest) as the processing order for Auto-Assignment.

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D. In the event that CHCN's, or a Health Network's, Auto-Assignment is suspended for any reason, CalOptima Health shall distribute that Health Network's, or CHCN's, allocation of Auto-Assigned Members amongst the remaining eligible Health Networks, or CHCN, in a manner that is proportional to each individual Health Network's, or CHCN's, Performance-based Auto-Assignment allocation.

E. CalOptima Health shall score a Health Network for an indicator as long as the Health Network maintains a Contract for Health Care Services for the entire measurement year and is contracted with CalOptima Health at the time of measurement calculation.

F. Performance-based Auto-Assignment allocation for a new Health Network, or CHCN:

1. A new Health Network, for purposes of Auto-Assignment, is considered a Health Network with less than one (1) full measurement year of data during the measurement period. Prior to one (1) full measurement year, a new Health Network will receive three (3.0) points per measure used in the AAQS. When a full year of data is available and an AAQS can be calculated, then the new Health Network shall receive an AAQS based on performance.

2. In the event of a declaration of a "extreme and uncontrollable event" declared by DHCS (such as the previous declarations for regional wild-fires and flooding which adversely impacted ability to collect data and calculate quality scores), there will be no penalties to scores and each HN will receive the better of the current or prior year AAQS.

G. CalOptima Health shall evaluate the performance-based Auto-Assignment allocation methodology for Health Networks and CHCN annually, or upon:

1. Addition, or termination, of a Health Network;

2. A material change; or

3. Change in indicators.

H. CalOptima Health shall notify Health Networks of any changes in the performance-based Auto-Assignment allocation methodology or measures prior to the measurement period.

III. PROCEDURE

A. CalOptima Health shall calculate each measure annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following measurement.

C. The AAQS shall be based on the following eleven (11) measures weighted equally:

Measure	Category
Adult Access to Preventive and Ambulatory Care Visits	HEDIS
Child and Adolescent Well-Care Visits	HEDIS
Childhood Immunization Status- Combination 10	HEDIS
Immunizations for Adolescents- Combination 2	HEDIS
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	HEDIS

Measure	Category
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	HEDIS
Prenatal and Postpartum Care: Postpartum Care	HEDIS
Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS
Cervical Cancer Screening	HEDIS
Getting Care Quickly	CAHPS
Getting Needed Care	CAHPS

D. Healthcare Effectiveness Data and Information Set (HEDIS) performance rates shall be calculated for each Health Network, including CHCN, using administrative data (claims and encounter data). The minimum denominator to report a performance rate shall be thirty (30) Members.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance rates will be calculated based on Member satisfaction surveys fielded by CalOptima Health for each Health Network, including CHCN, according to CalOptima Health Policy GG.1637: Assessing Member Experience.

F. Points will be allocated for each measure based on comparison to the most recent National Committee for Quality Assurance (NCQA) National Medicaid percentiles available at the time of measurement. Point allocation shall be as follows:

Points Earned for Individual Measures	
NCQA Percentile	**Points**
At or above the 75th percentile	10
At or above the 66.67th percentile, below the 75th percentile	8
At or above the 50th percentile, below the 66.67th percentile	6
At or above the 33.33rd percentile, below the 50th percentile	4
At or above the 25th percentile, below the 33.33rd percentile	2
Below the 25th percentile	0

G. A new Health Network, prior to the ability to report performance rates as described in Section II.G.1. of this Policy, shall receive three (3) points per measure.

H. The AAQS is calculated based on the sum of points for each measure divided by the number of reportable measures. The maximum possible AAQS is ten (10) points. Health Networks must report a minimum of three (3) HEDIS measures to generate an AAQS and to participate in Auto Assignment.

I. CalOptima shall calculate eligible and participating Health Network's (including CHCN's) performance-based Auto-Assignment allocation as follows:

1. For each Health Network, derive a score relative to the sum of all AAQS scores for all eligible and participating Health Networks;

2. For each Health Network, calculate the final allocation percentage by multiplying the relative score with the percent of the total Health Network Auto-Assignment in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
C. CalOptima Health Policy GG.1637: Assessing Member Experience

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/14/1995	Regular Meeting of the CalOptima Board of Directors
01/23/1996	Regular Meeting of the CalOptima Board of Directors
12/04/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
10/06/2022	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2009	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2011	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	07/01/2013	AA.1207b	Performance-based Health Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	12/01/2014	AA.1207b	Performance-based Health Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2016	AA.1207b	Performance-based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2017	AA.1207b	Performance-based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207b	Performance-Based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	10/06/2022	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2024	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	05/01/2024	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	TBD	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal

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IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Health Member who does not select a Primary Care Provider (PCP) and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health, Health Network or CalOptima Health Community Network (CHCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

Policy:	AA.1207c
Title:	**Performance-based Community Health Center Auto-Assignment Allocation Methodology**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	07/01/2013
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's methodology for determining a Community Health Center's Auto-Assignment allocation according to performance-based indicators.

II. POLICY

A. CalOptima Health shall auto-assign a Health Network Eligible Member who has not selected a Health Network, or CalOptima Health Community Network, to a Health Network, or CHCN, in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

~~B. CalOptima Health shall auto-assign no less than thirty-seven percent (37%) of eligible Members, not otherwise assigned, and up to forty-five (45%) in accordance with under CalOpt~~CalOptima Health ~~Policy AA.1207a: CalOptima Health Auto-Assignment, to a Health Network, or CHCN, based on the Members' assignment to a Community Health Center as a Primary Care Physician (PCP).~~

~~C.~~B. CalOptima Health shall auto-assign Members to a Community Health Center based on performance metrics established herein and indicators for population served by each Community Health Center.~~.~~

~~D. CalOptima Health shall determine a Community Health Center's performance-based Auto-Assignment allocation, in accordance with indicators listed in the Community Clinic Performance-based Auto-Assignment Allocation Table.~~

~~Indicators listed in the Community Clinic Performance-based Auto-Assignment Allocation Table shall measure the following:~~

~~a. Quality of clinical service; and~~

~~b. Member Experience.~~

~~E. The Community Clinic performance-based Auto-Assignment Allocation Table shall be generated every year~~annually ~~by the CalOptima Health Provider Data Management Services Department. The Allocation Table will include Community Clinic performance on all HEDIS clinical~~auto-assignment

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~~quality measures, provided by Quality Analytics Department, as well as the Member experience survey results that are the part of the P4V program for each measurement year.~~

C. CalOptima Health shall calculate a Community Health Center's performance-based Auto-Assignment allocation as follows:

~~F. For the Auto Assignment program, staff shall maintain Quality Rating methodology approved by the CalOptima Health Board of Directors for Health Networks, consistent with NCQA's validated methodology. Standard quality rating methodology has provided CalOptima Health with one reliable methodology to establish an overall quality rating score for each Health Network and community clinic.~~

~~1.~~ 1. CalOptima Health shall calculate an Auto Assignment Quality Score (AAQS) (scored between zero (0) ~~—~~and ten (10)) for each Community Health Center. A higher score indicates better performance. ~~CalOptima Health shall assign each indicator a weight percent and score based on performance. Each clinic will be assigned a clinic quality rating from 1.0–5.0 (a higher score is better) based on their performance on of the clinical quality measures.~~

1.

2. Annually, each Community Health Center will be provided with documentation of how their AAQS score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the AAQS.

~~G. CalOptima Health shall increase the Community Health Center Auto-Assignment allocation from thirty-seven percent (37%) to a maximum of forty-five percent (45%) of eligible Members based on individual clinic performance and Federally Qualified Health Center (FQHC) participation.~~

~~1. The base Community Health Center Auto-Assignment allocation shall increase by one percent (1%) for each new FQHC, or FQHC Look-Alike, that enters the CalOptima Health program. If a FQHC, or FQHC Look-Alike, terminates from the CalOptima Health program, the base Community Health Center Auto-Assignment allocation shall decrease by one percent (1%), not to fall below thirty-seven percent (37%).~~

~~H.~~D. Each individual Community Health Center shall be given a Clinic rank. The Clinic rank is determined by the Community Health Center's achieved ~~Clinic quality rating~~AAQS which is calculated annually. The Clinic ranking determines the order of the auto-assignment allocation run.

E. The aggregate Community Health Center allocation of auto-assigned Members shall be distributed amongst all eligible Community Health Centers to reflect AAQS score ranking and ~~in such a manner as to ensure that~~ensure Federally Qualified Health Centers (~~-~~FQHCs) and FQHC-Look-Alikes receive twice the allocation of other Community Health Centers.

~~1.~~

~~2. The total allocation of Community Health Center Members shall be initially divided into two (2) groups in order to establish the appropriate distribution of membership to the Community Health Centers so that FQHC's and FQHC Look-Alikes receive twice the allocation as all other Community Health Centers.~~

~~3. The allocation of auto-assigned Members for the FQHCs and FQHC-Look-Alikes shall be evenly distributed amongst all eligible FQHCs and FQHC Look-Alikes.~~

~~4. The allocation of auto-assigned Members for all other Community Health Centers shall be evenly distributed amongst all eligible Community Health Centers.~~

~~I.~~F. CalOptima Health shall evaluate the performance-based Auto-Assignment allocation methodology annually, or upon:

1. Addition, or termination, of a Community Health Center~~linic~~;

2. A material change of a Community Health Center~~linic~~; or

3. Change in indicators.

~~J.~~G. The Community Health Center Auto-Assignment allocation distribution shall be recalculated upon the addition of any new Community Health Centers to the CalOptima Health program. ~~-~~A new Community Health Center, for purposes of Auto-Assignment, is considered a Community Health Center with less than one (1) full measurement year of data during the measurement period. Prior to one full measurement year, a new Community Health Center will receive 3.0 points per measure used in the AAQS. When a full year of data is available and an AAQS can be calculated, then the new Community Health Center shall receive an AAQS based on performance. The established aggregate Auto-Assignment allocation for that calendar year shall be redistributed amongst all eligible Community Health Centers, in accordance with Section III.G. of this policy.

~~K.~~H. CalOptima Health shall notify Health Networks and Community Health Centers of any changes in the performance-based Auto-Assignment allocation methodology~~,~~ or ~~indicators~~measures prior to the measurement period.

III. PROCEDURE

A. CalOptima Health shall calculate each measure annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following measurement.

C. The AAQS shall be based on the following eleven (11) measures weighted equally:

Measure	Category
Adult Access to Preventive and Ambulatory Care Visits	HEDIS
Child and Adolescent Well-Care Visits	HEDIS
Childhood Immunization Status- Combination 10	HEDIS
Immunizations for Adolescents- Combination 2	HEDIS
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	HEDIS
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	HEDIS
Prenatal and Postpartum Care: Postpartum Care	HEDIS
Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS
Cervical Cancer Screening	HEDIS
Getting Care Quickly	CAHPS
Getting Needed Care	CAHPS

D. Healthcare Effectiveness and Data Information Set (HEDIS) performance rates shall be calculated for each Community Health Center using administrative data (claims and encounter data). The minimum denominator to report a performance rate shall be thirty (30) M~~m~~embers.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance rates will be calculated based on M~~m~~ember satisfaction surveys fielded by CalOptima Health according to CalOptima Health P~~p~~olicy GG.1637: Assessing Member Experience. A Community Health Center shall receive the CAHPS score achieved by their affiliated Health Network.

F. Points will be allocated for each measure based on comparison to the most recent National Committee for Quality Assurance (NCQA) National Medicaid percentiles available at the time of measurement. Point allocation shall be as follows:

Points Earned for Individual Measures	
NCQA Percentile	**Points**
At or above the 75th~~th~~ percentile	10
At or above the 66.67th~~th~~ percentile, below the 75th~~th~~ percentile	8
At or above the 50th~~th~~ percentile, below the 66.67th~~th~~ percentile	6
At or above the 33.33rd~~rd~~ percentile, below the 50th~~th~~ percentile	4
At or above the 25th~~th~~ percentile, below the 33.33rd~~rd~~ percentile	2
Below the 25th~~th~~ percentile	0

G. A new Community Health Center, prior to the ability to report performance rates as described in S~~s~~ection ~~K~~II.H. above, shall receive three (3) points per measure.

H. The AAQS is calculated based on the sum of points for each measure divided by the number of reportable measures. The maximum possible AAQS is ten (10) points. Community Health Centers must report a minimum of three (3) HEDIS measures to generate an AAQS and to participate in Auto Assignment.

I. CalOptima Health shall calculate eligible and participating Community Health Center's performance-based Auto-Assignment Allocation as follows:

a. For each Community Health Center, AAQS score is adjusted for FHQC status by applying an FQHC factor – two (2) for FQHC and FHQC-look-alike and one (1) for all others;

b. A relative score to the sum of all Community Health Center adjusted scores is calculated for each Community Health Center;

c. The Adjusted Relative Score is multiplied by the percent of the total Community Health Center Auto-Assignment allocation in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

~~A. CalOptima Health shall measure each indicator annually using the most current data available for the preceding year.~~

~~B. The measurement results shall take effect the year following the measurement.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
~~B.~~C. CalOptima Health Policy GG.1637: Assessing Member Experience

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/03/2011	Regular Meeting of the CalOptima Board of Directors
11/01/2012	Regular Meeting of the CalOptima Board of Directors
12/06/2012	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2013	AA.1207c	Performance-based Community Health Center Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2016	AA.1207c	Performance-based Community Health Center Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2017	AA.1207c	Performance-based Community Health Center Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2023	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2024	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	06/01/2024	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	TBD	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal

IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or to a Health Network or CalOptima Health Community Network.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network or CalOptima Health Community Network; and 3. Ability to function as a Primary Care Provider (PCP).
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Healthcare Effectiveness Data and Information Set (HEDIS)	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

Policy:	AA.1207c
Title:	**Performance-based Community Health Center Auto-Assignment Allocation Methodology**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	07/01/2013
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's methodology for determining a Community Health Center's Auto-Assignment allocation according to performance-based indicators.

II. POLICY

A. CalOptima Health shall auto-assign a Health Network Eligible Member who has not selected a Health Network, or CalOptima Health Community Network, to a Health Network, or CHCN, in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

B. CalOptima Health shall auto-assign Members to a Community Health Center based on performance metrics established herein and indicators for population served by each Community Health Center.

C. CalOptima Health shall calculate a Community Health Center's performance-based Auto-Assignment allocation as follows:

1. CalOptima Health shall calculate an Auto Assignment Quality Score (AAQS) (scored between zero (0) and ten (10)) for each Community Health Center. A higher score indicates better performance.

2. Annually, each Community Health Center will be provided with documentation of how their AAQS score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the AAQS.

D. Each individual Community Health Center shall be given a Clinic rank. The Clinic rank is determined by the Community Health Center's achieved AAQS which is calculated annually. The Clinic ranking determines the order of the auto-assignment allocation run.

E. The aggregate Community Health Center allocation of auto-assigned Members shall be distributed amongst all eligible Community Health Centers to reflect AAQS score ranking and ensure Federally Qualified Health Centers (FQHCs) and FQHC-Look-Alikes receive twice the allocation of other Community Health Centers.

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F. CalOptima Health shall evaluate the performance-based Auto-Assignment allocation methodology annually, or upon:

1. Addition, or termination, of a Community Health Center;

2. A material change of a Community Health Center; or

3. Change in indicators.

G. The Community Health Center Auto-Assignment allocation distribution shall be recalculated upon the addition of any new Community Health Centers to the CalOptima Health program. A new Community Health Center, for purposes of Auto-Assignment, is considered a Community Health Center with less than one (1) full measurement year of data during the measurement period. Prior to one full measurement year, a new Community Health Center will receive 3.0 points per measure used in the AAQS. When a full year of data is available and an AAQS can be calculated, then the new Community Health Center shall receive an AAQS based on performance. The established aggregate Auto-Assignment allocation for that calendar year shall be redistributed amongst all eligible Community Health Centers, in accordance with Section III.G. of this policy.

H. CalOptima Health shall notify Health Networks and Community Health Centers of any changes in the performance-based Auto-Assignment allocation methodology or measures prior to the measurement period.

III. PROCEDURE

A. CalOptima Health shall calculate each measure annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following measurement.

C. The AAQS shall be based on the following eleven (11) measures weighted equally:

Measure	Category
Adult Access to Preventive and Ambulatory Care Visits	HEDIS
Child and Adolescent Well-Care Visits	HEDIS
Childhood Immunization Status- Combination 10	HEDIS
Immunizations for Adolescents- Combination 2	HEDIS
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Prenatal and Postpartum Care: Postpartum Care	HEDIS
Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS
Cervical Cancer Screening	HEDIS
Getting Care Quickly	CAHPS
Getting Needed Care	CAHPS

D. Healthcare Effectiveness and Data Information Set (HEDIS) performance rates shall be calculated for each Community Health Center using administrative data (claims and encounter data). The minimum denominator to report a performance rate shall be thirty (30) Members.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance rates will be calculated based on Member satisfaction surveys fielded by CalOptima Health according to CalOptima Health Policy GG.1637: Assessing Member Experience. A Community Health Center shall receive the CAHPS score achieved by their affiliated Health Network.

F. Points will be allocated for each measure based on comparison to the most recent National Committee for Quality Assurance (NCQA) National Medicaid percentiles available at the time of measurement. Point allocation shall be as follows:

Points Earned for Individual Measures	
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At or above the 33.33rd percentile, below the 50th percentile	4
At or above the 25th percentile, below the 33.33rd percentile	2
Below the 25th percentile	0

G. A new Community Health Center, prior to the ability to report performance rates as described in Section II.H. above, shall receive three (3) points per measure.

H. The AAQS is calculated based on the sum of points for each measure divided by the number of reportable measures. The maximum possible AAQS is ten (10) points. Community Health Centers must report a minimum of three (3) HEDIS measures to generate an AAQS and to participate in Auto Assignment.

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b. A relative score to the sum of all Community Health Center adjusted scores is calculated for each Community Health Center;

c. The Adjusted Relative Score is multiplied by the percent of the total Community Health Center Auto-Assignment allocation in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
C. CalOptima Health Policy GG.1637: Assessing Member Experience

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

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Revised	01/01/2024	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	06/01/2024	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
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MY2025/RY2026/CY2027 Auto Assignment Policy Update

Quality Assurance Committee Meeting

October 9, 2024

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Auto Assignment Background

- CalOptima Health implements an auto-assignment process as a proxy for member selection when members do not actively choose a Health Network and primary care practitioner.
- The auto-assignment process utilizes factors that mimic selection criteria that a member may use when self-selecting.
- These factors include:
  - Geography
  - Previous member affiliation (prior Health Network, community clinic, or provider assignment) if available
  - Member family link (other eligible family members)
  - FQHC status
  - Quality scores

Auto-Assignment Policy Overview

- A process to assign new members who have not voluntarily selected a delegated HN or CCN and who have no other family members in a CalOptima Health Network.
- CalOptima's AA Policy was structured to ensure:
  - Members are assigned to a contracted Health Network to coordinate their care
  - Support Community Health Centers (Community Clinics, FQHCs and FQHC look-alikes)
  - Members have access to providers near their residence
- Community Health Centers (CHCs) receive no less than 37% of the AA allocations. Each new clinic increases the allocation by 1%, not to exceed 45%. If a clinic terminates with CalOptima Health, this decreases the total allocation by 1%, not to fall below 37%.

Quality Scores in Auto Assignment

- Quality scores are used in state Medicaid auto assignment programs in several states including the California Department of Health Care Services (DHCS) in local initiative and geographic managed care counties.
- CalOptima Health has utilized quality scores in its auto assignment program since 2006
- Auto assignment is one of several quality-based incentive programs implemented by CalOptima Health. The other quality-based incentive programs include the Health Network Pay for Value program and Hospital Quality Initiative.

Auto Assignment Quality Score Proposal

- Staff proposes a modified auto assignment quality score based on the following criteria:
  - Establish performance thresholds based on industry standards
  - Select measures based on alignment with DHCS priorities including MCAS MPL, quality withhold, and auto assignment measures
  - Utilize administrative data collection as designated by NCQA
  - Determine minimum eligible population with adequate volume to calculate meaningful rates
  - Include method for new providers to participate before quality scores can be calculated
- Proposed changes apply to providers participating in the auto assignment process including Health Networks and community clinics

MCAS MPL (Managed Care Accountability Set Minimum Performance Level)

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CalOptima Health

MY2025 Auto Assignment Quality Measurement Set

Measure
Adult Access to Preventive and Ambulatory Care Visits
Child and Adolescent Well-Care Visits
Childhood Immunization Status- Combination 10
Immunizations for Adolescents- Combination 2
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits
Prenatal and Postpartum Care: Postpartum Care
Prenatal and Postpartum Care: Timeliness of Prenatal Care
Cervical Cancer Screening
CAHPS- Getting Care Quickly
CAHPS- Getting Needed Care

Auto Assignment Quality Score Methodology

- Measure rates are based on administrative data only, using claims and encounter data
- Minimum denominator of 30 eligible members required to report a rate
- Points will be allocated per reportable auto assignment measure compared to the NCQA National Medicaid percentiles
- Each provider must qualify to report three of the nine HEDIS measures to calculate a quality score for auto assignment.
- Each provider earns an auto assignment quality score based on aggregate scores
- New providers attributed a baseline score of 3.0 points per measure for the first contract year, at a minimum

Points Earned for Individual Measures	
NCQA Percentile	**Points**
At or above the 75th percentile	10
At or above the 66.67th percentile, below the 75th percentile	8
At or above the 50th percentile, below the 66.67th percentile	6
At or above the 33.33rd percentile, below the 50th percentile	4
At or above the 25th percentile, below the 33.33rd percentile	2
Below the 25th percentile	0

The Auto Assignment Quality Score equals sum of points for each measure divided by the total number of reported measures.

Maximum possible score is 10.0

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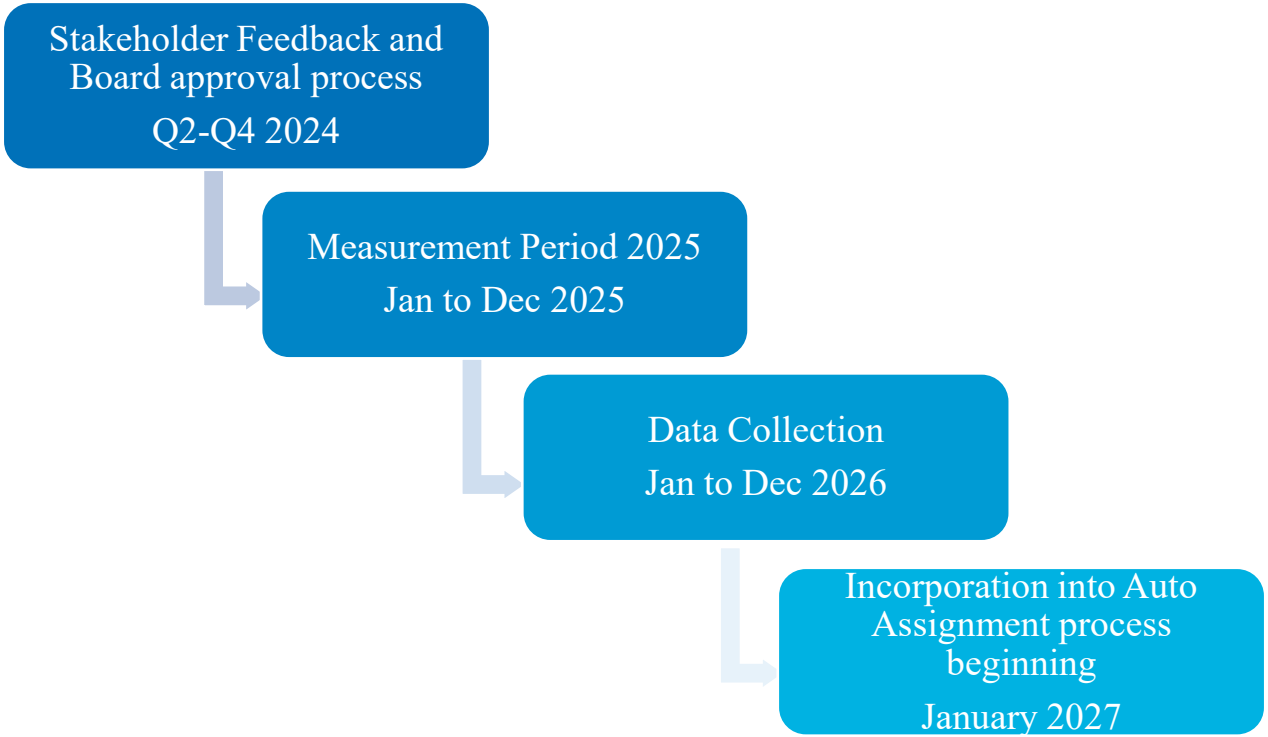
Proposed Implementation Timeline



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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 9, 2024
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

4. Recommend that the Board of Directors Approve CalOptima Health Measurement Year 2025 Medi-Cal and OneCare Pay-for-Value Programs

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Actions

Recommend that the Board of Directors:

1. Approve Measurement Year 2025 Medi-Cal Pay for Value Performance Program for the period effective January 1, 2025, through December 31, 2025.
2. Approve Measurement Year 2025 OneCare Pay for Value Performance Program for the period effective January 1, 2025, through December 31, 2025.
3. Approve the use of unearned Measurement Year 2025 Pay for Value Performance Program funds for quality initiatives and grants.

Background

CalOptima Health's Pay for Value Performance Program (P4V Program) recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health Networks (HNs), including CalOptima Health Community Network (CCN) and HNs' primary care physicians (PCPs) are eligible to participate in the P4V Programs.

The purpose of CalOptima Health's P4V Program is to:

1. Recognize and reward HNs and their PCPs for demonstrating quality performance;
2. Promote adherence to evidence-based practice and improve performance;
3. Provide comparative performance information for members, providers, and the public on CalOptima Health's HN and PCP performance; and
4. Provide industry benchmarks and data-driven feedback to HNs and their PCPs on their quality improvement efforts.

CalOptima Health has aligned P4V Program measures with regulatory requirements and priorities. The Medi-Cal P4V Program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. The OneCare P4V Program utilizes Centers for Medicare & Medicaid Services (CMS) Star HEDIS and CAHPS measures and focuses on measures with the greatest opportunity for improvement.

CalOptima Health staff have obtained feedback from HNs on recommendations to refine and improve the P4V Program by aligning with industry-based programs and by rewarding year-over-year

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improvements. These recommendations are incorporated into the Calendar Year 2025 program elements discussed below.

Discussion

Medi-Cal Pay for Value Program

Staff recommends implementing Measurement Year (MY) 2025 Medi-Cal P4V Program with the following program components:

1. Maintain Integrated Healthcare Association (IHA) pay for performance methodology to assess performance.
    - The methodology uses both attainment and improvement to assess performance and is based on the CMS hospital value-based purchasing model.
    - The greater of either the attainment or improvement score is used to calculate incentive payments.

2. Utilize the MY 2025 DHCS MCAS measures held to MPL for the HEDIS measurement set. Based on preliminary notice from DHCS, MY 2025 Medi-Cal P4V Program will have a total of 25 HEDIS measures. CalOptima Health's P4V Program will adopt the final MY 2025 MCAS MPL measure set upon availability by DHCS.

3. Continue to include CAHPS composites and overall ratings as member experience measures. Utilize both the child and adult CAHPS results, proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

4. Continue to use the National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles as benchmarks.

5. Maintain program funding methodology at ten percent (10%) of professional capitation (base rate only).

6. Corrective Action:
   HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.

7. Application of DHCS Quality Withhold:
   For calendar year 2025, DHCS will apply a quality withhold percent on capitation payments for each Medi-Cal managed care plan. Based on the DHCS quality measures, CalOptima Health will be assessed the amount of withhold payments that may be earned back.

   CalOptima Health will apply the unearned quality withhold percentage in the P4V Program calculation across all HNs and will continue to deduct the percent of unearned DHCS withhold from each HN's earned P4V Program payment.

8. Utilize unearned incentive dollars for quality improvement initiatives in the form of grants to HNs or for CalOptima Health-led initiatives.

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OneCare Pay for Value Program
Staff recommends implementing MY 2025 OneCare P4V Program with the following program components:

1. Adopt the IHA pay for performance methodology as described in the Medi-Cal section above to assess performance.

2. Utilize select CMS Part C and D measures for the P4V Program measurement set. Selected measures are those that have the greatest opportunity for improvement.

3. Continue to use the NCQA Quality Compass National Medicare percentiles as benchmarks.

4. Maintain program funding at $20 per member per month (PMPM).

5. HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.

6. Utilize unearned incentive dollars for quality improvement initiatives in the form of grants to HN or for CalOptima Health-led initiatives.

Measurement Process
CalOptima Health staff calculates the quality rating score for each HN and CCN PCP annually. CCN PCPs must have a minimum of 30 eligible members to report a measure for calculation of the quality rating score. For MY 2025, staff will use the IHA methodology for both Medi-Cal and OneCare. This will enable CalOptima Health to use an industry standard methodology and improve efficiencies by using one standard quality rating methodology. The performance score is derived from the most recently available audited HEDIS, CAHPs, and CMS Star measure data.

MY 2025 Unearned Incentive Dollars
MY 2025 P4V Program funds that remain unused – due to HNs failing to earn the maximum incentive possible or due to forfeitures based on CalOptima Health's failure to achieve the MPL – may be used for quality improvement initiatives. Grants will be available from unearned funds for both Medi-Cal and OneCare.

HNs may apply for grants to utilize incentive dollars for quality improvement initiatives. Grants may be awarded for individual measures or groups of measures targeting similar member populations, for example, well-child visits and childhood immunizations. Grant amounts may range from $50,000 to $500,000 per measure/measure group. Total grant funds to an individual HN shall not exceed the HN's maximum pool funding incentive for each MY, including deduction for DHCS quality withhold application. Grants may not be used to fund administrative staffing nor for capital investments but may be used for staff for direct implementation of quality initiatives.

Staff will provide oversight of grants pursuant to CalOptima Health Policy AA.1400p: Grants Management and will return to the Board of Directors to provide updates on the status of these grants at future meetings.

Eligibility for Incentive Payments

Performance incentive payments are distributed upon final calculation and validation of each measurement rate. To qualify for payments, a HN or their PCPs must be contracted with CalOptima Health during the entire measurement period (January 1, 2025, through December 31, 2025) and the calculation period (January 1, 2026, through June 30, 2026) and in good standing with CalOptima Health, as determined by the Audit and Oversight Department, at the time of disbursement of payment. HNs must distribute a minimum of 85% of their incentive payment to their contracted physicians.

Fiscal Impact

Medi-Cal P4V Program

Staff estimates that the fiscal impact for the MY 2025 P4V Program will be no more than ten percent (10%) of the professional capitation (base rate only) or approximately $97.2 million. Staff will include estimated pool funding for the MY 2025 P4V Program initiatives and grant activities in the Fiscal Year (FY) 2025-26 Operating Budget.

OneCare P4V Program

Staff estimates that the fiscal impact for the MY 2025 OneCare P4V Program will be no more than $20 PMPM or approximately $4.2 million. Staff will include estimated pool funding for the MY 2025 P4V Program initiatives and grant activities in the FY 2025-26 Operating Budget.

Rationale for Recommendation

CalOptima Health strives to continuously improve the quality of care and outcomes for all members. By aligning with industry methodologies for assessing performance and for measurement sets, CalOptima Health aims to minimize HN and provider burden and confusion. CalOptima Health is committed to demonstrating breakthrough improvement in all quality measures, achieving high performing managed care plan status and achieving 5-star rating status. Issuing unearned incentive dollars in the form of grants for quality improvement initiatives will support improvement goals.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

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Attachments

1. CalOptima Health's Measurement Year 2025 Medi-Cal and OneCare Pay for Value Programs
2. Measurement Year 2025 Pay for Value Program Proposal

/s/ Michael Hunn *10/04/2024*
Authorized Signature **Date**

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CalOptima Health Measurement Year (MY) 2025
Medi-Cal and OneCare Pay for Value Programs

MY2025 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the Medi-Cal P4V program.

Recommended for MY2025 Medi-Cal P4V

1. Include measures held to an MPL in the MY2025 MCAS measure set.

MY 2025 Medi-Cal Pay for Value Program Measurement Set	
Measure Category	**Measure**
HEDIS	Follow-up After ED Visit for Mental Illness- 30 days
	Follow-Up After ED Visit for Substance Abuse- 30 days
	Child and Adolescent Well-Care Visits
	Childhood Immunization Status- Combination 10
	Development Screening in the First Three Years of Life
	Immunizations for Adolescents- Combination 2
	Lead Screening in Children
	Topical Fluoride in Children
	Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits
	Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits
	Asthma Medication Ratio
	Controlling High Blood Pressure*
	Glycemic Status Assessment for Patients with Diabetes (>9%) lower is better*
	Chlamydia Screening in Women
	Prenatal and Postpartum Care: Postpartum Care
	Prenatal and Postpartum Care: Timeliness of Prenatal Care
	Breast Cancer Screening
	Cervical Cancer Screening
	Colorectal Cancer Screening
	Depression Remission or Response for Adolescents and Adults
	Depression Screening and Follow-Up for * Adolescents and Adults
	Pharmacotherapy for Opioid Use Disorder
	Postpartum Depression Screening and Follow Up
	Prenatal Depression Screening and Follow Up
	Prenatal Immunization Status
CAHPS	CAHPS- Rating of Health Plan: Adult and Child

	CAHPS- Rating of Health Care: Adult and Child
	CAHPS- Rating of Personal Doctor: Adult and Child
	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
	CAHPS- Getting Needed Care: Adult and Child
	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

- Utilize both the child and adult CAHPS results, proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

2. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
3. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points
       - Scale of 0-10 points
       - Points based on performance between 50th percentile and 95th percentile.
       - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
     - Improvement Points
       - Scale of 0-10 points
       - Points reflect performance in the prior year compared to the current year.
       - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
   - National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
   - Measure weighting
     - HEDIS measures weighted 1.0
     - CAHPS measures weighted 1.5
   - Performance incentive allocations will be distributed upon final calculation and validation of and each provider's performance.

CalOptima Health Measurement Year (MY) 2025
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on areas with the greatest opportunity for improvement and incentivizes performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

1. Utilize the following CMS Star Part C and Part D measures and measure weights:

MY 2025 OneCare Pay for Value Program Measurement Set	
Measure Category	**Measure**
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Statin Therapy for Patients with Cardiovascular Disease
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan
Part D HEDIS	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
Part D Member Experience	Rating of Drug Plan
	Getting Needed Prescription Drugs

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points
       - Scale of 0-10 points
       - Points based on performance between 50th percentile and 95th percentile.
       - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
     - Improvement Points
       - Scale of 0-10 points
       - Points reflect performance in the prior year compared to the current year.
       - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
   - National Committee for Quality Assurance (NCQA) Quality Compass National Medicare percentiles used as benchmarks.
   - Measure weighting
     - HEDIS process measures weighted 1.0
     - CAHPS measures weighted 2.0
     - Outcome measures weighted 3.0
   - Performance incentive allocations will be distributed upon final calculation and validation of and each provider's performance.

3. Program funding of $20 PMPM

MY2025 Pay for Value Program Proposal

Quality Assurance Committee Meeting

October 9, 2024

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

CalOptima Health
P4V Program Principles

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CalOptima Health P4V Program Principles

- Use industry standard measures aligned with product regulatory requirements i.e. DHCS MCAS and CMS Star measurement sets
- Align with DHCS Minimum Performance Levels (MPL)
  - Set minimum benchmark at 50th percentile
  - CalOptima Health may issue financial sanctions to health networks (HN) if CalOptima Health is issued a sanction
  - Align with DHCS Quality Withhold
- Align with CMS Star measurement set
- Assess performance on HN improvement and achieving benchmarks
- Require HNs to implement physician-level incentives
- Encourage continuous quality improvement by providing grant funding for lower performing measures

MY2025 P4V Program Components

MY2025 Incentive Pool

- Medi-Cal:
  - Ten percent of professional capitation (base rate only)
  - Estimated at $73.9 million

- OneCare:
  - $20pmpm
  - Estimated at $4.3 million

MY2025 P4V Program Elements

- Measure Sets
  - Medi-Cal: Align with DHCS MCAS MPL and Quality Withhold measures
    - Utilize NCQA National Medicaid percentiles
    - Utilize both Child and Adult CAHPS rates
  - OneCare: Align with CMS Star measures
    - Utilize NCQA National Medicare percentiles
- Measure Weights
  - Align with industry measure weights, where applicable
  - Clinical measures = 1.0
  - Medi-Cal Member experience measures = 1.5
  - OneCare Member experience measures = 2.0*
- Data Collection Methodology
  - To promote adoption of electronic clinical data sets, utilize administrative data

*CMS has proposed dropping the member experience weight for 2026 stars

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Performance Methodology and Benchmarks

- Adopt Integrated Healthcare Association (IHA) scoring method
  1. Performance points are calculated by comparing HN score to benchmarks, starting at the 50th percentile
  2. Performance points are also calculated by comparing a HN's prior year score to current score
- Use option 1 or 2, selecting option with higher number of points
- Medi-Cal
  - Based on NCQA National Medicaid Percentiles
- OneCare
  - Based on NCQA National Medicare Percentiles

Health Network Corrective Action

- Corrective action: HN scoring below the MPL must submit a corrective action plan

Unearned Incentive Dollars

- Issue quality grants using unearned dollars
- Grants will be used to improve individual or groups of measures
- Funds used for quality improvement efforts including staff directly involved with quality initiatives
- Health Networks submit a plan, subject to quarterly monitoring
  - Must meet implementation requirements to continue to access improvement funds
- CalOptima Health will implement delivery system-wide interventions with remaining incentive dollars

Appendix

MY2025 Medi-Cal Measurement Set

Measure	DHCS MPL	DHCS Quality Withhold	PV4 Program
Follow-up After ED Visit for Mental Illness- 30 days	X		X
Follow-Up After ED Visit for Substance Abuse- 30 days	X		X
Child and Adolescent Well-Care Visits	X	X	X
Childhood Immunization Status- Combination 10	X	X	X
Development Screening in the First Three Years of Life	X		X
Immunizations for Adolescents- Combination 2	X	X	X
Lead Screening in Children	X		X
Topical Fluoride in Children	X		X
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	X	X	X
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Two or More Well-Child Visits	X	X	X
Asthma Medication Ratio	X		X
Controlling High Blood Pressure*	X	X	X
Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) lower is better*	X	X	X

*Measure rate may include findings from medical record review

Measure set subject to change until DHCS issues final MY25 MCAS MPL set

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MY2025 Medi-Cal Measurement Set

Measure	DHCS MPL	DHCS Quality Withhold	PV4 Program
Chlamydia Screening in Women	X		X
Prenatal and Postpartum Care: Postpartum Care	X	X	X
Prenatal and Postpartum Care: Timeliness of Prenatal Care	X	X	X
Breast Cancer Screening	X		X
Cervical Cancer Screening	X		X
Colorectal Cancer Screening	X		X
Depression Remission or Response for Adolescents and Adults	X		X
Depression Screening and Follow-Up for Adolescents and Adults	X		X
Pharmacotherapy for Opioid Use Disorder	X		X
Postpartum Depression Screening and Follow Up	X		X
Prenatal Depression Screening and Follow Up	X		X
Prenatal Immunization Status	X		X

Measure rate may include findings from medical record review

Measure set subject to change until DHCS issues final MY25 MCAS MPL set

*

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MY2025 Medi-Cal Measurement Set

Measure	DHCS MPL	DHCS Quality Withhold	PV4 Program
CAHPS- Rating of Health Plan: Adult and Child		X	X
CAHPS- Getting Needed Care: Adult and Child		X	X
CAHPS- Getting Care Quickly: Adult and Child			X
CAHPS- Coordination of Care: Adult and Child			X
CAHPS- Rating of Personal Doctor: Adult and Child			X
CAHPS- Rating of Specialist Seen Most Often: Adult and Child			X
CAHPS- Rating of Health Care: Adult and Child			X

Measure rate may include findings from medical record review

*Measure set subject to change until DHCS issues final MY25 MCAS MPL set

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MY2025 OneCare Measurement Set

Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Statin Therapy for Patients with Cardiovascular Disease
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan

* Measure rate may include findings from medical record review

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MY2025 OneCare Measurement Set

Measure Category	Measure
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
	Rating of Drug Plan
	Getting Needed Prescription Drugs

Performance Scoring Methodology

- Adopt Integrated Healthcare Association (IHA) scoring method
- Attainment and Improvement score calculated for each measure
  - The better of the two scores is used.
- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 9, 2024
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

5. Recommend that the Board of Directors Approve Recommendations for the Chair and Vice Chair Appointments to the Whole-Child Model Family Advisory Committee

Contact

Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Recommend that the Board of Directors appoint Lori Sato as Chair and Erika Jewell as the Vice-Chair of the Whole-Child Model Family Advisory Committee to each serve a two-year term through November 5, 2026.

Background

The CalOptima Health Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC) by Resolution No. 17-1102-01 on November 2, 2017, to serve solely in an advisory capacity, providing input and recommendations concerning the Whole-Child Model program. The WCM FAC is comprised of 11 voting members, seven of whom are designated as family representatives and four of whom are designated as community seats representing the interests of children receiving services from California Children's Services (CCS).

Pursuant to Resolution No. 20-0806, the CalOptima Health Board of Directors is responsible for the appointment of the WCM FAC Chair and Vice Chair biennially from among appointed members. The Chair and Vice Chair may serve a two-year term.

Discussion

WCM FAC members were asked to submit a letter of interest in the open Chair and Vice-Chair positions. WCM FAC Authorized Family member Lori Sato and Community-Based Organization member Erika Jewell each submitted a letter of interest for these positions. At the September 24, 2024, WCM FAC meeting, the committee voted to recommend that the Board of Director's Quality Assurance Committee recommend that the Board of Directors approve Ms. Sato as the Chair and Ms. Jewell as Vice-Chair of the committee.

WCM FAC Chair Candidate

Lori Sato

Ms. Sato is the mother of a special needs child who currently receives CCS and Medi-Cal services. Ms. Sato has learned to navigate new systems to better advocate for children with special needs. She is familiar with medical therapy units for various therapies (physical and occupational) and for special equipment needs by CCS children. Ms. Sato has been a member on the committee since July 2022.

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WCM FAC Vice Chair Candidate
Erika Jewell

Ms. Jewell currently holds a Community-Based Organization seat on the WCM FAC and has been on the committee since 2022. She is the Manager for Case Management at Children's Hospital Orange County and has a good working knowledge of the needs of the WCM FAC.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Open nominations were held at the September 24, 2024, WCM FAC meeting based on the letters of interest received. There were no additional nominations from the floor. The WCM FAC forwards the recommended Chair and Vice Chair candidates to the Board of Directors' Quality Assurance Committee for consideration and recommended appointment by the Board of Directors.

Concurrence
Whole-Child Model Family Advisory Committee
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *10/04/2024*
Authorized Signature **Date**

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Board of Directors'
Quality Assurance Committee Meeting
October 9, 2024

PACE Member Advisory Committee Update

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

June 26, 2024: PMAC Meeting Summary

Updates from the Director
Director Monica Macias thanked PMAC members for joining the meeting in person. Members were updated on the status of the program, open positions, respiratory illnesses updates, and transportation. The director welcomed new members who were joining us for the first time. Director updated members on our continued growth and projected census to be at 500 by July. In addition, they were provided with an update of a new addition of a fifth Interdisciplinary Team to support the growth. Participants expressed concerns around transportation and scheduling outside appointments, more so with the growth. Director mentioned that we are looking at these two areas closely and plan on adding resources.

Respiratory Illness Updates
Jennifer Robinson, Quality Improvement Manager, provided updates related to respiratory illnesses and heat related tips to stay cool/hydrated. Jennifer reviewed symptoms related to heat stroke and heat exhaustion. Finally, members were reminded that the PACE clinic provides vaccinations for both Flu and COVID.

PMAC Member Forum

- Participants mentioned that transportation continues to be a concern.
- The participants would like to have a review of the scheduling process.
- Participants expressed feeling content about the growth and want to ensure we have the proper resources in place.

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Board of Directors'
Quality Assurance Committee Meeting
October 9, 2024

Regular Meeting of the
Whole-Child Model Family Advisory Committee
Report to the Quality Assurance Committee

On June 18, 2024 the Whole-Child Model Family Advisory Committee (WCM FAC) conducted its quarterly meeting in-person and telephonically using Zoom Webinar technology.

In addition to approving WCM FAC quarterly schedule for FY 2024-2025, the committee received the following presentations:

Linda Lee, Executive Director, Quality Improvement, provided an update on quality improvement projects that affect CalOptima Health members in both OneCare and Medi-Cal. She noted that the Department of Health Care Services (DHCS) requires CalOptima Health to engage in several quality improvement projects on an annual basis and that some of those projects are selected by DHCS based on statewide priorities. Ms. Lee reviewed several of the projects with the committee and answered many questions.

Cheryl Meronk, Director, Medicare Program Operations, and Hannah Kim, Director, Case Management, presented on the OneCare Program. Ms. Meronk presented an overview on the benefits of the OneCare Program, which is for dually eligible Medicare and Medi-Cal recipients (Medi-Medi). Ms. Meronk noted that in many cases that children with special needs would qualify for Medicare under their parent's Medicare record and would be eligible to become a OneCare member with their existing Medi-Cal. Ms. Kim reviewed the case management criteria of being a patient in the OneCare program, noting that typically Medicare does not have case management support; however, because on the Medi-Cal side under OneCare they are able to receive case management support to its members.

Yunkyung Kim, Chief Operating Officer, updated the committee on the draft strategic plan for CalOptima Health and asked Michell Nielsen to present on her behalf. Ms. Nielsen reviewed the five components of the revised strategic plan. She noted that they had expanded the plan into a more comprehensive strategic plan framework which included mission, vision and values. She also reviewed the three-year organizational goals with measurable objectives by setting targets which will be used for performance measurements. Ms. Nielsen asked for feedback on several items she discussed.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, presented on how Measles and Pertussis are making a comeback and stressed the importance of vaccines. He noted that in 2023 there were 58 cases of the measles in the United States and that number in the first four months of 2024 measles cases had risen to 138. For Pertussis also known as Whooping Cough he noted that approximately 20 babies per year died in the United States between 2010 – 2020.

Michael Hunn, Chief Executive Officer thanked the members of the committee for their time in service to CalOptima members. He asked the members to please reach out to Cheryl Simmons with any feedback they might have on the strategic plan draft.

The WCM FAC appreciates and thanks the CalOptima Board Directors' Quality Assurance Committee for the opportunity to present input and updates on its current activities.

Board of Directors'
Quality Assurance Committee Meeting
October 9, 2024

Regular Meeting of the
Whole-Child Model Family Advisory Committee
Report to the Quality Assurance Committee

On September 24, 2024 the Whole-Child Model Family Advisory Committee (WCM FAC) conducted its quarterly meeting in-person and telephonically using Zoom Webinar technology.

The committee held nominations for the Chair and Vice Chair and voted on a recommendation to appoint Lori Sato as the Chair and Erika Jewell as the Vice-Chair.

Doris Billings, Program Manager and Chief Therapist, California Children Services (CCS) program in Orange County. Ms. Billings noted that CalOptima Health and CCS held a joint training in July for health networks and community providers on the WCM concept and the CCS program with the goal to share roles and responsibilities of both the managed care plan and CCS and to provide information on established policies. She also noted that in July CCS had implemented the Newborn Gateway Program for babies in the Neonatal Intensive Care Unit (NICU) who would now be assigned their own Client Index Number (CIN) versus assuming their mother's CIN number. Ms. Billings also discussed how the CCS program throughout the State continues to experience ongoing budget allocation challenges with increased shortfalls to the counties. She noted that CCS has seen decreases in budget allocations for the last three years; however, the continue to serve the CCS population to the best of their ability.

Veronica Carpenter, Chief Administrative Officer, and Donna Laverdiere, Executive Director, Strategic Development, jointly presented on Covered California. Ms. Carpenter and Ms. Laverdiere provided an overview on how CalOptima Health is re-exploring the possibility of joining Covered California in 2026. They both reviewed the background on Covered California and talked about the added value for CalOptima Health's participation in Covered California for those low-income residents of Orange County.

Yunkyung Kim, Chief Operating Officer, thanked the committee for their feedback on initiatives that are working and those that are not achieving the desired impact, as well as what CalOptima Health could improve upon with regard to care for some of the most at-risk children. Ms. Kim also reviewed the quality incentive grants for eligible providers currently contracted with CalOptima Health. She noted that approximately $80 million in quality Pay-For-Value payments has been allocated for these quality

incentives so that when health networks or physicians achieve certain quality metrics, they receive an additional payment to again thank them for helping CalOptima Health maintain a high level of quality for all of our members. Ms. Kim also noted that the quality grants would also be available soon for the OneCare line of business.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, presented a Communicable Disease Update that included Mpox, Syphilis and other communicable diseases that are on CalOptima Health's radar. He reviewed Mpox and Syphilis trends and answered questions from the committee.

Michael Hunn, Chief Executive Officer, reviewed the Fast Facts report with the committee and answered questions about budget allocations contained in the report.

The WCM FAC appreciates and thanks the CalOptima Board Directors' Quality Assurance Committee for the opportunity to provide input and updates on its current activities.

Overview of Quality Improvement

Quality Assurance Committee Meeting
October 9, 2024

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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- Background
- CalOptima Health Quality Program
- Program Summaries and Updates
  - Star Rating Systems
  - Healthcare Effectiveness Data and Information Set (HEDIS®)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Network Adequacy
  - Timely Access
  - Provider Satisfaction

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Background

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Background

- Quality is a foundational priority for members, health care regulators, payers, providers and stakeholders
- Quality in health care has been defined by industry experts, regulators and stakeholders
- The Institute of Medicine (IOM) of the National Academy of Sciences was the first to define quality health care as “safe, effective, patient-centered, timely, efficient and equitable”
- The Agency for Healthcare Research and Quality (AHRQ) defines quality health care “as doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results”
- Key to quality is measurement, transparency and accountability

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Quality Program Regulatory Requirements

- The Centers for Medicare & Medicaid Services (CMS) developed a national quality strategy to ensure that members have access to a high-value health care system measured by quality outcomes, safety, equity and accessibility for all
- The California Department of Health Care Services (DHCS) developed a comprehensive quality strategy in 2022 that is aligned with CMS goals
- Both CMS and DHCS require the collection and reporting of quality performance measures, including HEDIS, CAHPS and Health Outcomes Survey (HOS)
- CMS and DHCS post quality scores for public transparency and to inform stakeholders
- Consequences for failing to meet quality goals may result in sanctions, corrective action and contract non-compliance

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CalOptima Health Quality Program

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CalOptima Health Quality Components

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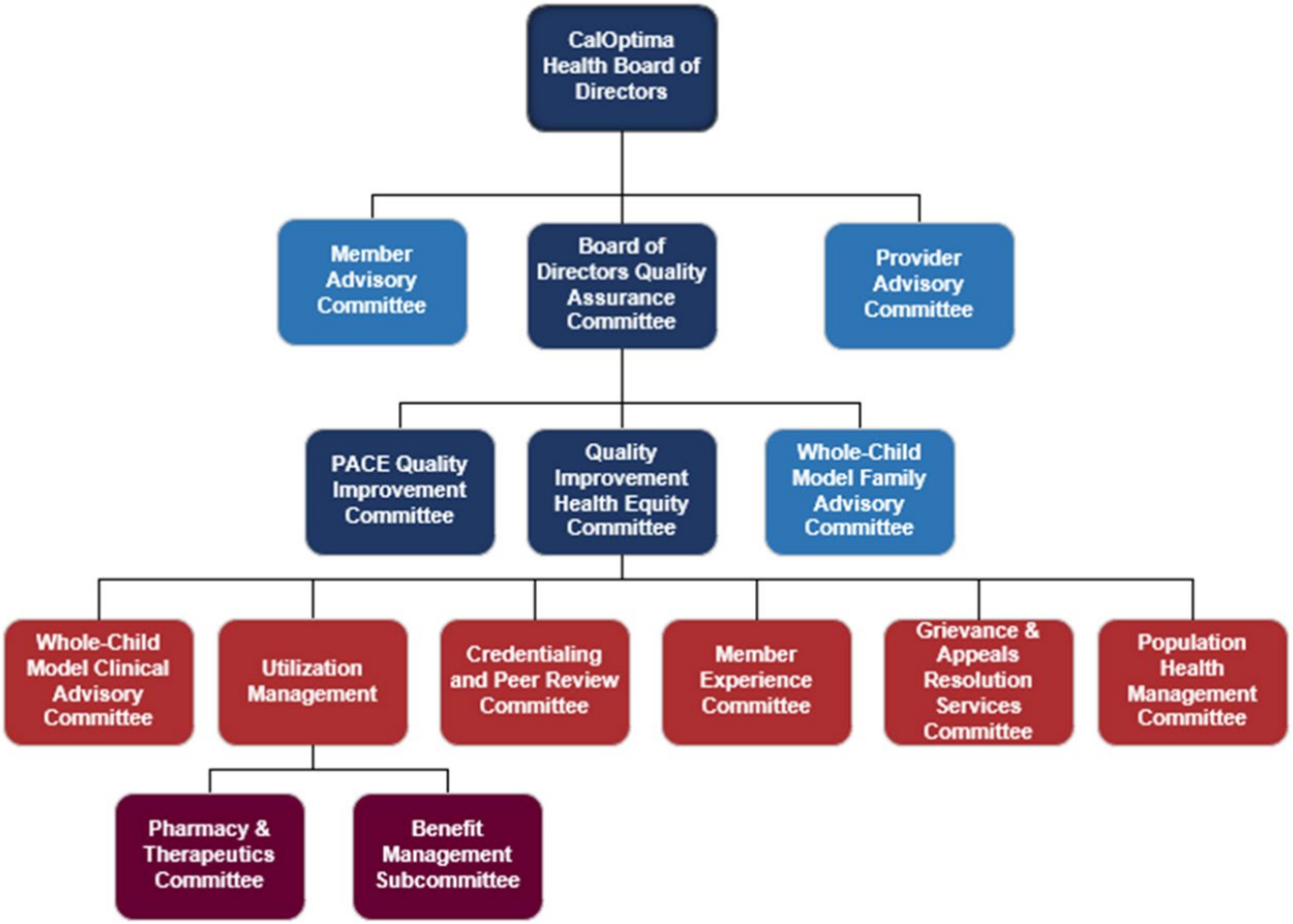
Quality Improvement and Health Equity Governance



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Quality Program Documents and Policies

Program	Work Plan	Evaluation
• Overview of strategy, resources, programs and initiatives • Operational policies including credentialing, potential quality issues and facility site review	• Detailed work plan of activities, progress updates, timelines, resources, and outcomes to implement quality program • Updated quarterly	• Results and program evaluation • Descriptive analysis of impact, barriers and achievement of program goals • Sets priorities and goals for the following year

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Quality Initiatives and Projects

- Activities to improve outcomes and metrics are identified through analysis, comparison to goals, health disparities and stakeholder feedback
- Activities may be formal quality improvement projects or business initiatives
- Metrics and benchmarks are utilized to monitor impact of activities
- Includes quality programs such as accreditation, value-based payments, auto assignment, member health rewards, etc.

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CalOptima Health

Quality Measurement

Quality of Care

- HEDIS
- Over and under utilization
- Health Outcomes Survey
- Patient safety
- Sentinel events
- Key Performance Indicators: potential quality issues, credentialing, facility site review

Quality of Service

- Member experience/CAHPS
- Grievances
- Appeals
- Provider satisfaction

Access to Care

- Network adequacy
  - Time and distance
  - Member-to-provider ratios
- Timely access
  - Appointment wait times
  - Telephone wait times

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Program Summaries and Updates

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Star Rating Systems

- Both CMS and NCQA utilize quality measures to rate health plans. Measures are based on clinical guidelines (HEDIS), member experience (CAHPS), health outcomes (HOS), medication safety, and health plan administration. The measure rates are compared to national benchmarks and converted to stars for ease of consumer comparison.

Quality Rating	Medi-Cal Accountability Set	Medicare Stars	NCQA Health Plan Rating
Scope	Medi-Cal	Medicare (OneCare)	Medi-Cal
Program Elements	HEDIS CMS Quality Measures	HEDIS CAHPS HOS Health Plan Administration Medication Safety	HEDIS CAHPS
CalOptima Health Overall Rating	Not applicable	2023 – 3.0 2024 – 3.0	2023 – 4.0 2024 – 3.5

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HEDIS

- HEDIS was developed by the National Committee for Quality Assurance (NCQA) to standardize quality measurement with more than 90 measures across six domains:
  - Effectiveness of care
  - Access/availability of care
  - Experience of care
  - Utilization/risk-adjusted utilization
  - Health plan descriptive information
  - Measures reported using electronic clinical data systems
- Allows for transparent reporting of quality measures and accountability
- Widely adopted to assess health plan and provider quality
- CMS and DHCS use HEDIS measures for assessing quality performance in Star Ratings, Medi-Cal Accountability Set (MCAS) minimum performance levels (MPL) and quality withholds

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HEDIS

Requirements	Impact on Quality Programs	Monitoring
• Annual reporting of audited rates to DHCS, CMS and NCQA	• HEDIS results impact MCAS MPL, Medi-Cal quality withhold, CMS Stars, CMS quality bonus payment and NCQA Health Plan rating	• Monthly prospective rate reports and clinical care gaps

2024 Priority: Enhance reporting capabilities through selection and implementation of new HEDIS reporting vendor.

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CalOptima Health

MY2023 Medi-Cal Results Summary

- 16 out of 18 Medi-Cal measures achieved the MPL
  - Two measures did not meet the MPL
    - Follow-up After ED Visit for Alcohol and Other Drug Dependence Within 30 days (FUA)
    - Follow-up After ED Visit for Mental Illness Within 30 days (FUM)
- NCQA Health Plan Rating 2024 — 3.5 rating
  - HEDIS Prevention measures maintained 4.0 rating
  - HEDIS Treatment measures decreased to 3.0 rating
  - CAHPS Patient Experience measures improved to 2.5 rating

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CalOptima Health

Medicare Results Summary (OneCare)

- HEDIS Star Ratings measures projected to improve compared with prior year
  - Projected to reach 4 Stars*
    - Controlling High Blood Pressure (CBP)
    - Care for Older Adults (COA – Pain assessment)
    - Diabetes Care – Blood Sugar Controlled (HBD)
    - Transitions of Care (TRC – Med Reconciliation)
  - Projected to reach 3 Stars*
    - Statin Therapy for Patients with Cardiovascular Disease (SPC)
- HEDIS Star Ratings measures projected to decline compared with prior year
    - Plan All-Cause Readmissions (PCR)

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HEDIS Improvement Activities

- Conduct omnichannel member outreach for education, appointment reminders and care gap closure
- Offer member incentive rewards to promote preventive screenings and chronic care tests
- Share care gap reports with health networks and CalOptima Health Community Network PCPs
- Educate providers on best practices to improve lagging measures
- Conduct collaborative quality work groups with health networks to share best practices and commit to joint interventions
- Implement virtual behavioral health provider visits to improve timely access to appointments
- Partner with community-based organizations to promote screenings and services

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CalOptima Health

Member Satisfaction

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized survey tool to assess member experience with the health care system
- CAHPS was developed and is maintained by the Agency for Healthcare Research and Quality (AHRQ)
- Distinct survey tools for health plans, hospitals, provider groups and home/community-based services
- CalOptima Health fields both child and adult CAHPS surveys at the plan level and health network level
- CAHPS questions are organized into composites, ratings and single questions
- CAHPS results are used in quality programs, i.e., Stars, accreditation

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Member Satisfaction

Requirements	Impact on Quality Programs	Monitoring
• Annual Medicare survey • Annual DHCS survey: adult and child	• CAHPS composites and ratings are used in Medicare Star Ratings • CAHPS composites are part of DHCS quality withhold program	• Annual fielding of health network-level surveys • Results used in health network pay for value and auto assignment

2024 Priority: Implemented predictive analytics to identify actionable members for "just in time" outreach. Leverage omnichannel outreach to improve member experience.

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CalOptima Health

Medi-Cal CAHPS Results

CAHPS Measure	MY2023 Results
Getting Needed Care	★★
Getting Care Quickly	★★
Rating of Primary Care Doctor	★★★
Rating of Health Care	★★★
Rating of Health Plan	★★

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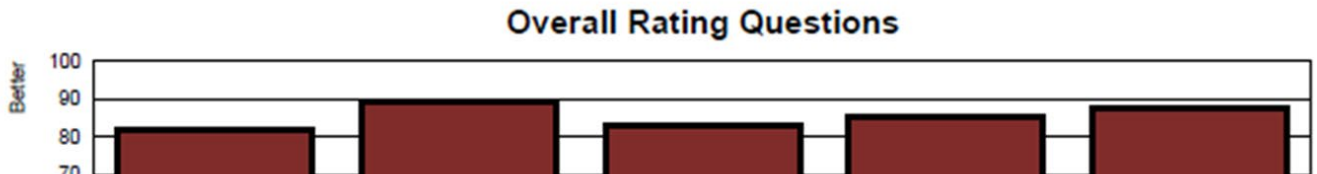
CalOptima Health

OneCare CAHPS Results



	Q9. Rating of health care quality	Q17. Rating of personal doctor	Q31. Rating of specialist seen most often	Q38. Rating of health plan	Q47. Rating of drug plan
OneCare	81.9%	89.0%	82.9%	85.0%	87.4%
Rating Score (Percentile)	1 (<15th)	NA	NA	2 (≥15th to <30th)	4 (≥60th to <80th)

NA: Pecentiles not published by CMS

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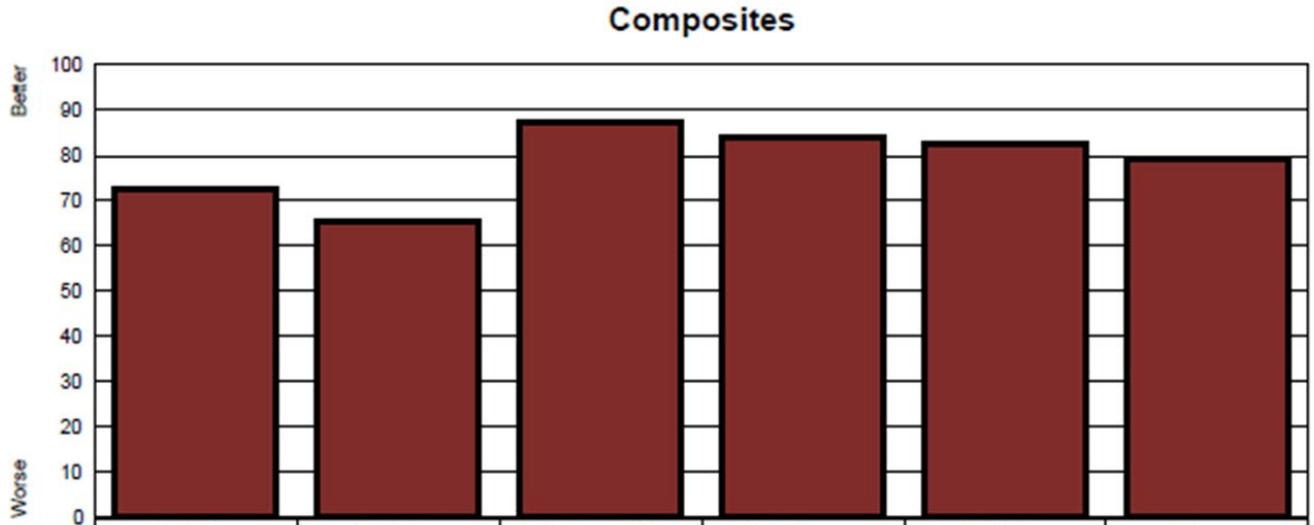
CalOptima Health

OneCare CAHPS Results



	Getting Needed Care	Getting Appointments and Care Quickly	Doctors Who Communicate Well	Customer Service	Getting Needed Prescription Drugs	Care Coordination
OneCare	72.5%	65.5%	87.1%	84.2%	82.8%	79.3%
Rating Score (Percentile)	1 (<15th)	1 (<15th)	NA	1 (<15th)	1 (<15th)	1 (<15th)

NA: Pecentiles not published by CMS

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CalOptima Health

CAHPS Improvement Activities

- Conducted outreach in January 2024 to Medi-Cal and OneCare members to promote access to annual well care visit
- Convening member sentiment focus groups to identify member pain points, solicit direct feedback and identify ways to improve
- Conducting a series of practice site improvement webinars
  - Completed
    - May 8 – Leading to a Positive Patient Experience
    - May 22 – Managing Challenging Situations With Patients
    - June 5 – Efficient and Effective Patient Encounters
  - Upcoming
    - October 16 – Building a Highly Effective Health Care Team
    - October 23 – Improving Service Excellence Through Successful Telephone Communication
    - October 30 – Improving Patient Access and Flow

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CalOptima Health

Network Adequacy

- Network adequacy criteria establishes minimum count, full time equivalent (FTE), and time and distance standards for mandatory provider types
- CMS sets standards based on defined county designations for provider and facility specialty types
- CMS conducts triennial network adequacy review unless there is a triggering event, such as an application, network gap or significant provider termination
- DHCS established member-to-provider ratios, and time and distance standards for providers and facilities

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CalOptima Health

Network Adequacy

Requirements	Impact on Quality Programs	Monitoring
• DHCS Annual Network Certification (ANC): Plan level for Medi-Cal • Sub-Delegate Network Certification (SNC) and Corrective Action Plans • Quarterly Network Adequacy Summary Reports	• Network Adequacy results impact Medi-Cal member accessibility, DHCS ANC and SNC submission	• Annually monitor all functional areas delegated to subcontractors for network adequacy • Must impose corrective action plan on subcontractors upon discovery of noncompliance and report to DHCS

2024 Priority: Working with health networks to identify deficiencies to close gaps for access and availability.

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CalOptima Health

Medi-Cal Areas of Deficiencies and Non-Compliance

	FTE	Provider to Member Ratios	Time or Distance*
	Q3 2024	Q3 2024	Q3 2024
Medi-Cal Plan level	Met	Not Met 3/11 Gastroenterology, Orthopedic Surgery & LMFT	Met
AltaMed Health Services	Met	2/10 Not Met Ob/Gyn & Ophthalmology	Not Met
AMVI Medical Group	Met	2/10 Not Met Neurology & Pulmonology	Not Met
CalOptima Health Community Network	Met	Met	Not Met
CHOC Health Alliance	Met	Met	Not Met
Family Choice Health Services	Met	Met	Not Met
HPN – Regal Medial Group	Met	Met	Not Met
Noble Mid-Orange County	Met	Met	Not Met
Optum	Met	3/10 Not Gastroenterology, Ophthalmology & Orthopedic Surgery	Not Met
Prospect Medical Group	Met	Met	Not Met
United Care Medical Group	Met	Met	Not Met

Data source: August 274 file

*Time or Distance Q3 2024: methodology (assigned membership)

Medi-Cal Plan level & All Health Networks Met FTE Provider to Member Ratio Standards: PCP = 1:2000 & Physician = 1:1200

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CalOptima Health

Medi-Cal Time/Distance – Plan & HN Level: Q3 2024

Spec	Plan	AltaMed	AMVI	CHCN	CHOC	Family Choice	Regal	Optum	Noble	Prospect	UCMG
Adult Primary Care	0	0	15	0	0	0	0	0	12	0	0
Pediatric Primary Care	0	0	0	0	0	0	0	0	0	0	0
Hospitals	0	0	0	0	0	0	0	0	0	0	0
Pharmacies	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OB/GYN Specialist	0	0	15	0	0	14	13	0	0	11	0
Cardiology/Interventional Cardiology	0	0	1	0	0	23	0	0	0	0	0
Dermatology	0	1	0	0	0	18	0	0	0	0	86
Endocrinology	0	26	31	0	0	23	19	0	23	13	0
ENT/Otolaryngology	0	2	1	0	0	0	2	0	0	1	9
Gastroenterology	0	0	34	0	0	0	0	0	0	0	0
General Surgery	0	0	0	0	0	0	0	0	0	0	0
Hematology	0	0	0	0	0	28	3	2	0	0	0
HIV/AIDS Specialist/Infectious Diseases	0	0	26	0	2	3	27	0	16	0	0
Nephrology	0	0	2	0	0	1	2	2	5	6	0
Neurology	0	4	30	0	0	25	0	0	0	19	3
Oncology	0	0	0	0	0	4	0	2	0	0	0
Ophthalmology	0	0	0	0	0	0	0	0	0	0	0
Orthopedic Surgery	0	0	0	2	1	0	38	2	0	0	0
Physical Medicine & Rehabilitation	0	1	32	2	1	29	31	0	14	32	38
Pulmonology	0	0	35	0	0	1	29	0	0	0	0
Psychiatry	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mental Health Outpatient Providers	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Number of Zip Codes Not Met	0	**34↓**	**222↓**	**4↑**	**4↓**	**116↓**	**119↓**	**8↓**	**70↓**	**82↓**	**136↑**

Internally developed standards in GG 1600

For Time/Distance: Assigned membership methodology has been used to run Q3 report (RED = Number of non-compliant ZIP codes)

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CalOptima Health

Network Adequacy Improvement Activities

- Network Adequacy workgroup reviewed deficiencies and identified action items
  - CalOptima Health issued corrective action plans to health networks
  - Conducted audits of health network actions from June to August
  - CalOptima approved Alternative Access Standards (AAS) requests (4 out of 6 health networks)
  - Health networks received Network Adequacy Quarterly Report on September 19 identifying gaps and actions required
- Contracting has a preliminary list of providers to contract with to close plan and CHCN level gaps

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CalOptima Health

Timely Access

- CMS and DHCS establish timely access standards for members to obtain appointments for specific types of care including:
  - Routine care
  - Urgent care
  - Routine specialty referral appointments
  - Prenatal care
  - Children's preventive periodic health assessments
  - Adult initial health appointments
- Contracted providers and health networks are expected to comply with these timely access standards
- CalOptima Health fields a Timely Access Survey annually via a contracted vendor

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Timely Access (Cont.)

- Monitoring of access standards includes the following providers:
  - Primary Care Physicians
  - Specialists
  - Behavioral Health
  - Ancillary
- CalOptima Health may issue a notice of non-compliance and develop corrective action plans (CAP) for providers and health networks that do not meet these standards
- Plan and Health Network MPL: 80%

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Timely Access (Cont.)

Requirements	Impact on Quality Programs	Monitoring
• Annual Timely Access Survey	• Appointment access impacts timely provision of care, member experience, grievances, and appeals	• Quarterly updates provided to DHCS via Subcontractor Network Certification (SNC) Monitoring • Monitoring of delegates on correction action

2024 Priority: Enhance timely access monitoring process to shorten the time it takes to issue notices of non-compliance and develop tools to facilitate tracking of CAP submissions.

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CalOptima Health

Timely Access Survey 2023

- CalOptima Health fielded a timely access survey to monitor appointment and telephone wait times
- Fielding Period: September 26–December 1, 2023
- Line of Business: Medi-Cal and OneCare
- Minimum Performance Level (MPL): 80%
- Methodology: Direct Survey
- Appointment survey results shows two compliance rates:
  - Compliance rate for individual provider: Rate calculation of individual providers selected to participate in the survey
  - Compliance rate for another office provider: Rate calculation includes availability of any provider at the same location who can possibly see patient sooner

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Timely Access Standards: Medi-Cal

- 2023 Appointment Availability Results

Provider Type	Appointment Type	Standard	Compliance Rate Individual Provider	Compliance Rate Another Office Provider	MPL
PCP	Urgent – No Prior Auth Required	48 Hours	60.3%	74.8%	80%
	Non-Urgent	10 Business Days	75.2%	**88.1%**	80%
	Physical Exam and Health Assessment	30 Calendar Days	**81.2%**	**86.8%**	80%
Specialists	Urgent – Prior Auth Required	96 Hours	46.8%	58.9%	80%
	Non-Urgent	15 Business Days	58.4%	73.9%	80%
OB/GYN	Urgent – No Prior Auth Required	48 Hours	33.8%	63.6%	80%
	Non-Urgent	15 Business Days	64.1%	73.5%	80%
Psychiatrist	Urgent – No Prior Auth Required	48 Hours	45.5%	47.4%	80%
	Non-Urgent	15 Business Days	66.7%	**88.5%**	80%
	Non-Urgent Follow-Up of Initial Visit	30 Calendar Days	63.9%	**85.0%**	80%
Ancillary	Non-Urgent	15 Business Days	64.3%	–	80%

Compliance Rate Individual Provider: Rate calculation includes availability of individual providers selected to participate in the survey.

Compliance Rate Another Office Provider: Rate calculation includes availability of any provider at same office location who can see the patient sooner.

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CalOptima Health

Timely Access Standards: Medi-Cal (Cont.)

2023 Appointment Availability Results

Provider Type	Appointment Type	Standard	Compliance Rate Individual Provider	Compliance Rate Another Office Provider	MPL
Non-Physician Behavioral Health (NPBH)	Urgent – No Prior Auth Required	48 Hours	43.8%	69.6%	80%
	Non-Urgent	10 Business Days	76.6%	**83.3%**	80%
	Non-Urgent Follow-Up of Initial Visit	20 Calendar Days	79.1%	**81.0%**	80%

2023 Telephone Results

Type of Administrative Call	Compliance Rate	MPL
Prerecorded message instructs caller to go to nearest ER or dial 911 in event of emergency	62.5%	80%
Prerecorded message informs caller of return call time	20.1%	80%
Callback time within 24 hours	65.4%	80%
Callback time within 30 minutes (urgent)	0%	80%
Telephone triage or screening services within 30 minutes	91.4%	80%
Offers flexibility in scheduling members with disabilities	95.9%	80%

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CalOptima Health

Timely Access Standards: OneCare

- 2023 Appointment Availability Results

Provider Type	Appointment Type	Standard	Compliance Rate Individual Provider	Compliance Rate Another Office Provider	MPL
PCP	Non-Urgent Appointment Services – Not Emergent or Urgently Needed but Requires Medical Attention	7 Business Days	66.3%	79.6%	80%
	Routine and Preventive – Physical Exams and Health Assessments	30 Business Days	**87.6%**	**92.8%**	80%
Psychiatrist	Routine and Preventive	30 Business Days	**91.7%**	**96.8%**	80%
NPBH	Routine and Preventive	30 Business Days	**93.9%**	**94.7%**	80%

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CalOptima Health

Timely Access Monitoring and Corrective Action Process

- CalOptima Health monitors timely access with escalating notifications and actions for multiple years of non-compliance:
  - First Year: Providers who do not meet timely access standards for one year are sent an education letter
  - Second Year: Providers who do not meet timely access standards for two consecutive years are sent a warning letter
  - Third Year: Provider who do not meet timely access standards for three consecutive years are sent an escalation letter and CAP

- Timely Access Subcommittee of the Member Experience Committee oversees provider non-compliance and recommends further action to the Quality Improvement Health Equity Committee

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Provider Satisfaction

- Field annual provider satisfaction survey to gather feedback on providers' experience interacting with CalOptima Health
- Survey tool assesses rating of satisfaction with:
  - CalOptima Health operations including member eligibility, provider training programs and communications
  - Access to primary, specialty, ancillary and behavioral health care
  - Contracted health network and health network operations: credentialing, authorizations, provider relations, referrals and claims payment
  - Programs including health and wellness, cultural and linguistic services, care management, translation, interpreters and transportation

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Provider Satisfaction (Cont.)

- Advance notice was issued in August 2024 provider newsletter
- Survey is currently being fielded for a 6-week period via Survey Monkey
- Reminders will be sent at two- and four-week intervals
- Survey results will be analyzed and used to identify opportunities to improve programs and processes

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CalOptima Health

APPENDIX

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Network Adequacy Standards for Medi-Cal

Element	Provider Population	Standard
Time OR Distance Standards	PCPs (Adults & Pediatric)	Plan level: 10 miles OR 30 minutes from any anticipated member Health network level: 10 miles OR 30 minutes from any assigned member
	Specialties (Adults & Pediatric)	Plan level: 15 miles OR 30 minutes from any anticipated member Health network level: 15 miles OR 30 minutes from any assigned member
Mandatory Provider Types (MPT)*	Federally Qualified Health Center (FQHC)	One FQHC
	Freestanding Birthing Centers (FBC)**	N/A
	Certified Nurse Midwives (CNM)	One CNM
	Licensed Midwives (LM)	One LM
Physician-to-Member Ratios	Total FTE Primary Care Practitioner to Members	1:2,000
	Total FTE Physician to Members	1:1,200

*MPT is required for fully delegated health network as per APL 23-006.

**Health networks are not required to meet the FBC MPT requirement at this time, since there are no active providers meeting this requirement in the service area.

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Timely Access: By Provider Type

Specialists	Behavioral Health (BH)	Ancillary
Cardiology/Interventional Cardiologists Dermatologists Endocrinologist ENT/Otolaryngologists Gastroenterologists General Surgeon Hematology/Oncology HIV/AIDS/Infectious Disease Nephrologists Neurologists Obstetrician/Gynecologists Ophthalmologists Orthopedic Surgeons Physical Medicine/Rehabilitation Podiatry Pulmonologists Urology	Psychiatrists Non-Physician Behavioral Health • Medical: LCSW/SW; Psychologists, LMFT/MFT, Psychiatric Nurse Practitioner, LPCC • OneCare: LCSW/SW; Psychologists, LMFT/MFT, Psychiatric Nurse Practitioner, MHC/LPCC	MRI Specialists Mammography Physical Therapists

BH Acronyms:
LCSW/SW: Licensed Clinical Social Worker/Social Worker
LMFT/MFT: Licensed Marriage Family Therapist/Marriage Family Therapist
MHC/LPCC: Mental Health Counselors /Licensed Professional Clinical Counselor

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CalOptima Health

Timely Access Standards: Medi-Cal

Appointment Standards

Type of Care	Standard
Emergency Services	24 hours a day, 7 days a week
Urgent Appointments that DO NOT Require Prior Authorization	Within 48 hours of request
Urgent Appointments that DO Require Prior Authorization	Within 96 hours of request
Initial Health Appointment (IHA)	Within 120 calendar days of enrollment or for members less than 18 months of age within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures
Non-Urgent Appointments for Primary Care	Within 10 business days of request
Non-Urgent Appointments with Specialist Physicians	Within 15 business days of request
Non-Urgent Appointment with a Non-Physician Mental Health Provider	Within 10 business days of request
Non-Urgent Follow-Up Appointment with a Non-Physician Mental Health Provider	Within 10 business days of last appointment
Non-Urgent Appointments for Ancillary Services	Within 15 business days of request

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CalOptima Health

Timely Access Standards: Medi-Cal

Telephone Access Standards

Type of Care	Standard
Telephone Triage or Screening Services	Telephone triage or screening will be available 24 hours a day, 7 days a week. Telephone triage or screening waiting time will not exceed 30 minutes.
Telephone Access After and During Business Hours for Emergencies	The phone message or live person must instruct members: • The length of wait time for a return call from the provider; and • How the caller may obtain urgent or emergency care

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Timely Access Standards: OneCare

Primary Care and Behavioral Health Services

Type of Care	Standard
Emergency Services	Immediately
Urgent Care Services	Immediately
Services Not Emergent or Urgently Needed but Require Medical Attention	Within 7 business days
Routine and Preventive Care	Within 30 business days

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Update on Quality Improvement Program

Quality Assurance Committee Meeting

October 9, 2024

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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Agenda

- Credentialing
- NCQA Health Plan Accreditation
- NCQA Health Equity Accreditation

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CalOptima Health

Credentialing

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Credentialing Status Update

- In March 2024, CalOptima Health executed a contract with a NCQA-Certified Credentialing Verification Organization (CVO)
- Implementation began in April 2024 and ended in June 2024, with the submission of the first credentialing file to the CVO
- Credentialing has transitioned to the credentialing verification organization (CVO) as of 8/1/2024
- All new initial credentialing and ongoing recredentialing will be conducted by the CVO
- CalOptima Health will retain responsibility for approvals and denials of credentialing files, oversight of delegated credentialing, and monitoring of the CVO

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CalOptima Health

NCQA Health Plan Accreditation

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CalOptima Health

NCQA Health Plan Accreditation Renewal Timeline

- CalOptima Health successfully renewed our health plan accreditation status on 7/10/2024
- Our NCQA Health Plan Rating was updated on 9/15/2024 and achieved a rating of 3.5 stars
- The NCQA Health Plan Rating is based on performance on quality measures in domains of patient experience, prevention and equity, and treatment

	2024	2023
Overall	3.5 ↓	4.0
Prevention and Equity	4.0	4.0
Treatment	3.0↓	3.5
Patient Experience	2.5↑	3.0

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NCQA Health Equity Accreditation

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CalOptima Health

NCQA Health Equity (HE) Accreditation

- DHCS will require all Health Plans to obtain Health Equity accreditation by January 1, 2026
- CalOptima Health's goal is to be accredited by **Q3 2025.**
- CalOptima Health engaged our NCQA consultant to conduct a readiness assessment and gap analysis.
- NCQA consultant provided recommendations and developed a work plan
- CalOptima Health developed a HE Steering Committee and five work groups for implementation
- We submitted our Health Equity pre-application on 9/13/2024 and requested a survey date of **10/7/2025**

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CalOptima Health

Health Equity Accreditation Standards

- NCQA's health equity accreditation is built on the premise that high quality care is equitable care
- The goal for health plans is to create a system and structure that enables every part of the organization to contribute to health equity and quality goals of improving member care and health.
- Health equity standards are built on a framework of:

HE1: Organizational readiness Diverse staff Promoting diversity among staff	HE4: Practitioner Network cultural responsiveness
HE2: Collection of race/ethnicity, gender identity, and sexual orientation data	HE5: Culturally and linguistically appropriate services program
HE3: Access and availability of language services	HE6: Reducing health care disparities

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Health Equity Work Groups

	HE 1: Organizational Readiness	HE 2: Data Collection	HE 3: Access and Availability of Language Services	HE 4: Practitioner Network Cultural Responsiveness	HE 5 and 6: Culturally and Linguistically Appropriate Services
Business Lead	Michael Coringrato, *Director Human Resources (HR)*	Albert Cardenas, *Director Customer Service*	Albert Cardenas, *Director Customer Service*	Quynh Nguyen, *Director Provider Data Management Services*	Katie Balderas, *Director Equity and Community Health*
Work Group Members	Greta Rice, *Manager HR* Jeffrey Lum, *Manager HR* Kathleen Lee-Gilbert, *HR Business Partner*	Katie Balderas, *Director Equity and Community Health* Fay Ho, *Director Compliance* Carlos Soto, *Manager Cultural and Linguistic*	Carlos Soto, *Manager Cultural and Linguistic* Adriana Ramos, *Senior Manager Provider Relations* Jane Flanagan-Brown, *Director Provider Relations* Quynh Nguyen, *Director Provider Data Management Services*	Rick Quinones, *Manager Credentialing* Michael Gomez *Executive Director Network Operations* Adriana Ramos, *Senior Manager Provider Relations* Jane Flanagan-Brown, *Director Provider Relations*	Andrew Tse, *Director Customer Service* Mike Wilson, *Director Stars/Quality Initiatives* Carlos Soto, *Manager Cultural and Linguistic* Megan Dankmyer, *Senior Director Medical Management* Stacie Oakley, *Director Utilization Management* Cesar Tungol, *Director Claims Administration* Tyronda Moses, *Director, Grievance and Appeals* Hannah Kim, *Director Case Management*

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CalOptima Health

Health Equity Accreditation Status Update

- CalOptima Health engaged a new consulting firm, Health Management Associates (HMA), to provide expert guidance and conduct a current-state assessment for health equity accreditation readiness
- From July 26 through August 27, 2024, HMA reviewed 71 documents and participated in work group meetings with our five health equity work groups
- HMA has provided feedback on each document to remedy gaps and to ensure full compliance
- Business owners continue to meet in work groups to identify and implement operational policies and procedures
- The next five months will focus on document, process, and report development to ensure full compliance prior to the survey look-back period

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HEDIS® MY2023 Results

Quality Assurance Committee Meeting

October 9, 2024

Linda Lee
Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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Healthcare Effectiveness Data and Information Set (HEDIS)

- HEDIS is a set of standardized measures designed to provide health care purchases and consumers with reliable comparison of health plan performance

- HEDIS includes near 100 measures across six domains of care and relates to many significant public health issues, such as cancer, heart disease, smoking, asthma and diabetes

- NCQA uses HEDIS measures in its health plan ratings and accreditation program

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CalOptima Health

HEDIS and Regulatory Requirements

- California Department of Health Care Services (DHCS)
  - Managed Care Accountability Set (MCAS) — select measures must achieve a minimum performance level (MPL) which is set at the national Medicaid 50th percentile
    - Financial sanctions and corrective action plans may be imposed for measures that do not meet the MPL
  - Medi-Cal Quality Withhold

- Centers for Medicare & Medicaid Services (CMS)
  - Medicare Star Ratings
  - D-SNP contract

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CalOptima Health

HEDIS Reporting Process

- HEDIS results are audited by National Committee for Quality Assurance (NCQA) certified auditors.
  - All measures passed audit and are reportable for MY2023

- Medical records review was required for 23 measures and sub-measures with more than 5,000 chart chases completed.
  - Chart retrieval rate is approximately 90%

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CalOptima Health

Medi-Cal Results Summary

- 16 out of 18 MCAS selected measures with a MPL requirement achieved MPL
  - Follow-up After ED visit for Alcohol and Other Drug Dependence within 30 days (FUA) did not meet MPL
  - Follow-up After ED visit for Mental Illness within 30 days (FUM) did not meet MPL

- Health Plan Rating (HPR) — 3.5
  - HEDIS Prevention and Equity maintained 4.0 rating
  - HEDIS Treatment measures decreased to 3.0 rating
  - CAHPS Patient Experience measures improved to 2.5 rating

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CalOptima Health

Top Opportunities for Improvement: Medi-Cal

- Measures that did not meet the MPL
  - Follow-up After ED visit for Alcohol and Other Drug Dependence within 30 days (FUA)
  - Follow-up After ED visit for Mental Illness within 30 days (FUM)
- Medi-Cal Quality Withhold measures that lost points
  - Postpartum Care (PPC)
  - Well-Child Visits in the First 30 Months of Life (W30 0-15 months)
- Current performance within 3% of MPL margin
  - Lead Screening in Children (LSC)
  - Cervical Cancer Screening (CCS)
  - Asthma Medication Ratio (AMR)

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Medicare Results Summary - OneCare

- HEDIS Star Ratings measures projected to improve compared to prior year
  - Projected to reach 4-Stars*
    - Controlling High Blood Pressure (CBP)
    - Care for Older Adults (COA - Pain assessment)
    - Diabetes Care - Blood Sugar Controlled (HBD)
    - Transitions of Care (TRC - Med Reconciliation)
  - Projected to reach 3-Stars*
    - Statin Therapy for Patients with Cardiovascular Disease (SPC)
- HEDIS Star Ratings measures projected to decline compared to last year
    - Plan All-Cause readmissions (PCR)

* Star Rating cut-off values are based on SR2024 Part C & D Star Tech Notes updated 3/13/2024

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OneCare HEDIS Star Rating Measures

Abbrev	Medicare HEDIS Measures	HEDIS MY2022	HEDIS MY2023	SR2024 (MY2022)	Estimated SR2025 (MY2023)	SR2024 Star Ratings Tech Notes updated 3/13/2024			
						2-Star	3-Star	4-Star	5-Star
BCS	Breast Cancer Screening (C01)	66%	67%	3	3	52%	63%	71%	79%
CBP	Controlling High-Blood Pressure (C11)	68%	74%	3	4	58%	68%	74%	82%
COL	Colorectal Cancer Screening (C02)	65%	69%	3	3	50%	61%	71%	80%
COA	Care for Older Adults (SNP) - Medication Review (C06)	84%	88%	3	3	72%	84%	93%	98%
	Care for Older Adults (SNP) - Pain assessment (C07)	85%	91%	3	4	74%	83%	91%	96%
HBD	Diabetes Care - Blood Sugar Controlled (A1c>9) (C10)	22%	15%	3	4	42%	28%	20%	13%
EED	Diabetes Care - Eye Exam (C09)	73%	75%	4	4	52%	65%	73%	81%
OMW	Osteoporosis Management in Women Who Had a Fracture (C08)	NA	35%		2	29%	42%	55%	71%
PCR	Plan All-Cause readmissions - 18+ (C15)	9%	12%	4	2	13%	11%	10%	8%
SPC	Statin Therapy for Patients with Cardiovascular Disease - treatment (C16)	82%	85%	2	3	79%	84%	86%	90%
TRC	Transitions of Care - Notification Admission	18%	25%						
	Transitions of Care - Receipt Discharge Info	7%	14%						
	Transitions of Care - Engmt after discharge	78%	85%						
	Transitions of Care - Med Reconciliation (C14)	62%	72%	3	4	38%	52%	68%	82%
	Transitions of Care - (average) (C17)	41%	49%	2	2	40%	52%	64%	78%
FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (C18)	47%	51%	2	2	44%	53%	60%	68%

* Star Rating cut-off values are based on 2 display year 2024 Part C & D Star Tech Notes updated 3/13/2024

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CalOptima Health

Top Opportunities for Improvement: Medicare

- Star measures below 3-Star cut-point
  - Osteoporosis Management in Women Who Had a Fracture (OMW)
  - Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
  - Transitions of Care (TCR)
  - Plan All-Cause readmissions (PCR)
- Star measure with 3-fold weight
  - Controlling of blood pressure (CBP) – (rate 74% vs 5-Star cut-point 82%)
    - BP can be submitted through claims by using CPT II code
  - Diabetes Care - Blood Sugar Controlled (rate 85% vs 5-Star cut-point 87%)
    - HbA1c level can be submitted through claims by using CPT II code

* Star Rating cut-off values are based on SR2024 Part C & D Star Tech Notes updated 3/13/2024

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Next Steps

- Present results to Executive Team, committees, and stakeholders
- Calculate Health Network Quality Rating Scores and P4V payments
- Prioritize and implement strategies on low performing areas
  - Expand data sources to identify non-compliant members and providers
  - Collect medical record data for critical measures as supplemental data
  - Conduct health disparity analysis to further refine focus areas

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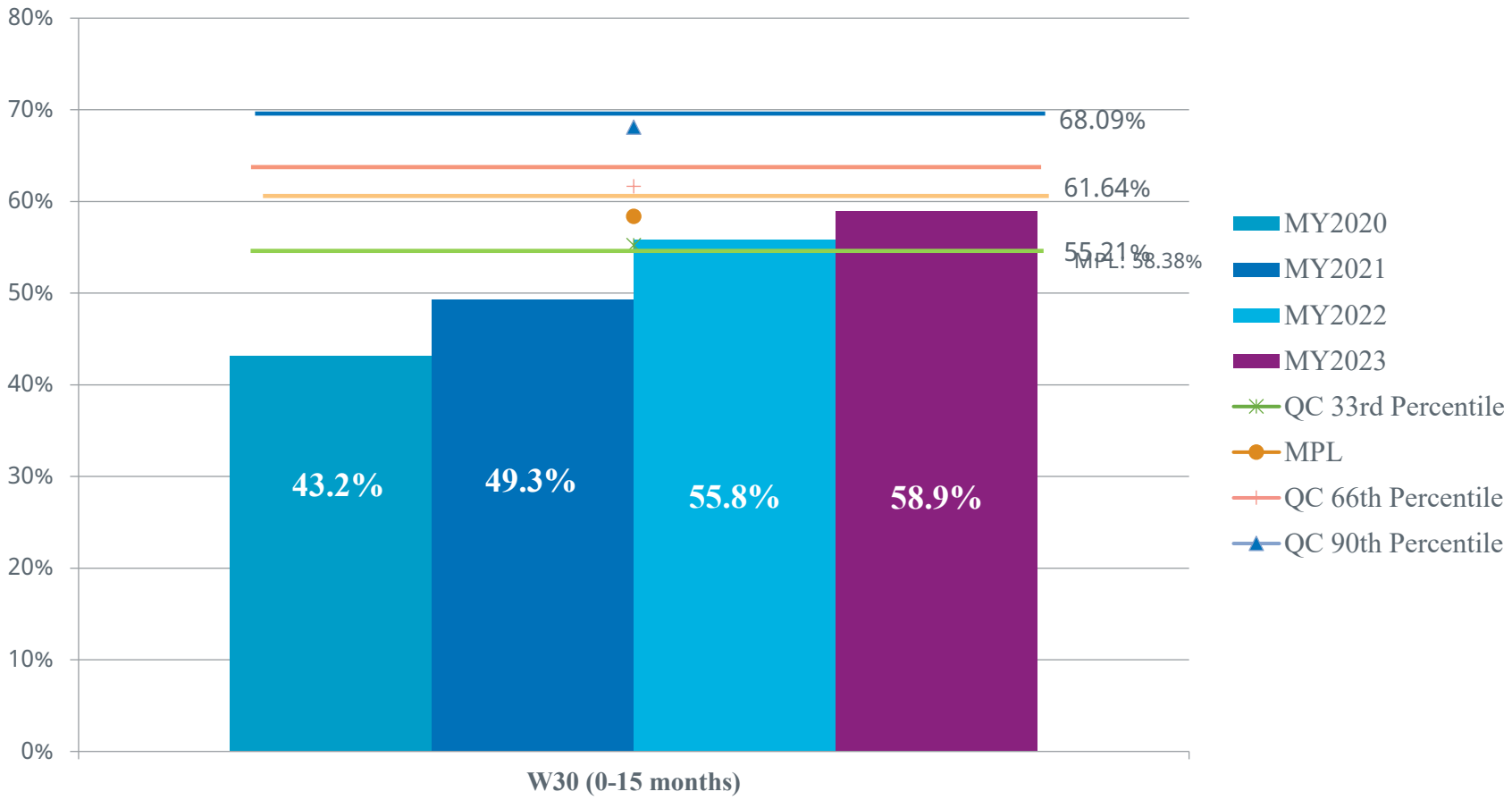
HEDIS MY2023 Results: Medi-Cal

Well-Child Visits in the First 30 Months of Life (0-15)(W30)



Per HEDIS 2022 Quality Compass Percentile

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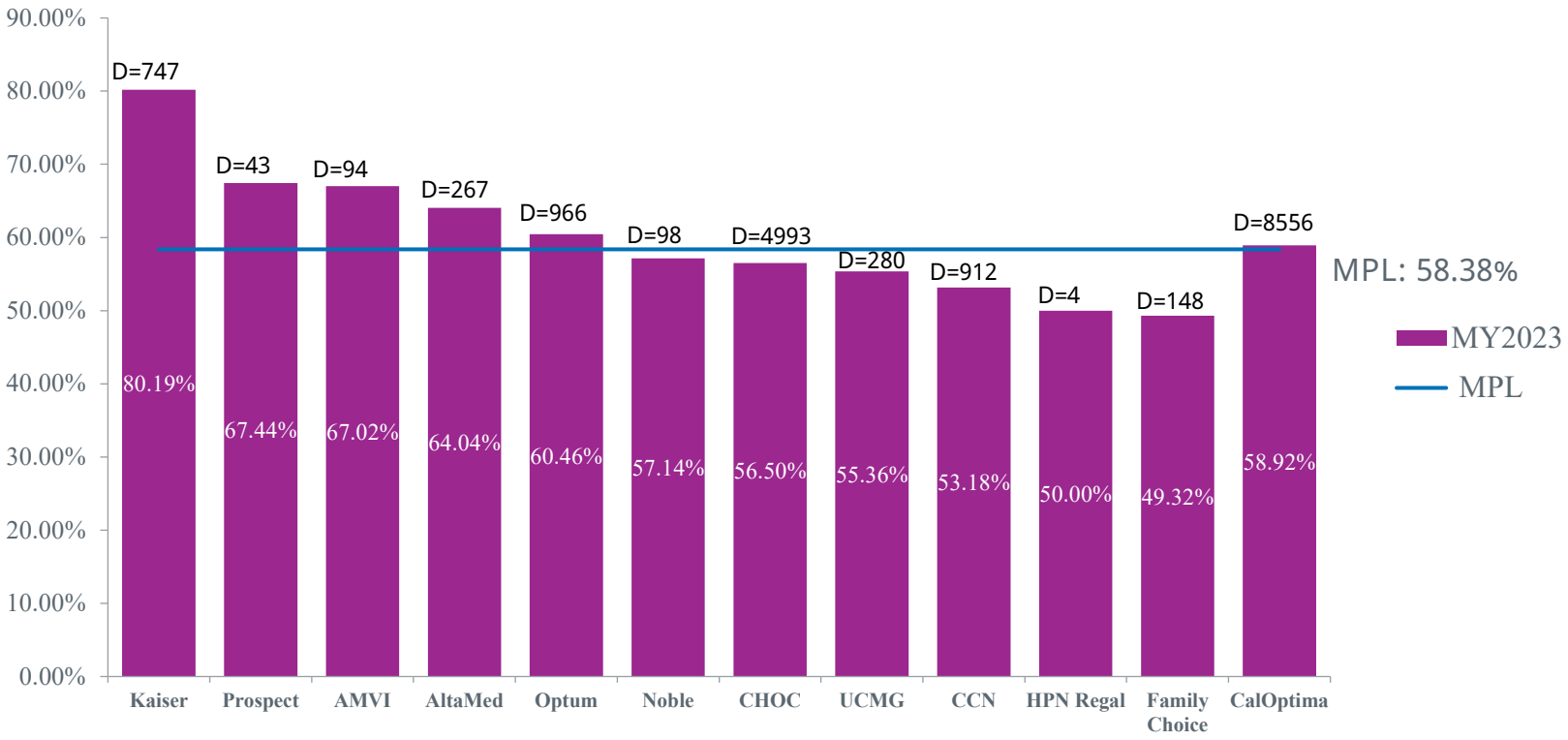
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Well-Child Visits in the First 30 Months of Life (0-15)(W30)



* Per HEDIS 2022 Quality Compass Percentile

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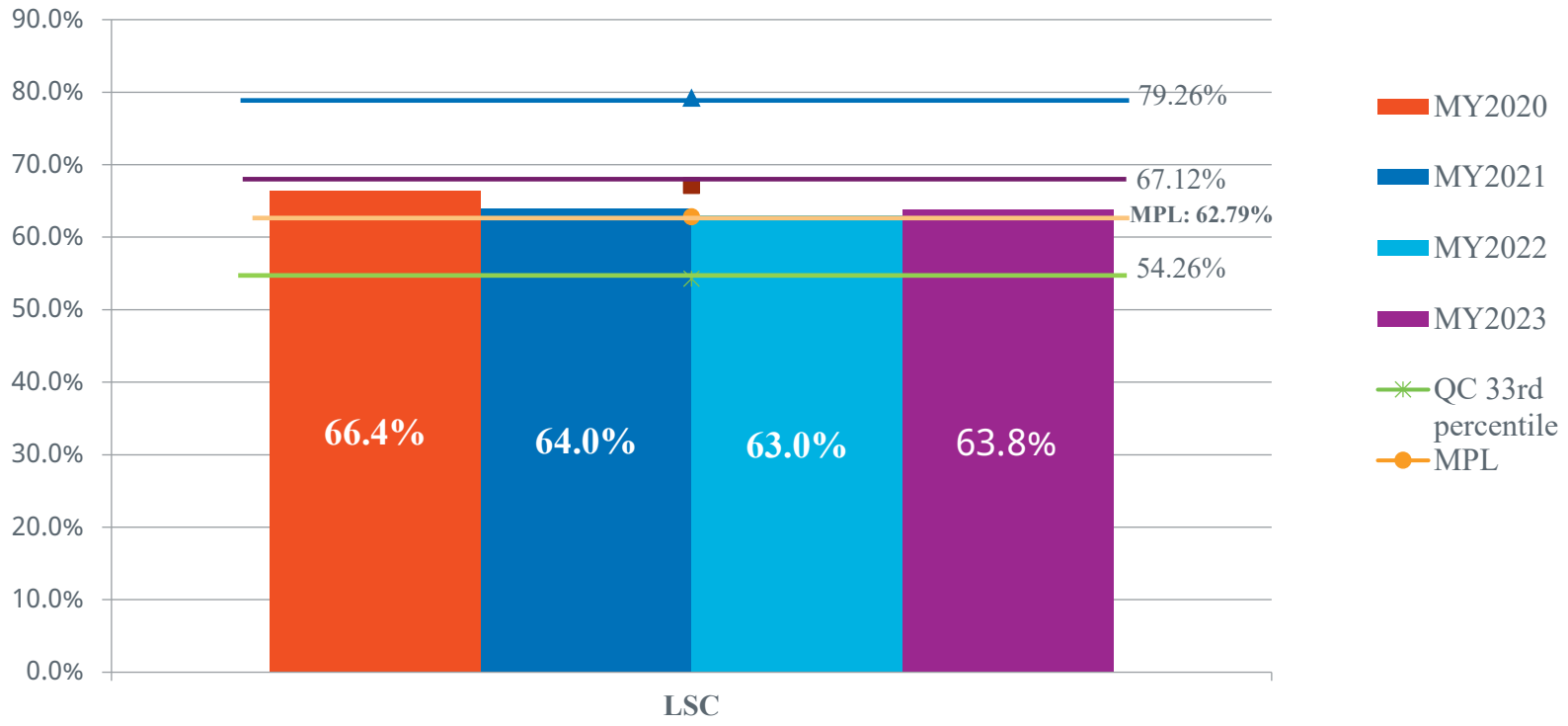
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Lead Screening in Children (LSC)



* Per HEDIS 2022 Quality Compass Percentile

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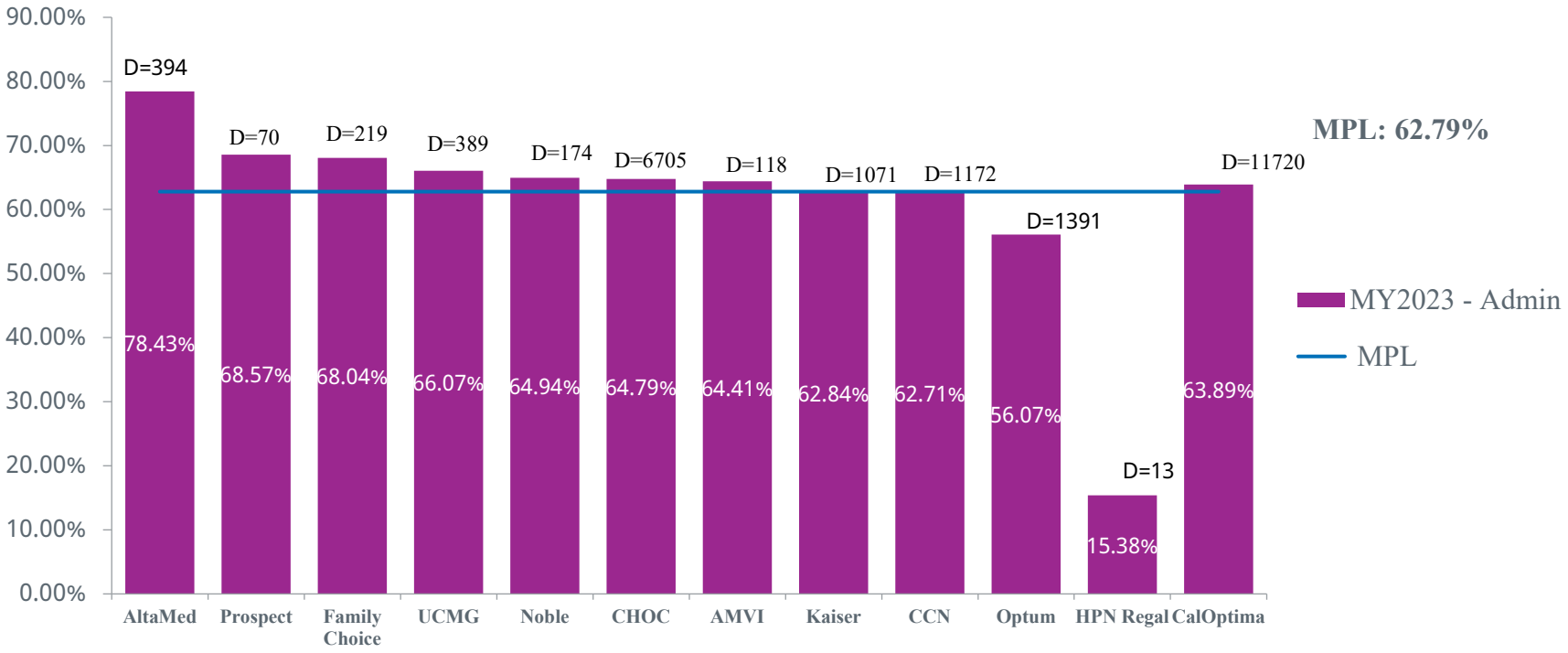
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Lead Screening in Children (LSC)



* Per HEDIS 2022 Quality Compass Percentile

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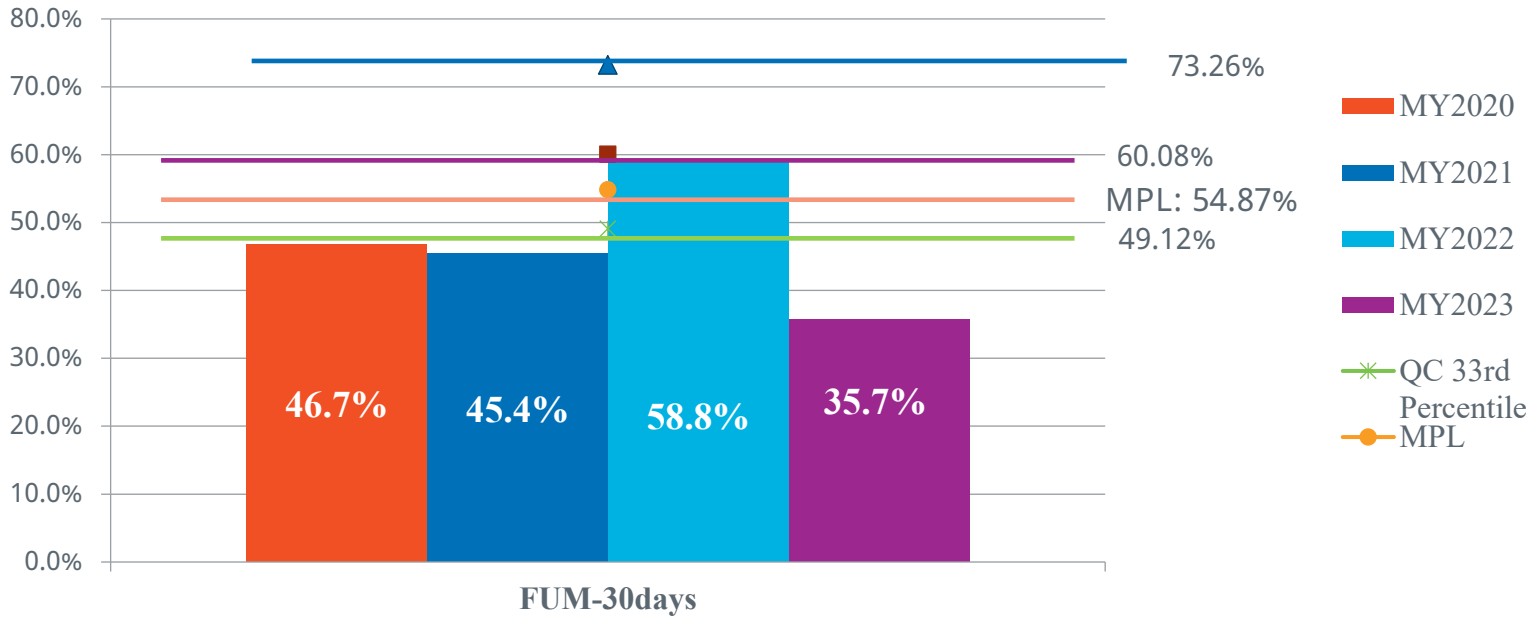
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Follow-Up After ED Visit for Mental Illness – 30 days (FUM)



* Per HEDIS 2022 Quality Compass Percentile

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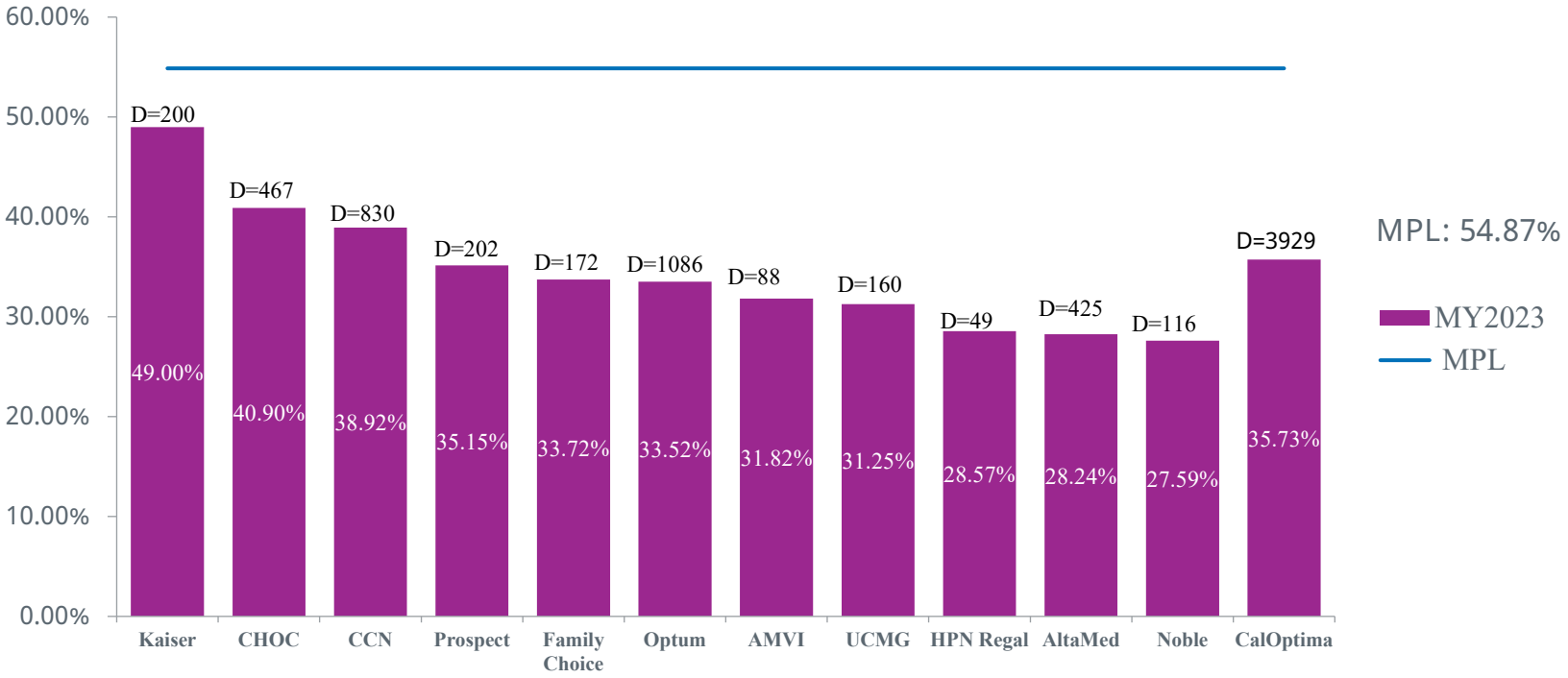
HEDIS MY2023 Results: Medi-Cal

Follow-Up After ED Visit for Mental Illness – 30 days (FUM)



* Per HEDIS 2022 Quality Compass Percentile

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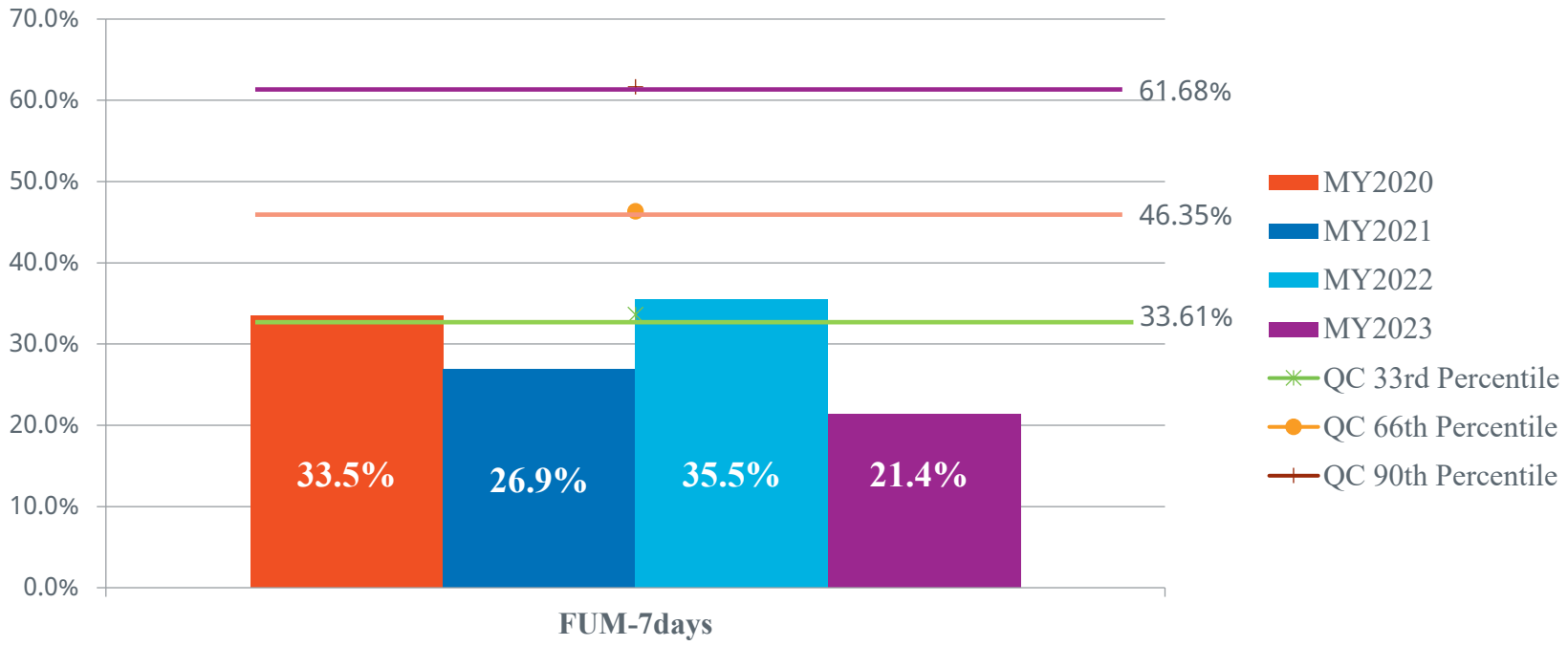
CalOptima Health

HEDIS MY2022 Results: Medi-Cal

Follow-Up After ED Visit for Mental Illness – 7days (FUM)



* Per HEDIS 2022 Quality Compass Percentile

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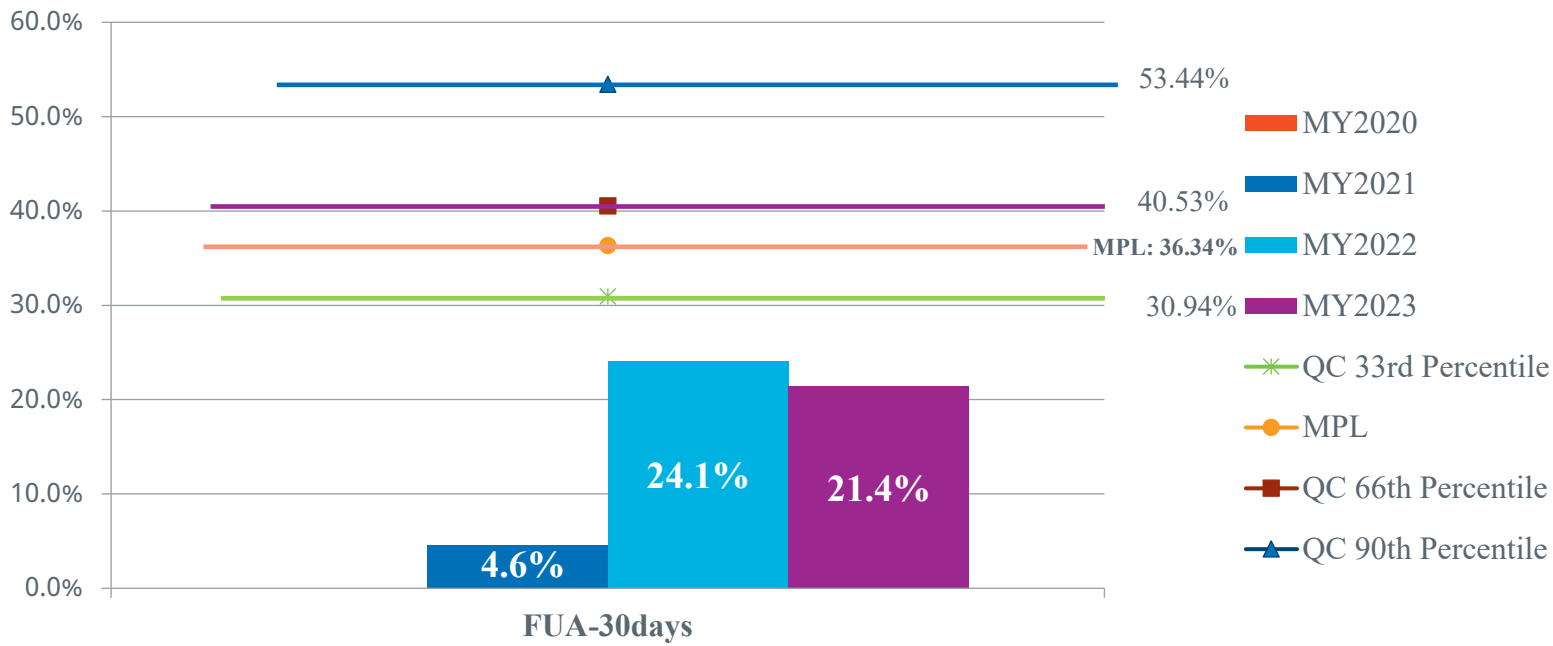
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days (FUA)



* Per HEDIS 2022 Quality Compass Percentile

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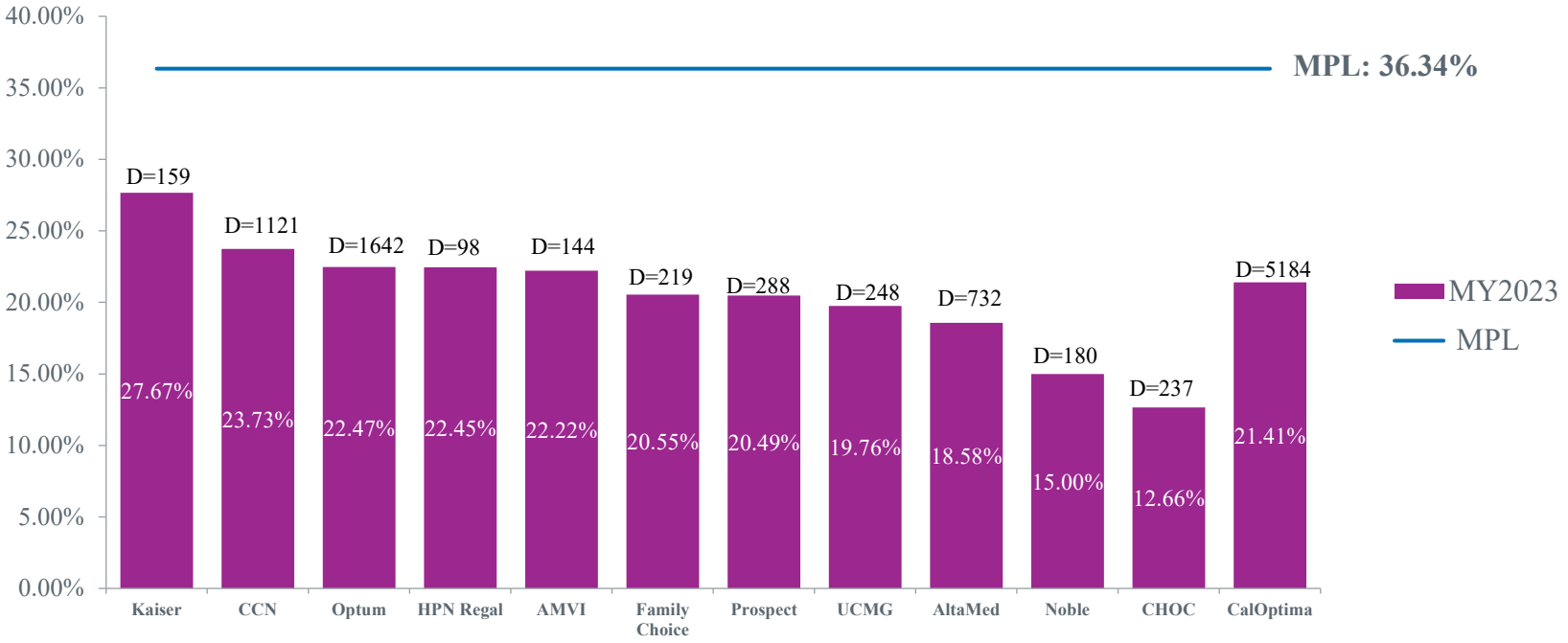
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days (FUA)



* Per HEDIS 2022 Quality Compass Percentile

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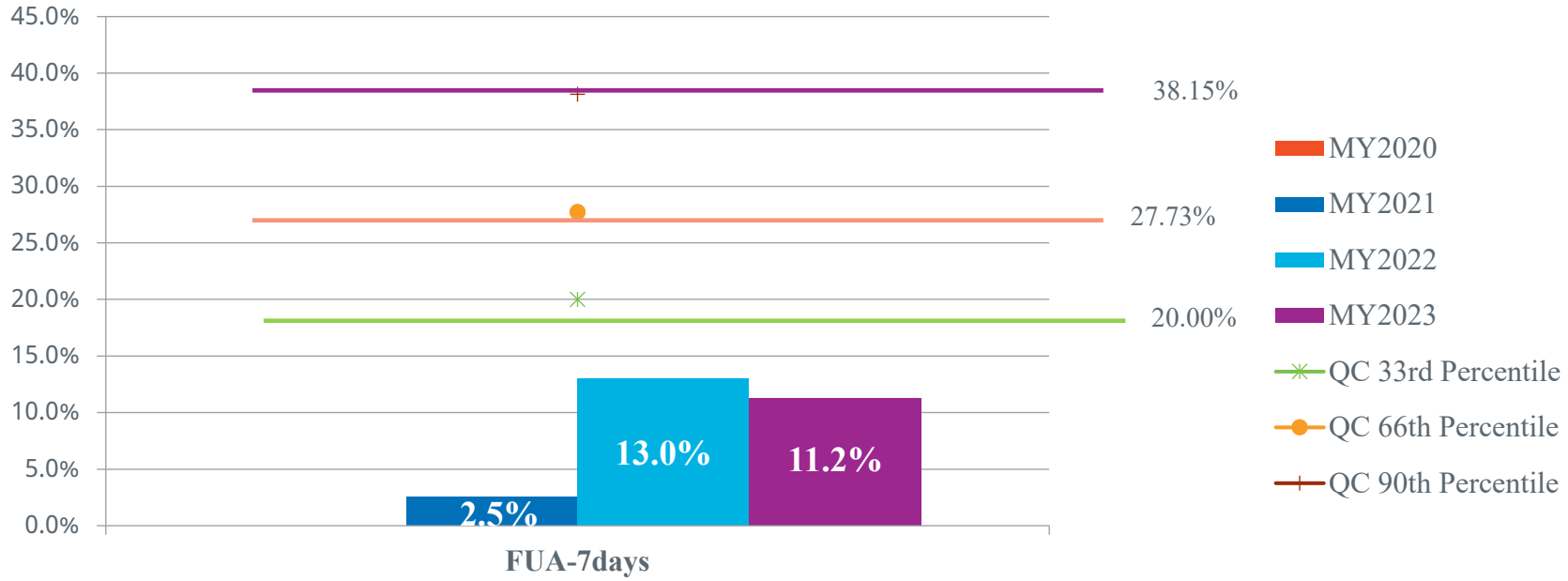
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days (FUA)



* Per HEDIS 2022 Quality Compass Percentile

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APPENDIX

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Medi-Cal Four Year Trended Results

National Medicaid MY 2022 Percentiles: NCQA Quality Compass

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Children's Health

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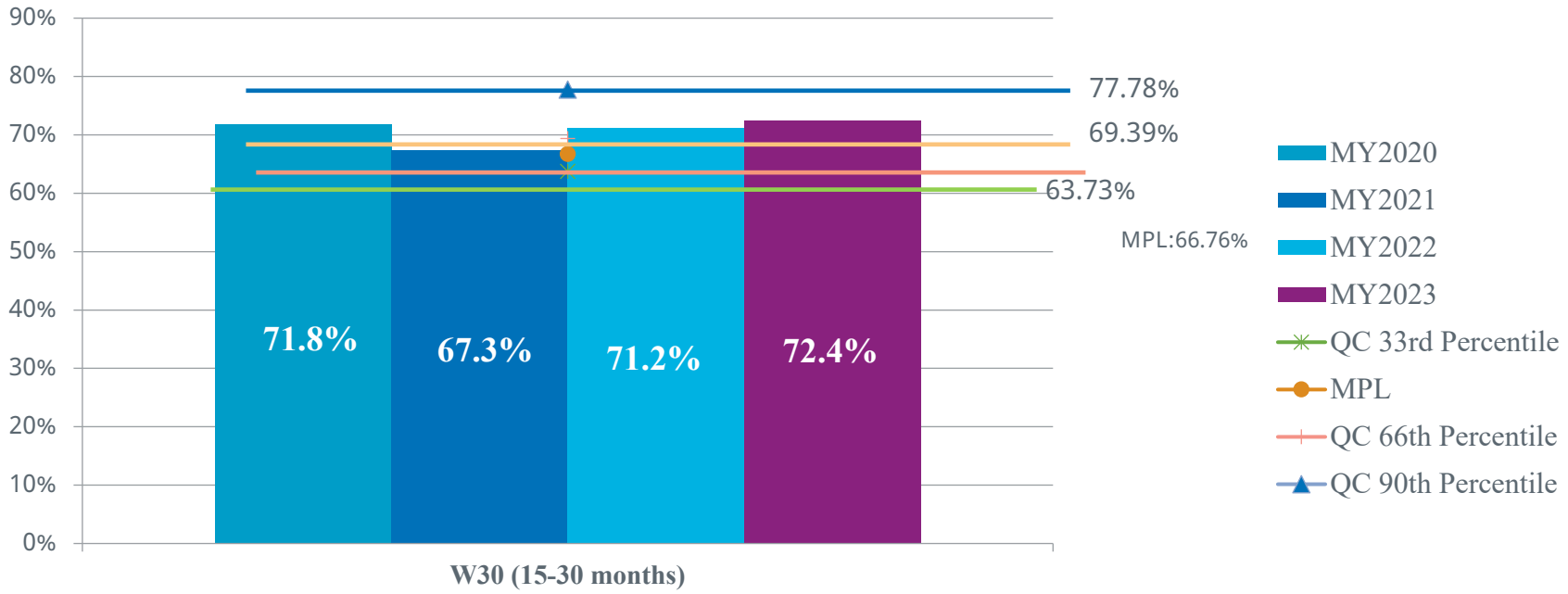
HEDIS MY2023 Results: Medi-Cal

Well-Child Visits in the First 30 Months of Life (15-30)(W30)



- Per HEDIS 2022 Quality Compass Percentile

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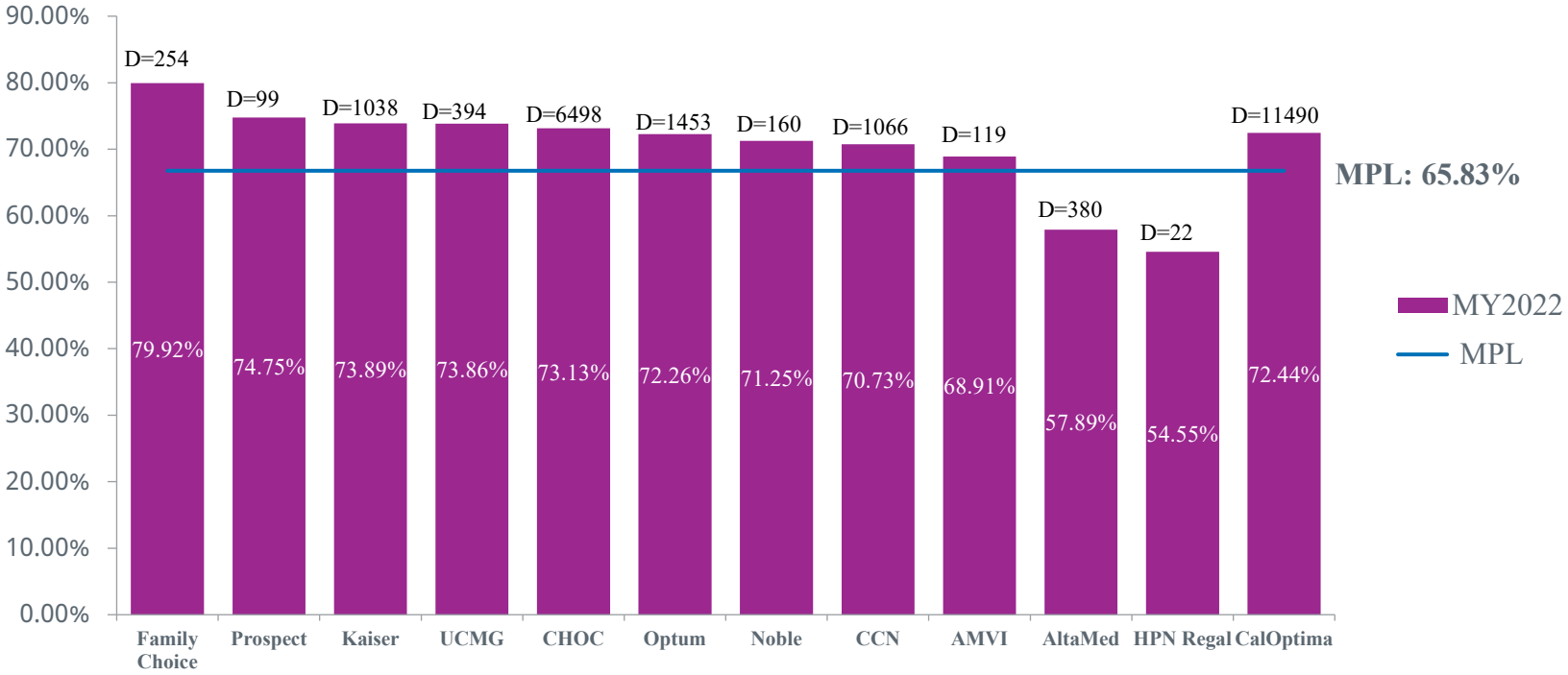
HEDIS MY2023 Results: Medi-Cal

Well-Child Visits in the First 30 Months of Life (15-30)(W30)



* Per HEDIS 2022 Quality Compass Percentile

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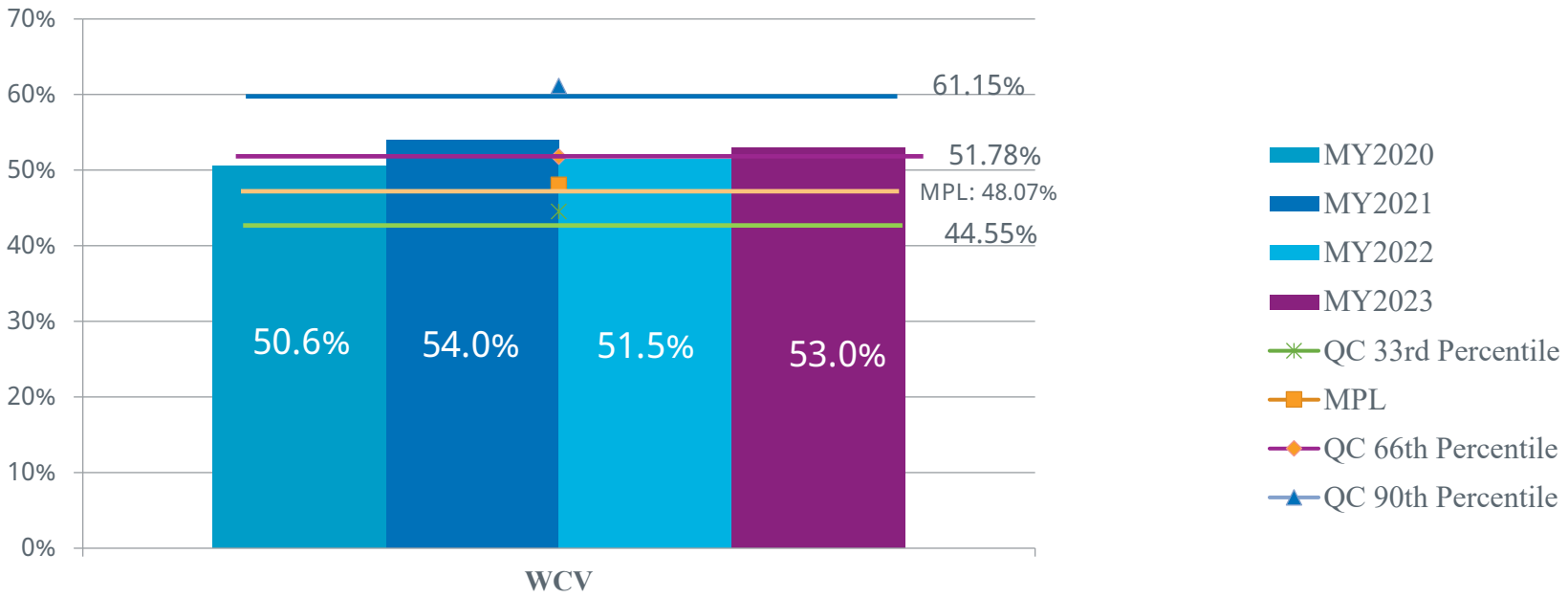
HEDIS MY2023 Results: Medi-Cal

Child and Adolescent Well Care Visits – Total (WCV)



- Per HEDIS 2022 Quality Compass Percentile

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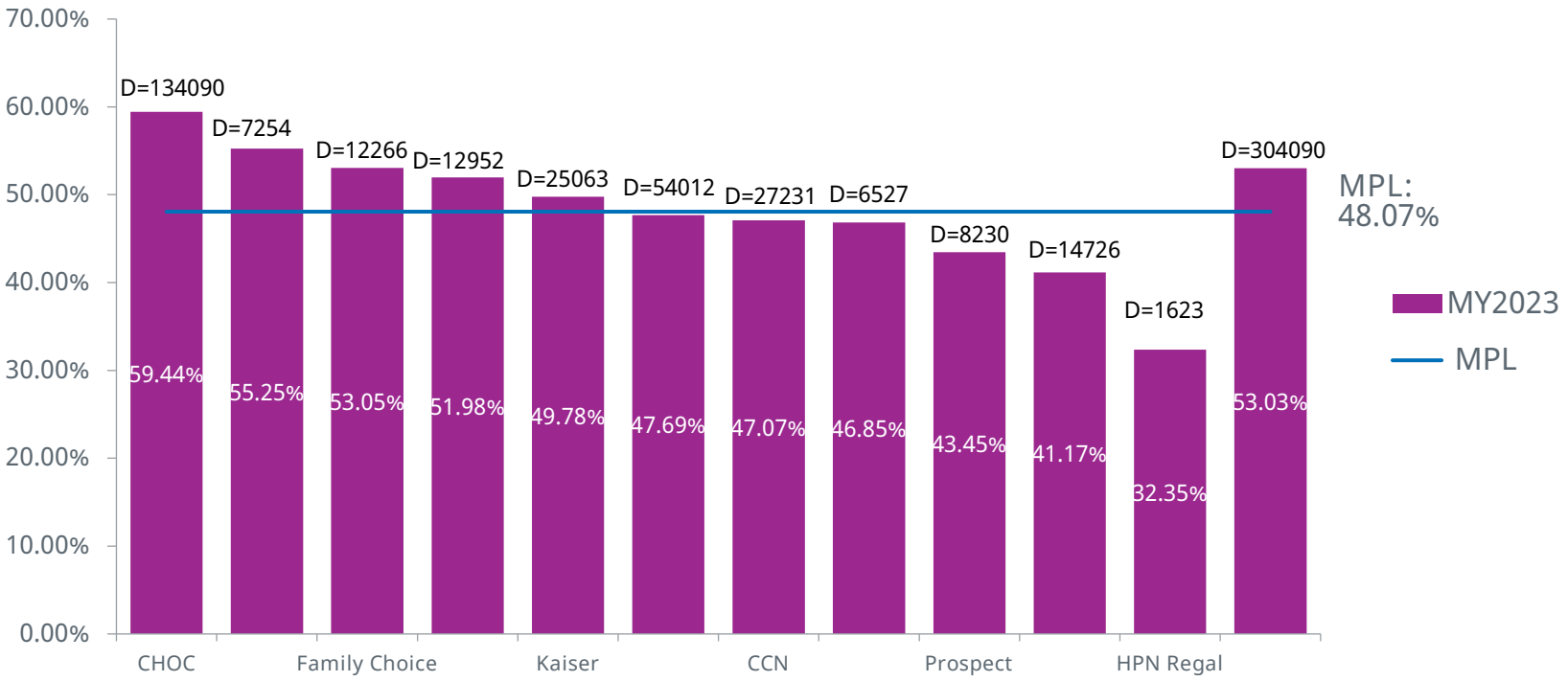
HEDIS MY2023 Results: Medi-Cal

Child and Adolescent Well Care Visits – Total (WCV)



* Per HEDIS 2022 Quality Compass Percentile

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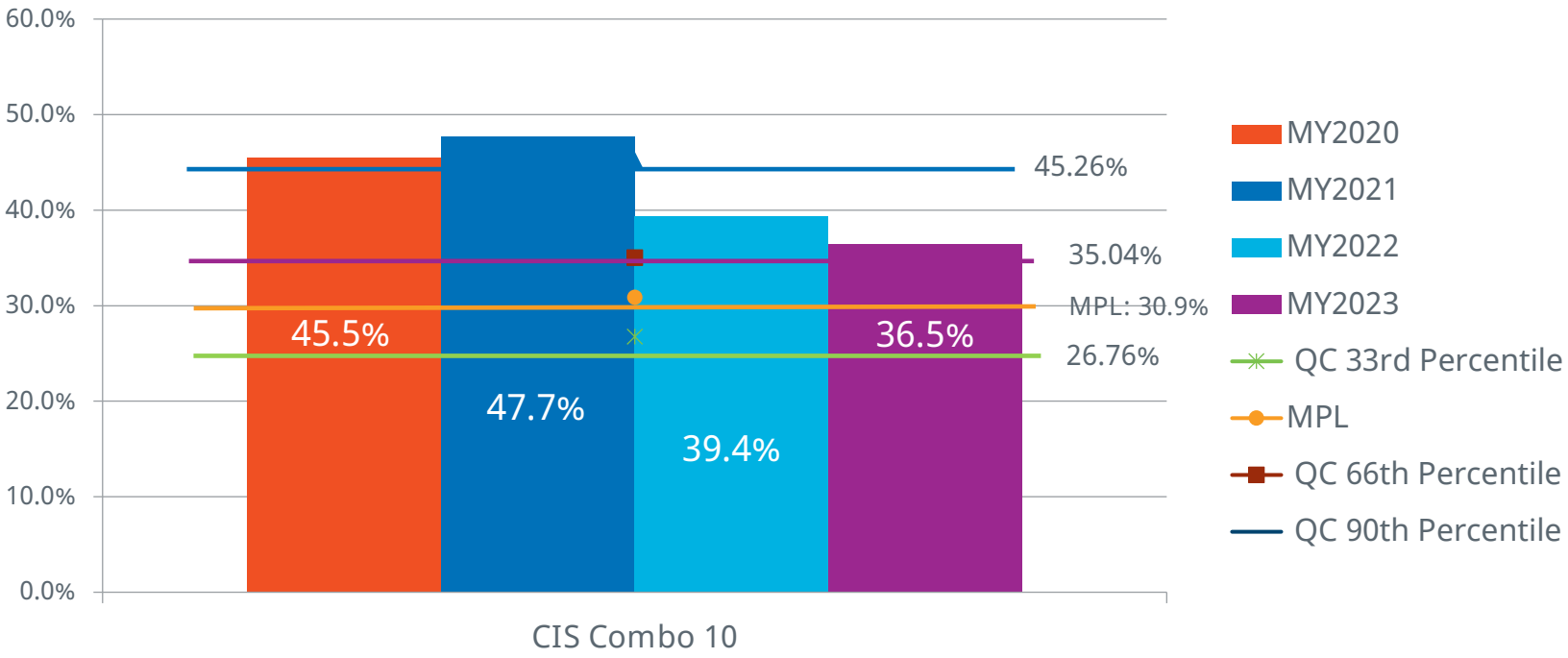
HEDIS MY2023 Results: Medi-Cal

Childhood Immunization Status – Combo 10 (CIS)



* Per HEDIS 2022 Quality Compass Percentile

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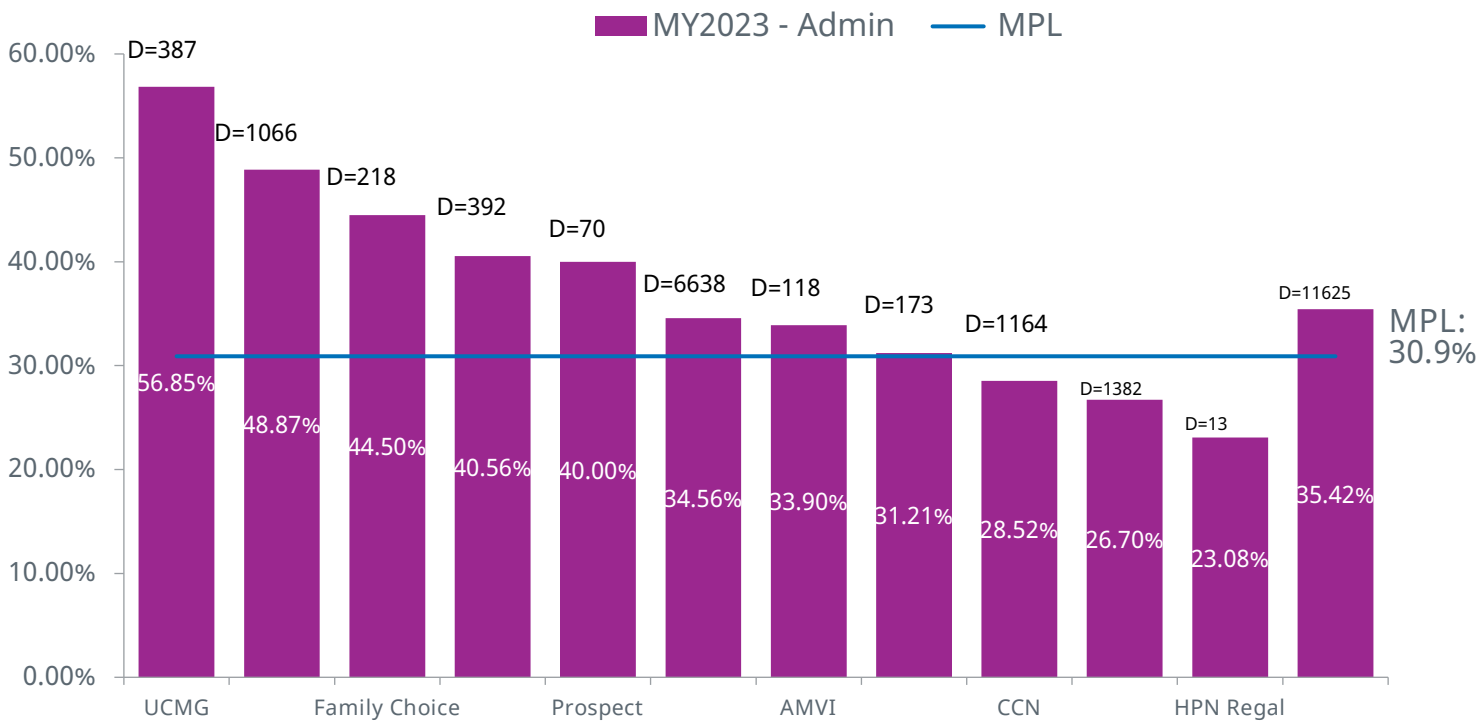
HEDIS MY2023 Results: Medi-Cal

Childhood Immunization Status– Combo 10 (CIS)



* Per HEDIS 2022 Quality Compass Percentile

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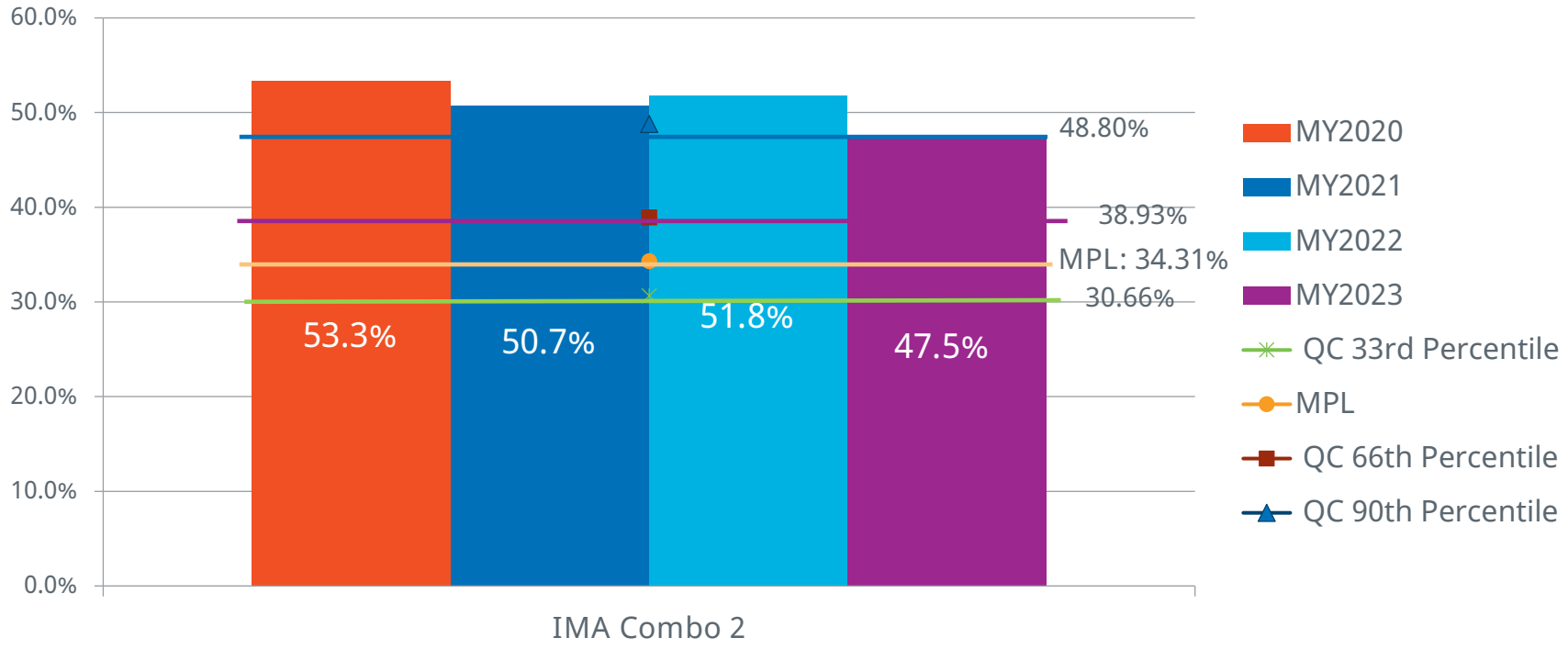
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Immunizations for Adolescents – Combo 2 (IMA)



* Per HEDIS 2022 Quality Compass Percentile

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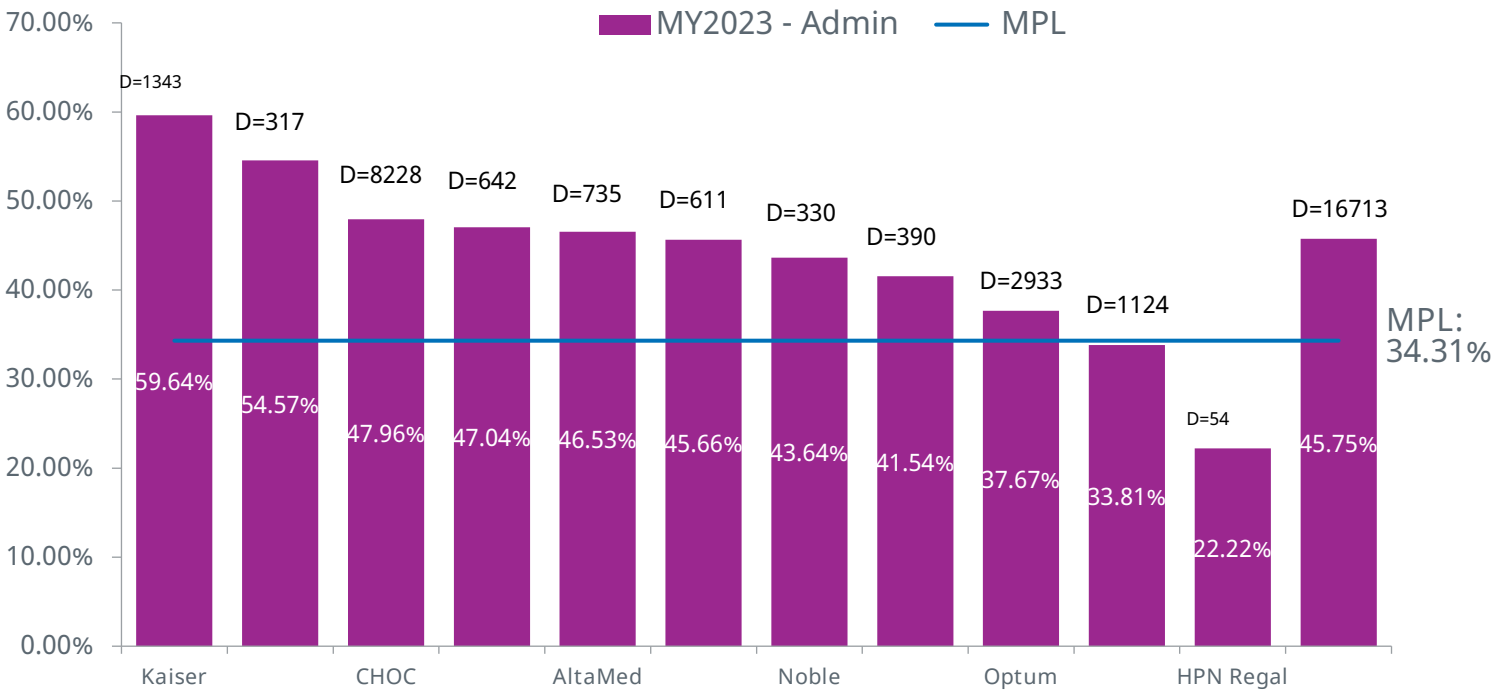
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Immunizations for Adolescents – Combo 2 (IMA)



* Per HEDIS 2022 Quality Compass Percentile

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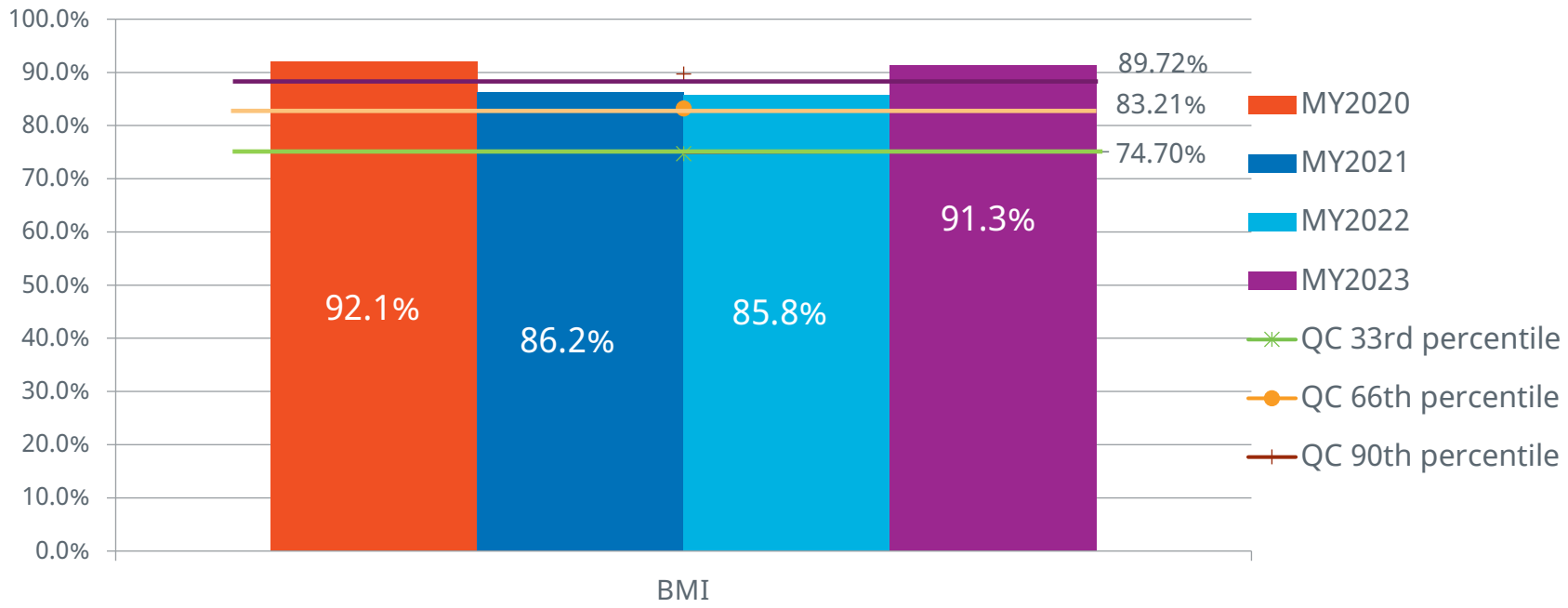
HEDIS MY2023 Results: Medi-Cal

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)– BMI



* Per HEDIS 2022 Quality Compass Percentile

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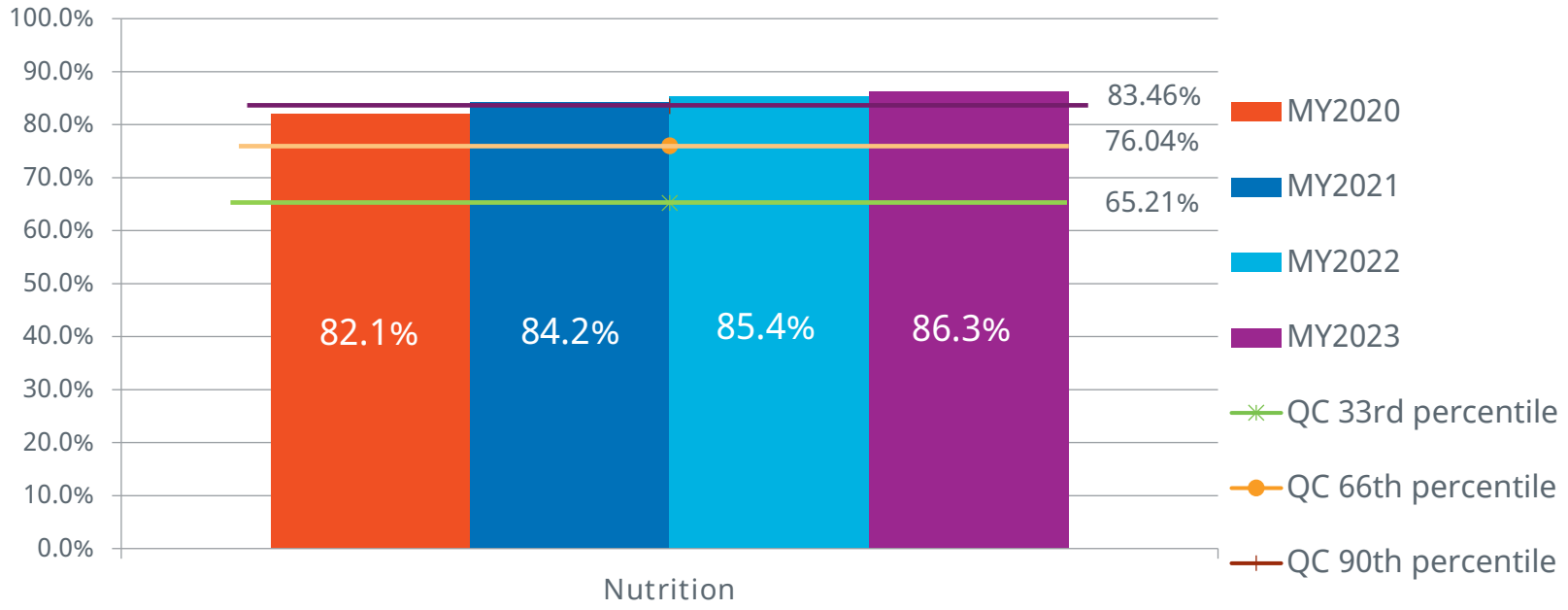
HEDIS MY2023 Results: Medi-Cal Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)–Nutrition



* Per HEDIS 2022 Quality Compass Percentile

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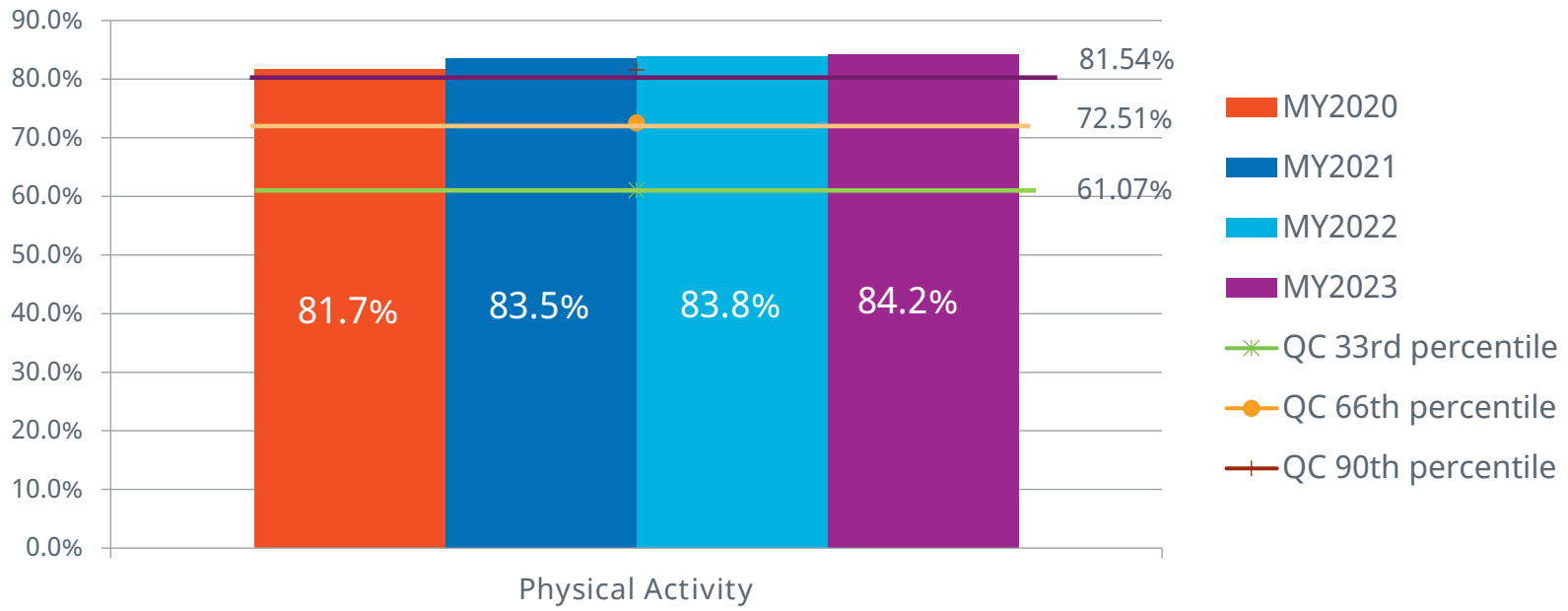
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Physical Activity



* Per HEDIS 2022 Quality Compass Percentile

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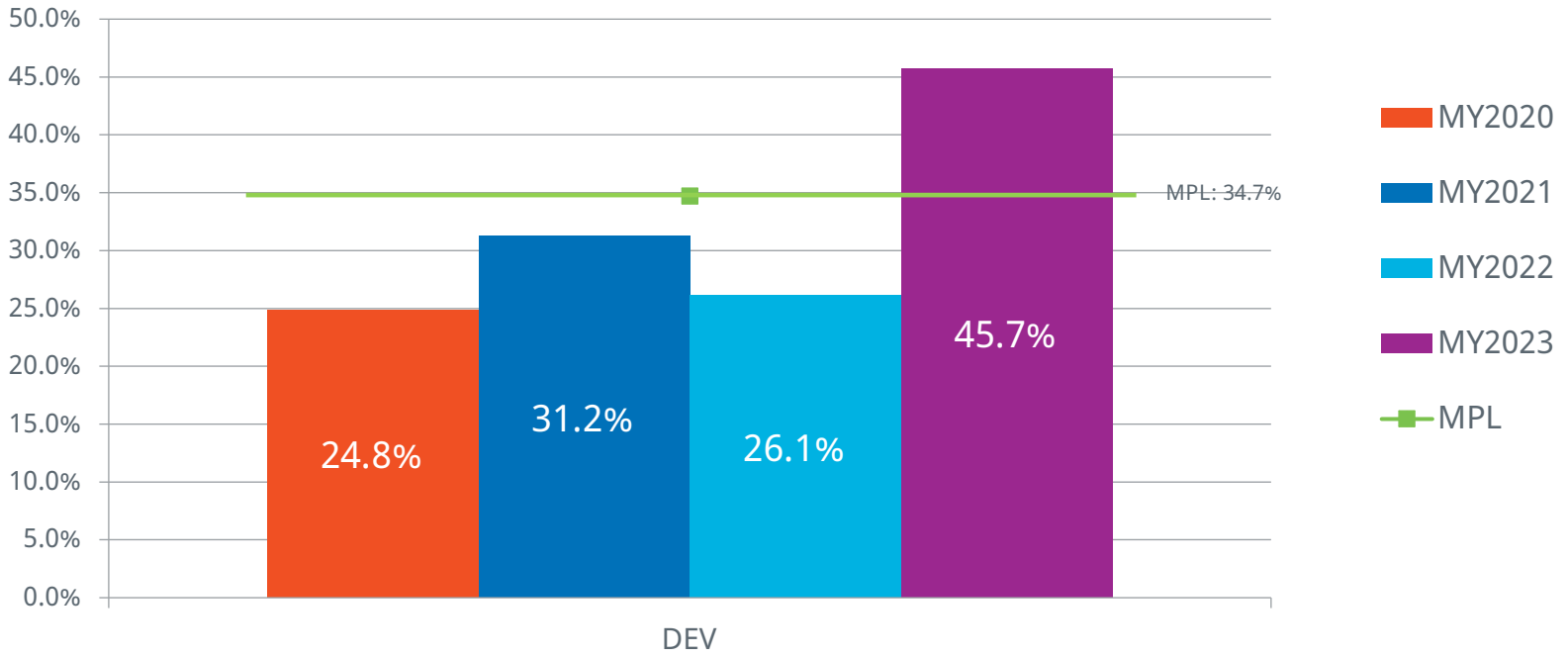
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Developmental Screening in the First Three Years of Life (DEV)



* Per HEDIS 2022 Quality Compass Percentile

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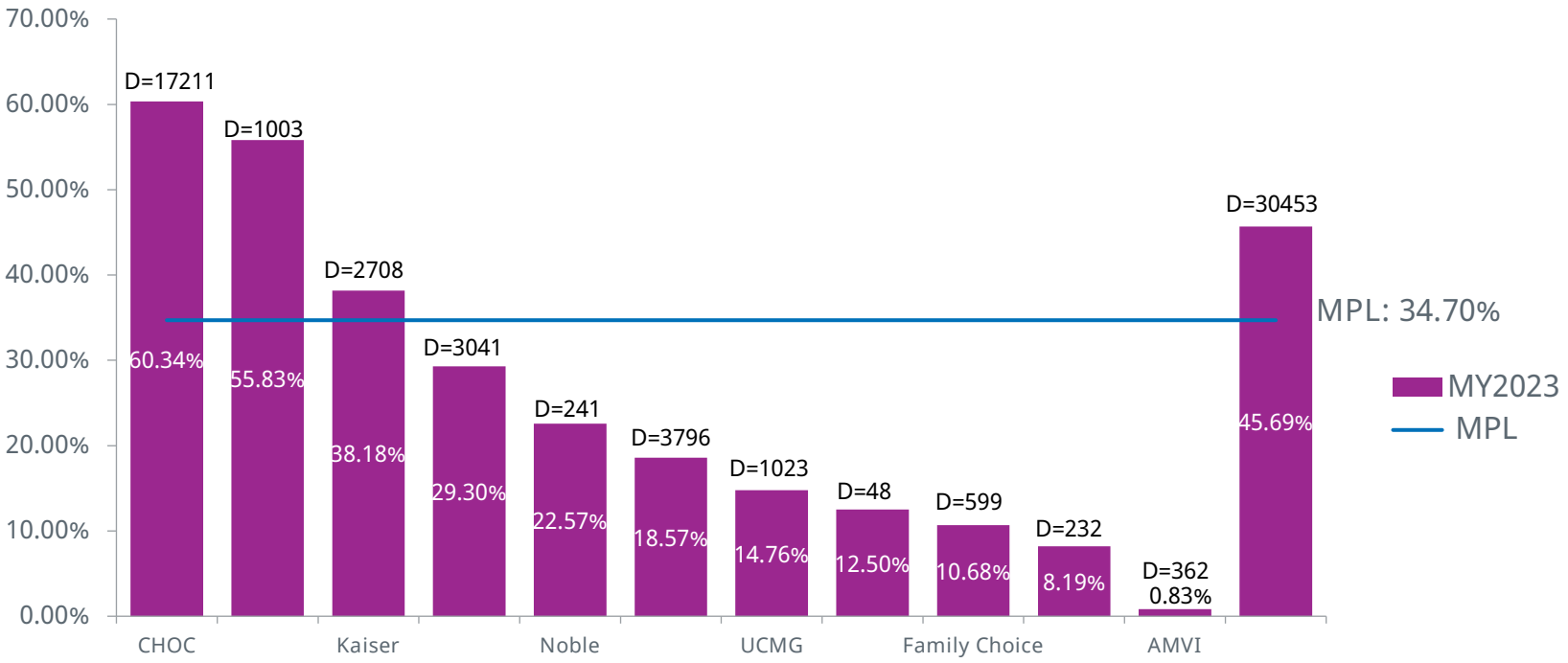
HEDIS MY2023 Results: Medi-Cal

Developmental Screening in the First Three Years of Life (DEV)



* Per HEDIS 2022 Quality Compass Percentile

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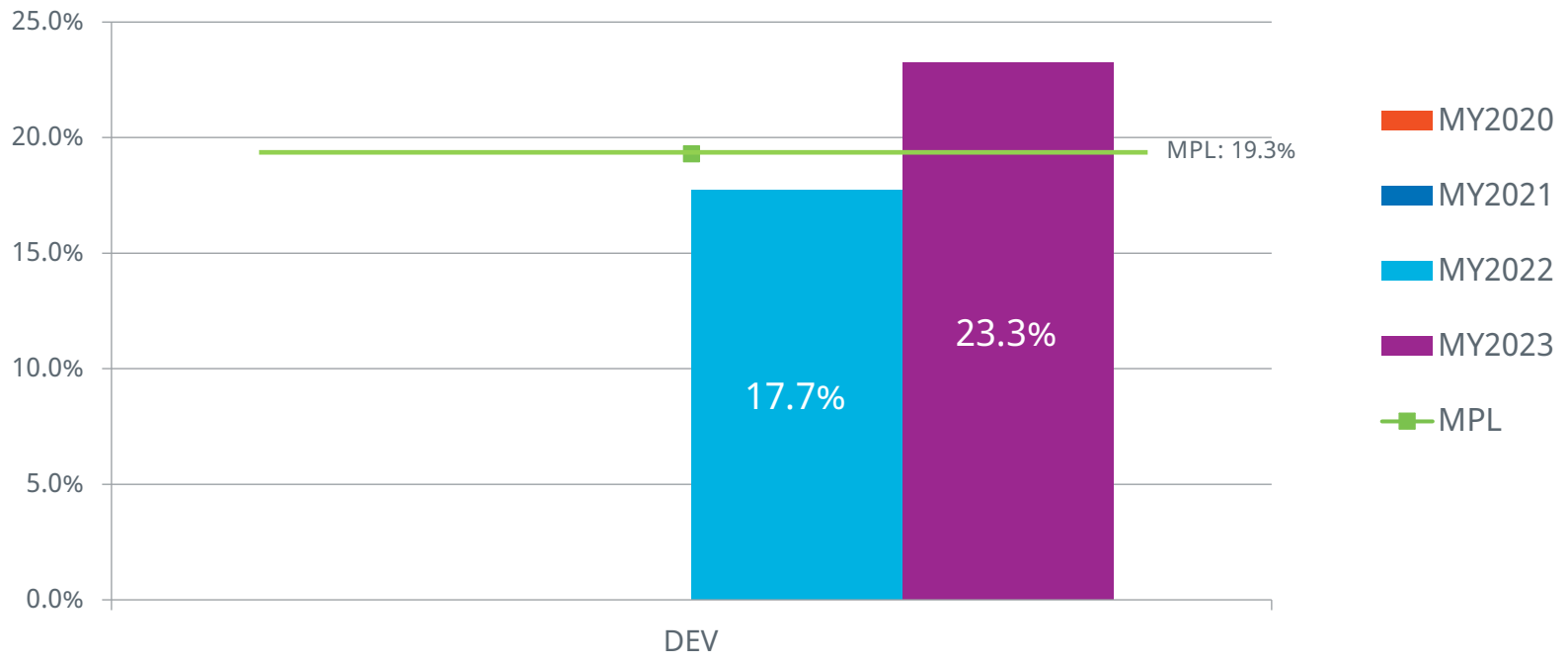
HEDIS MY2023 Results: Medi-Cal

Dental Fluoride Varnish for Children (TFL)



* Per HEDIS 2022 Quality Compass Percentile

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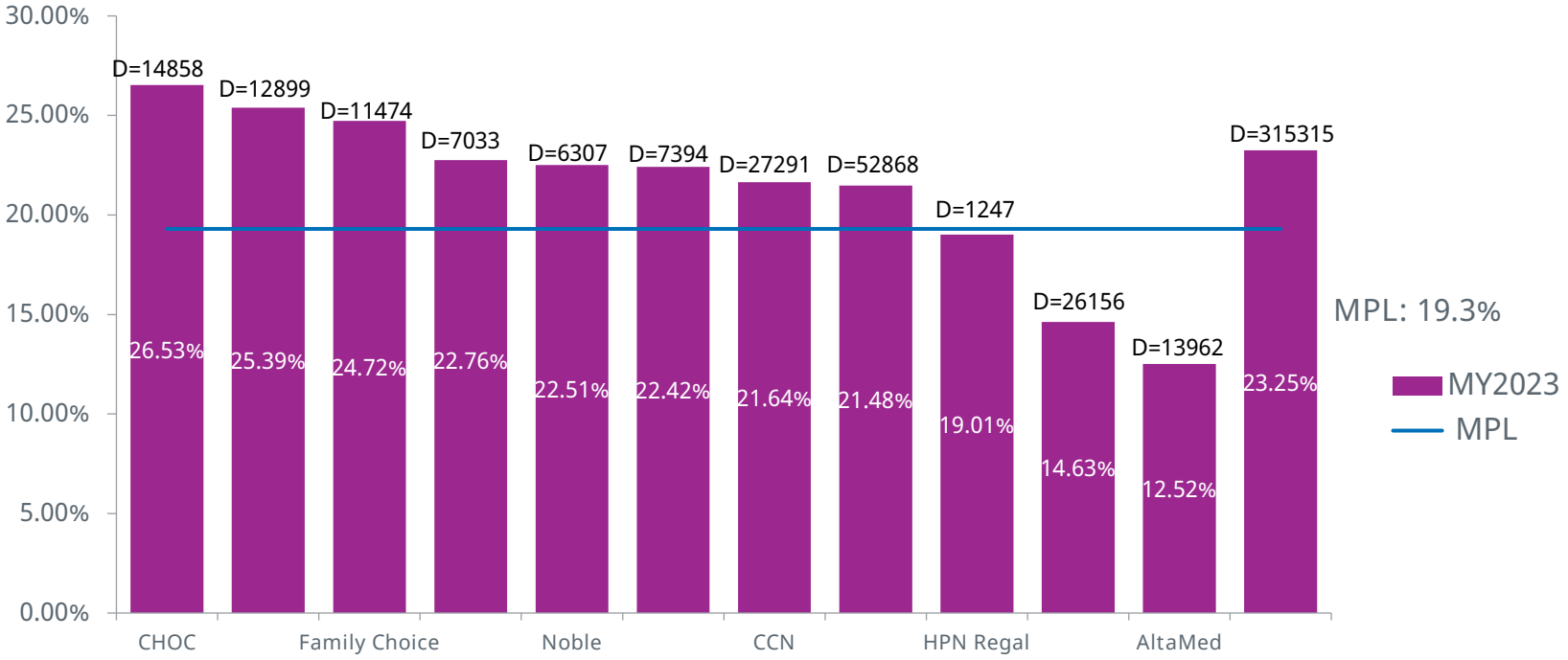
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Dental Fluoride Varnish for Children (TFL)



* Per HEDIS 2022 Quality Compass Percentile

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Cancer Prevention

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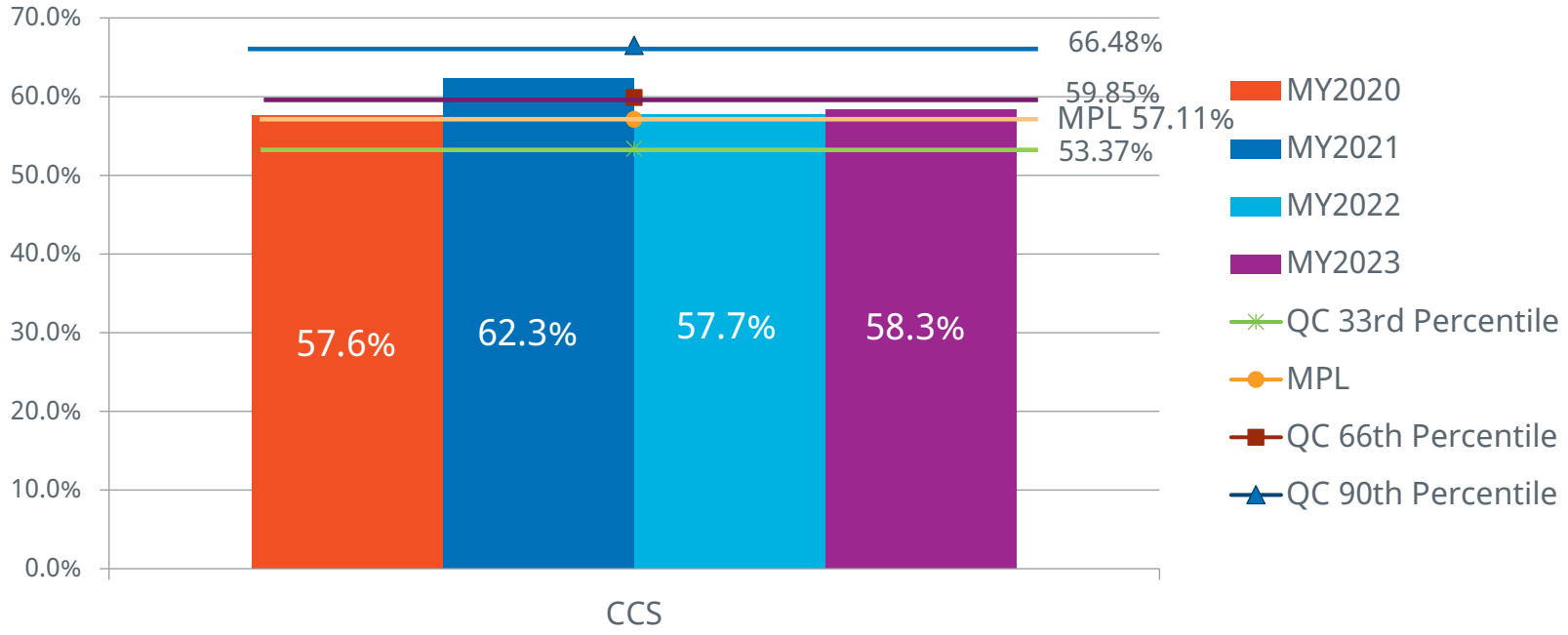
HEDIS MY2023 Results: Medi-Cal

Cervical Cancer Screening (CCS)



* Per HEDIS 2022 Quality Compass Percentile

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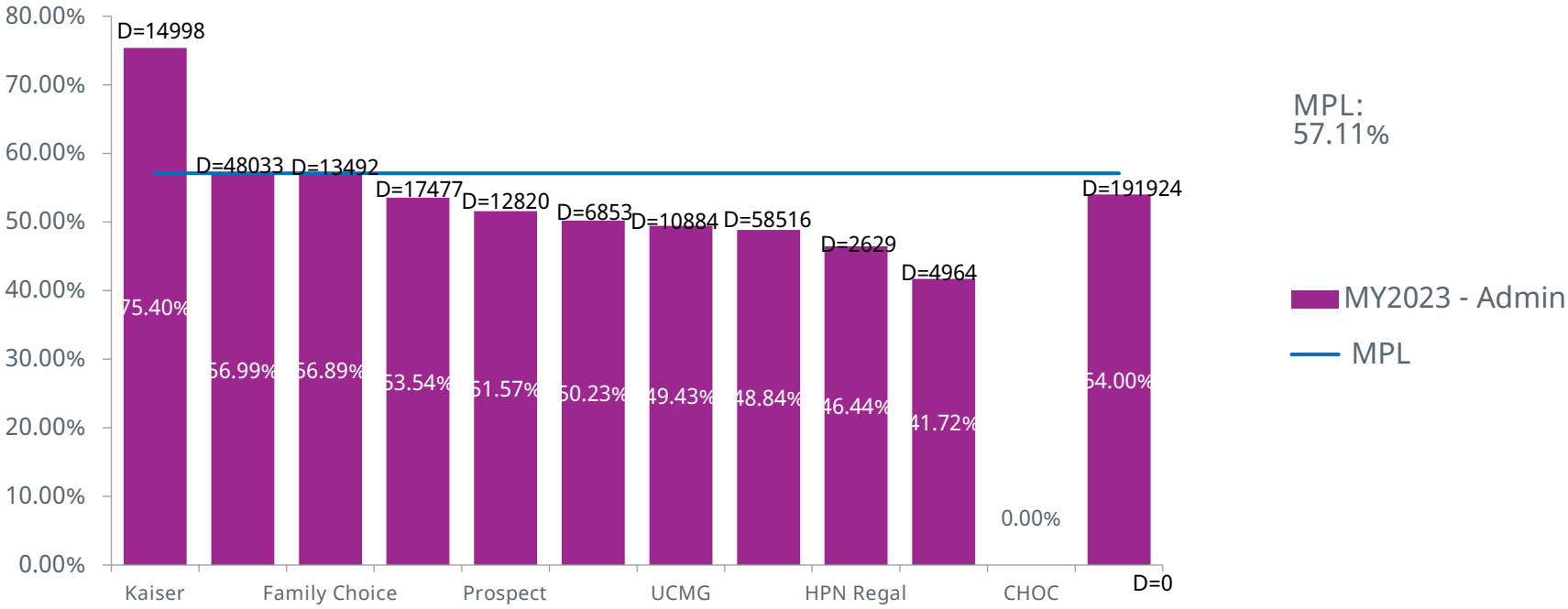
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Cervical Cancer Screening (CCS)



* Per HEDIS 2022 Quality Compass Percentile

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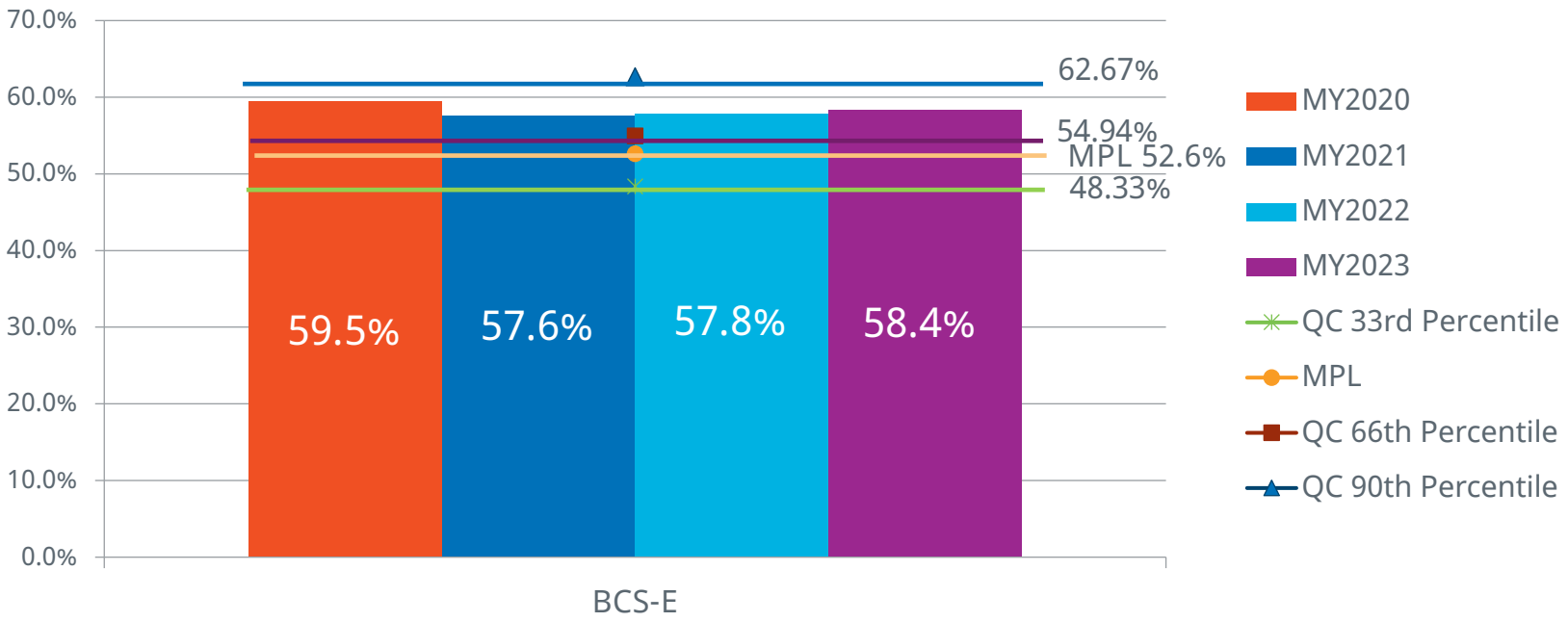
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Breast Cancer Screening (BCS)



* Per HEDIS 2022 Quality Compass Percentile

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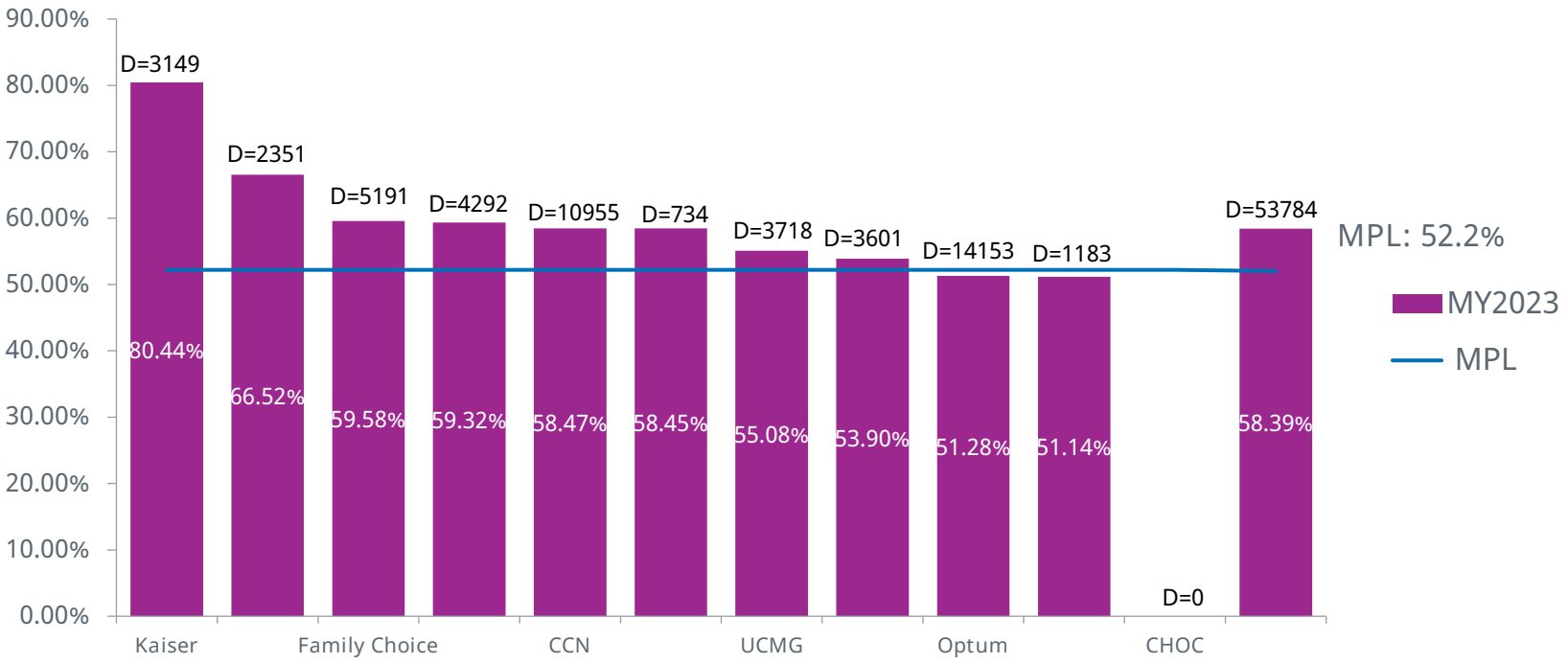
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Breast Cancer Screening (BCS)



* Per HEDIS 2022 Quality Compass Percentile

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Reproductive Health

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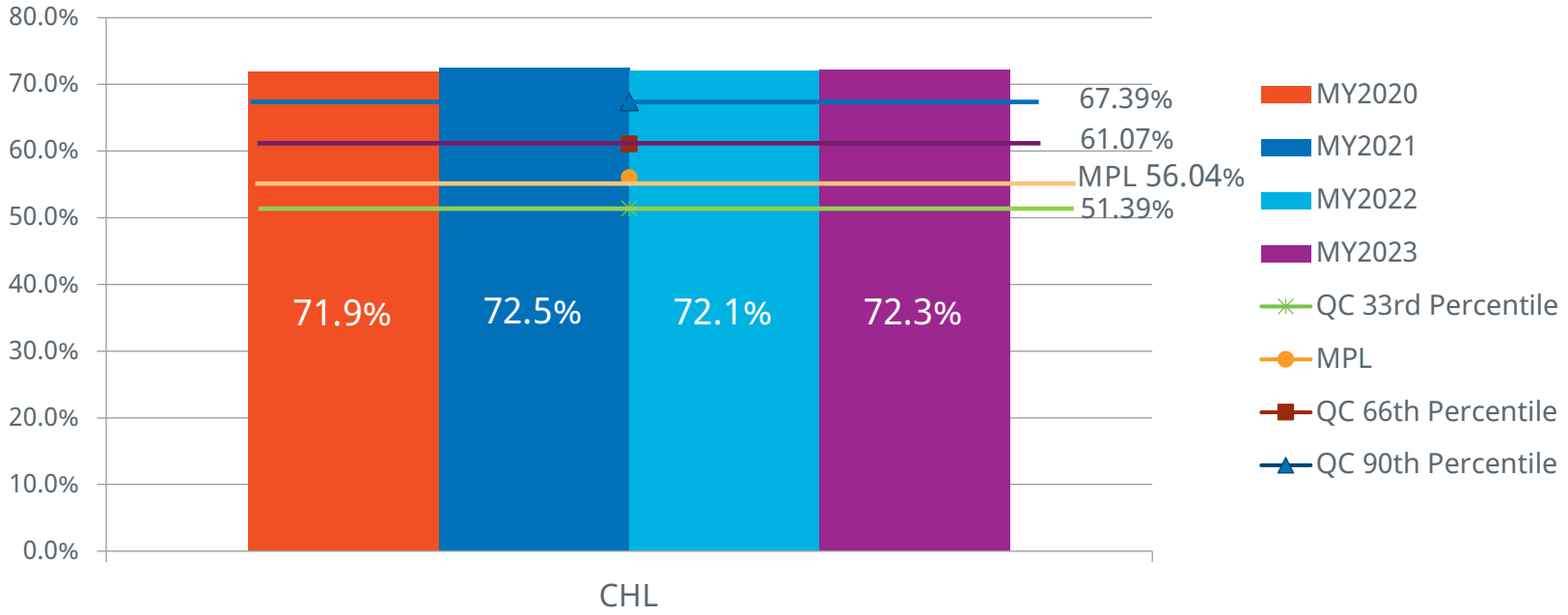
HEDIS MY2023 Results: Medi-Cal

Chlamydia Screening in Women (CHL) - Total



* Per HEDIS 2022 Quality Compass Percentile

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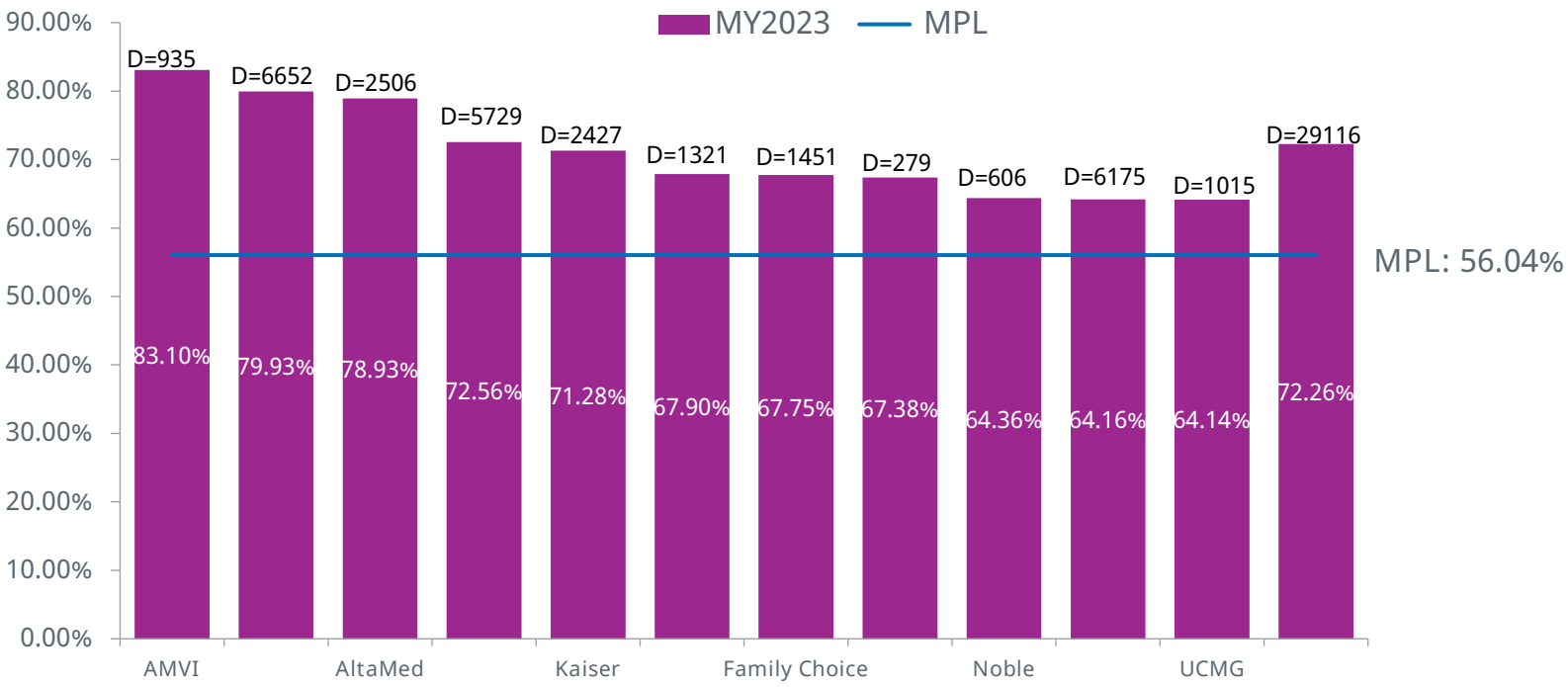
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Chlamydia Screening in Women (CHL) - Total



* Per HEDIS 2022 Quality Compass Percentile

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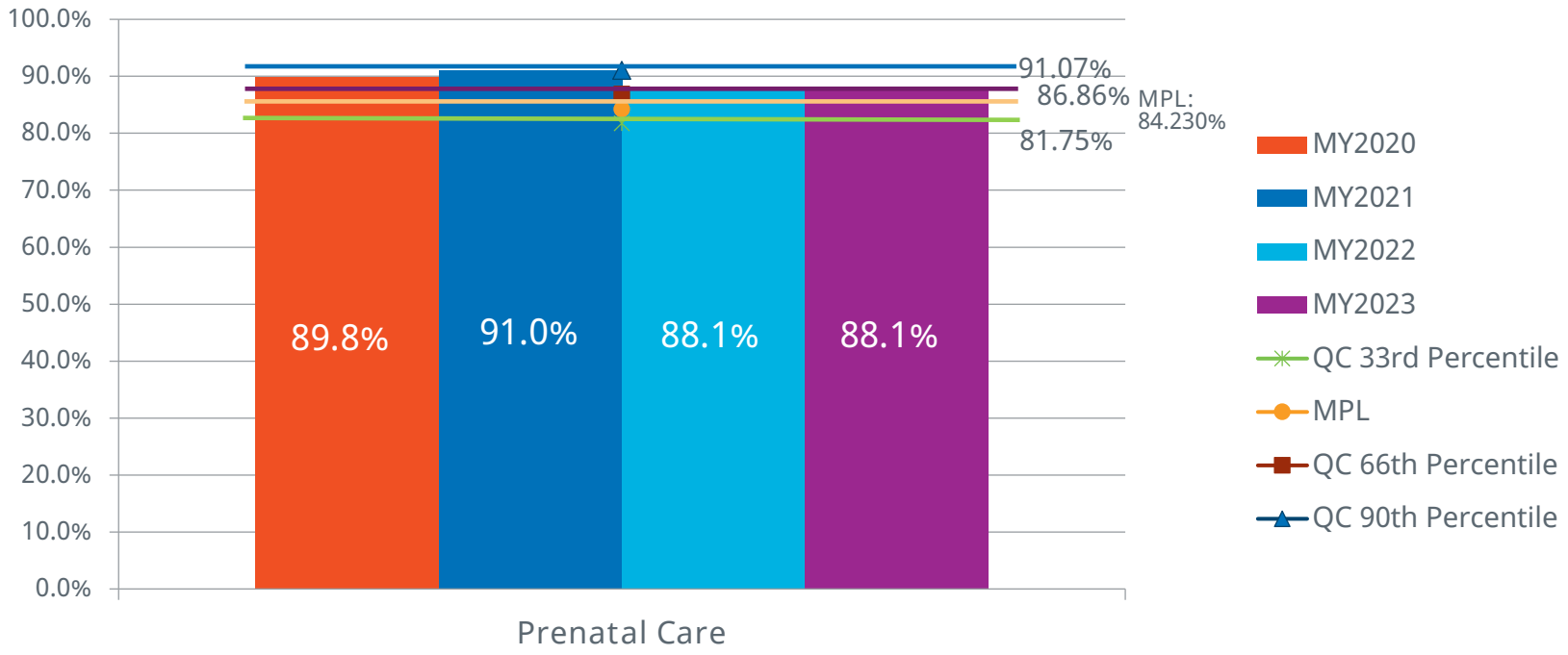
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Prenatal and Postpartum Care – Prenatal Care (PPC)



* Per HEDIS 2022 Quality Compass Percentile

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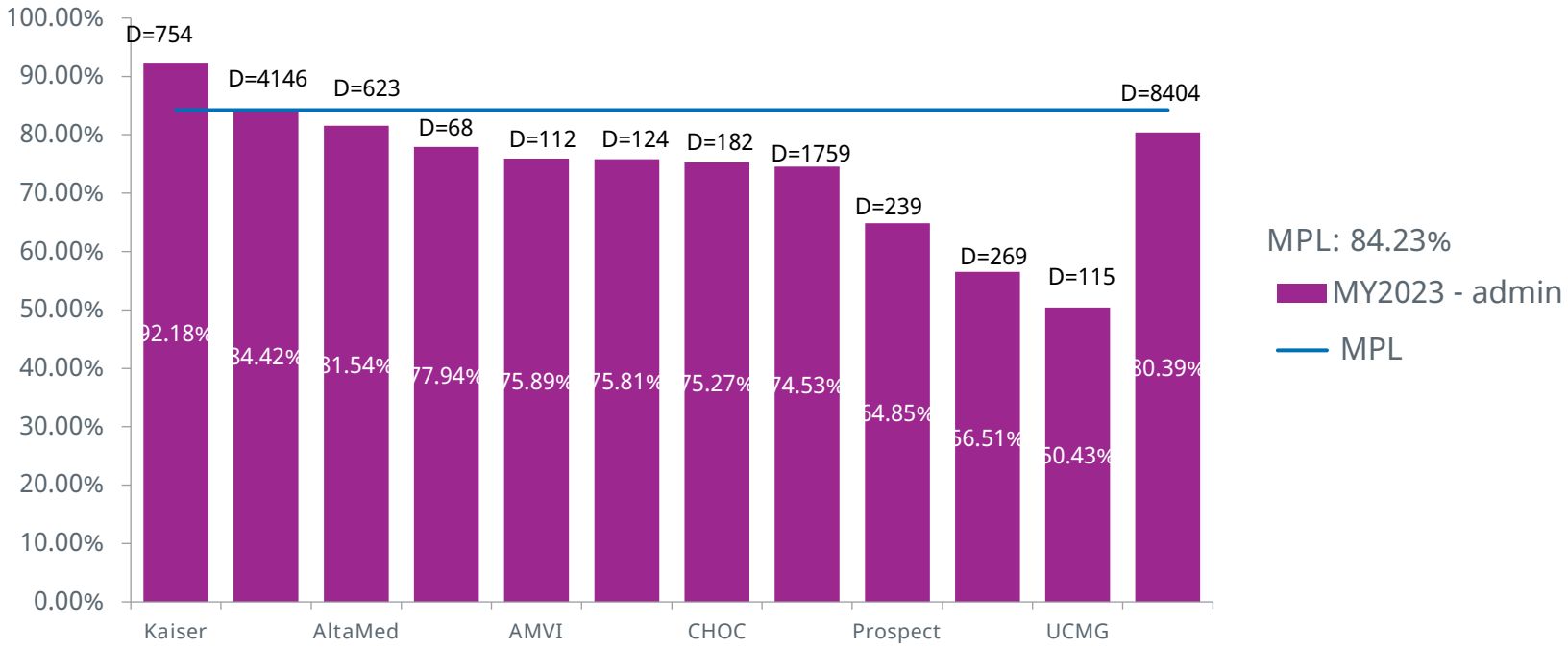
HEDIS MY2023 Results: Medi-Cal

Prenatal and Postpartum Care – Prenatal Care (PPC)



* Per HEDIS 2022 Quality Compass Percentile

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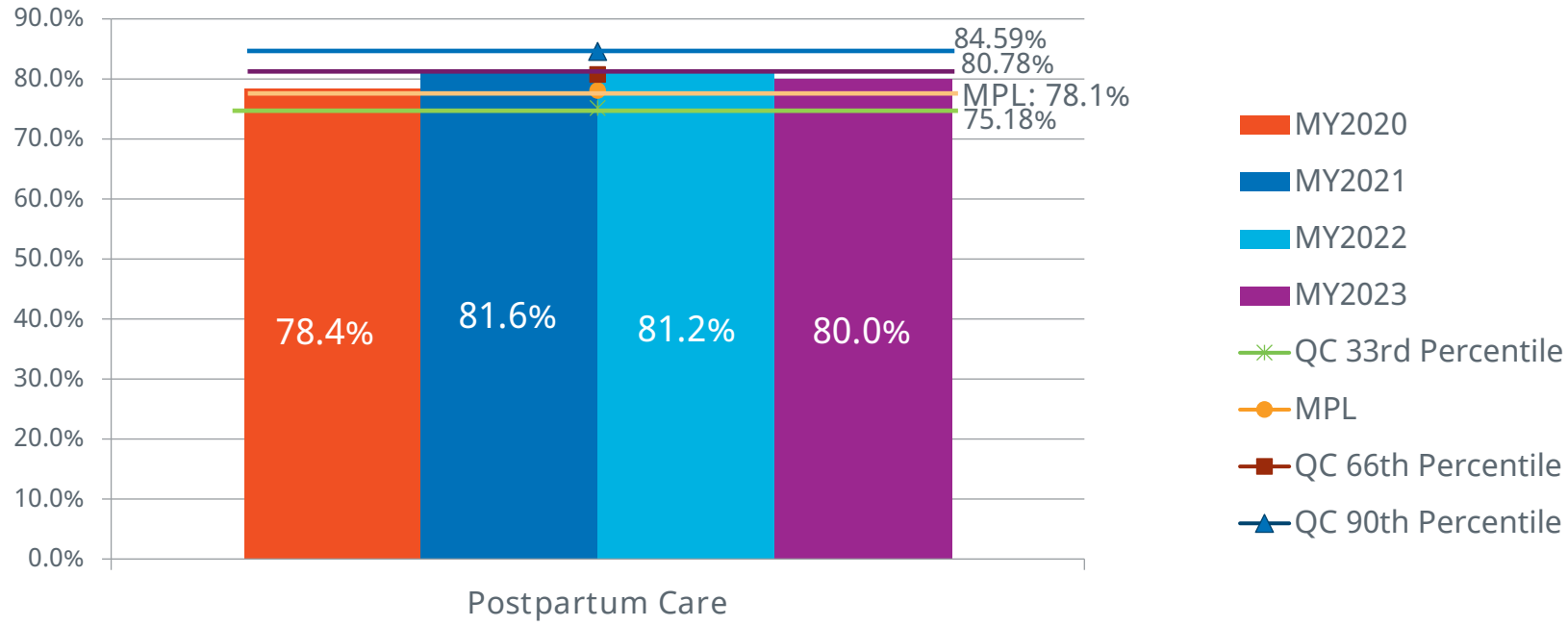
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Prenatal and Postpartum Care – Postpartum Care (PPC)



* Per HEDIS 2022 Quality Compass Percentile

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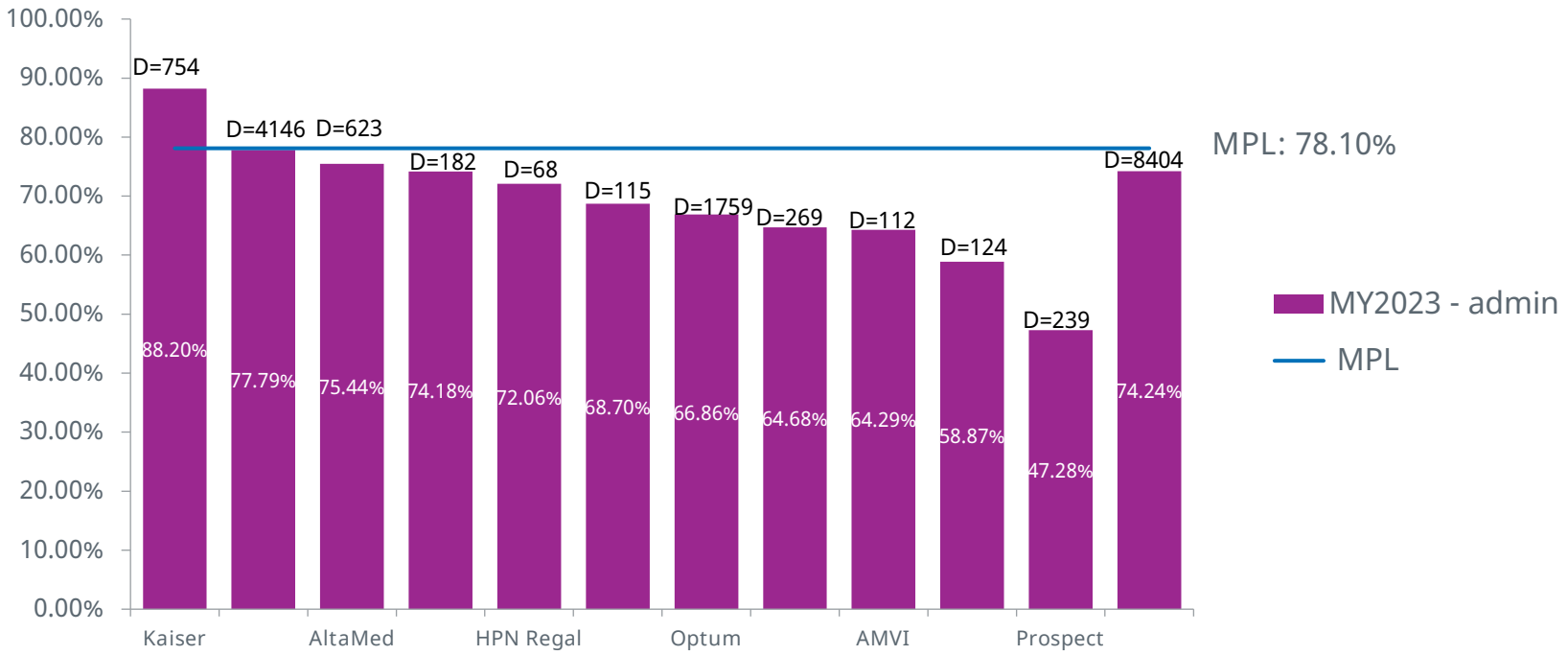
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Prenatal and Postpartum Care – Postpartum Care (PPC)



* Per HEDIS 2022 Quality Compass Percentile

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CalOptima Health

Diabetes

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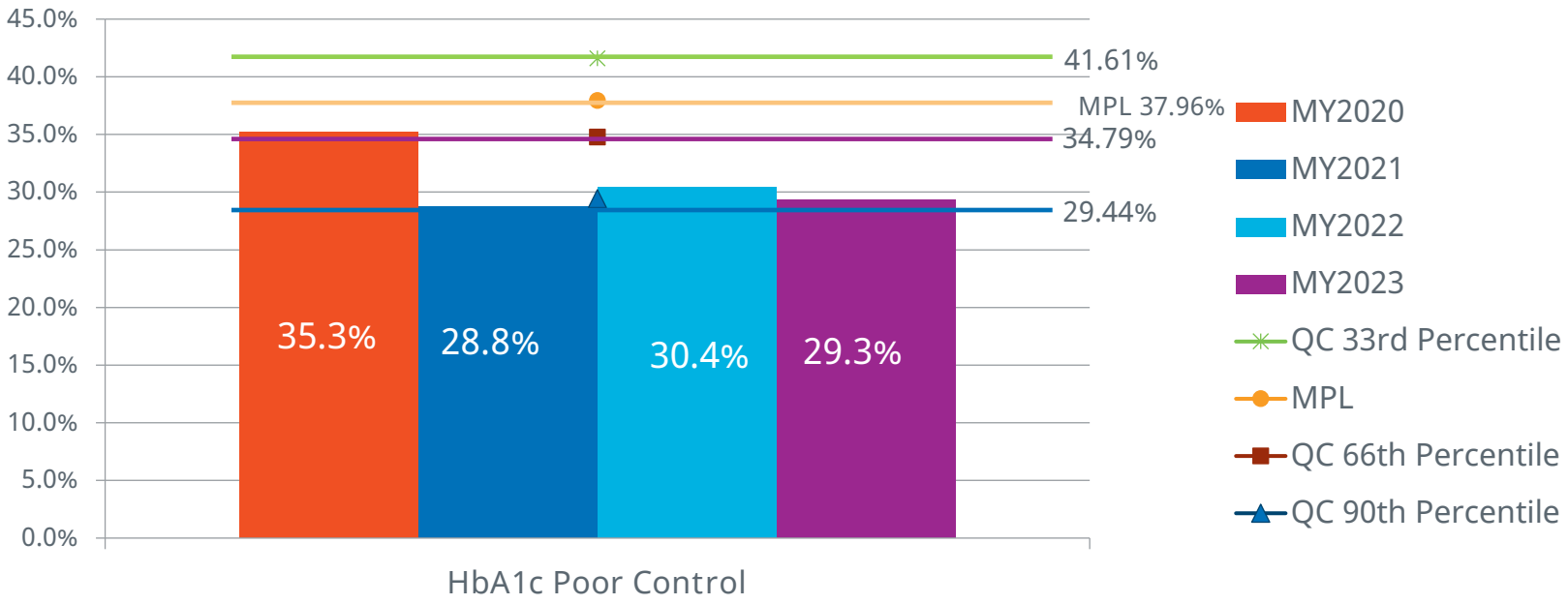
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

HbA1c Control for Patients with Diabetes (HBD) – Poor Control >9.0% (Lower is better)



* Per HEDIS 2022 Quality Compass Percentile

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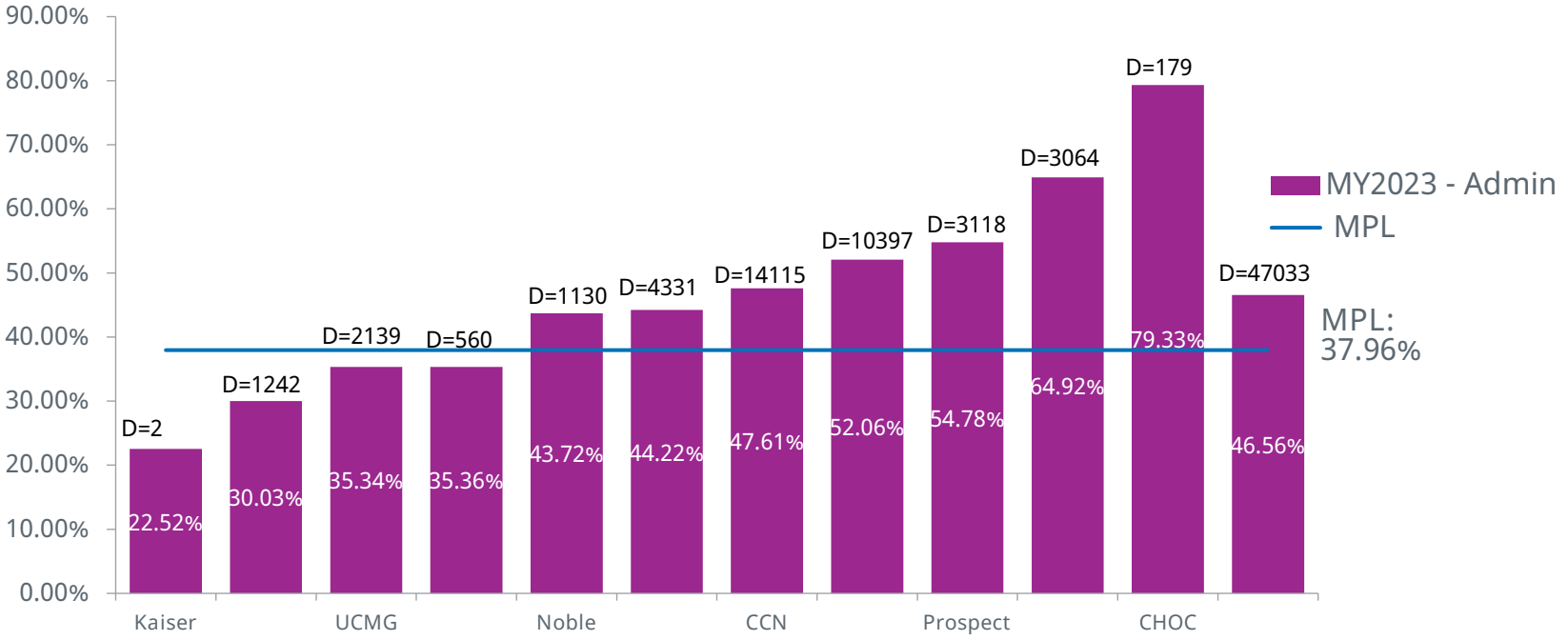
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

HbA1c Control for Patients with Diabetes (HBD) – Poor Control >9.0% (Lower is better)



* Per HEDIS 2022 Quality Compass Percentile

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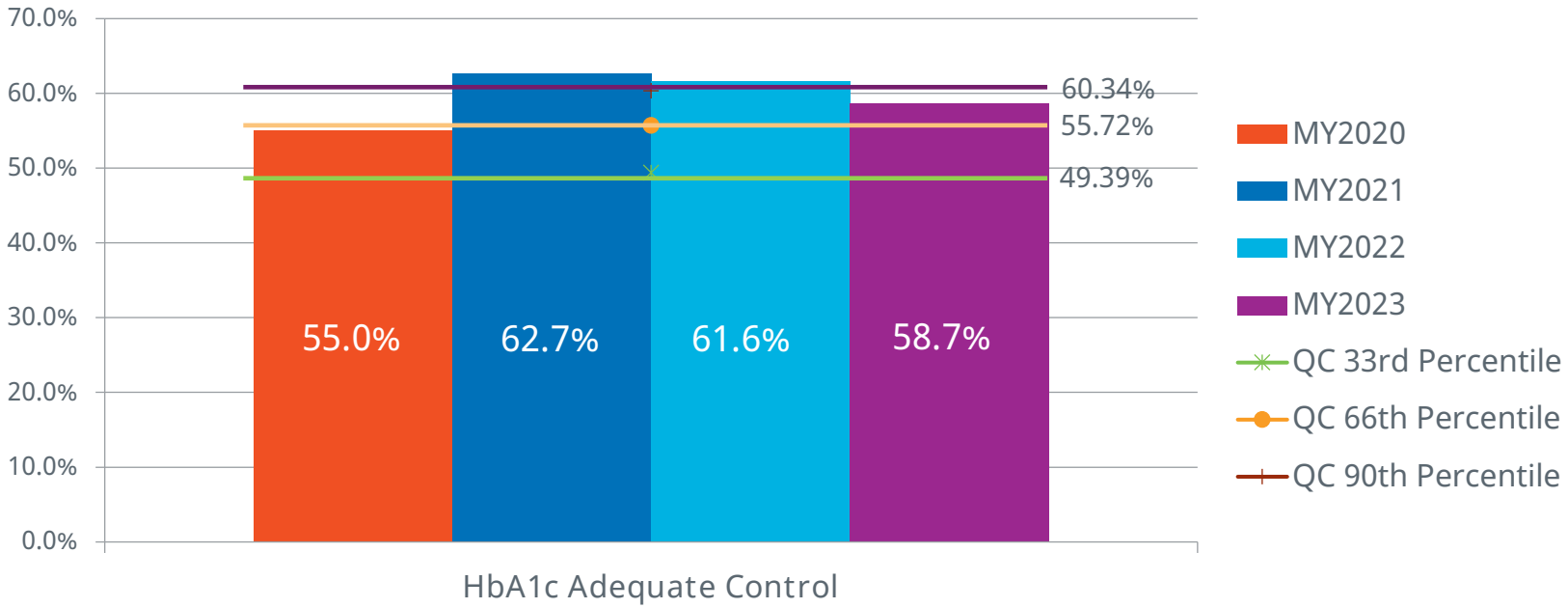
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

HbA1c Control for Patients with Diabetes (HBD) - Adequate Control <8.0%



* Per HEDIS 2022 Quality Compass Percentile

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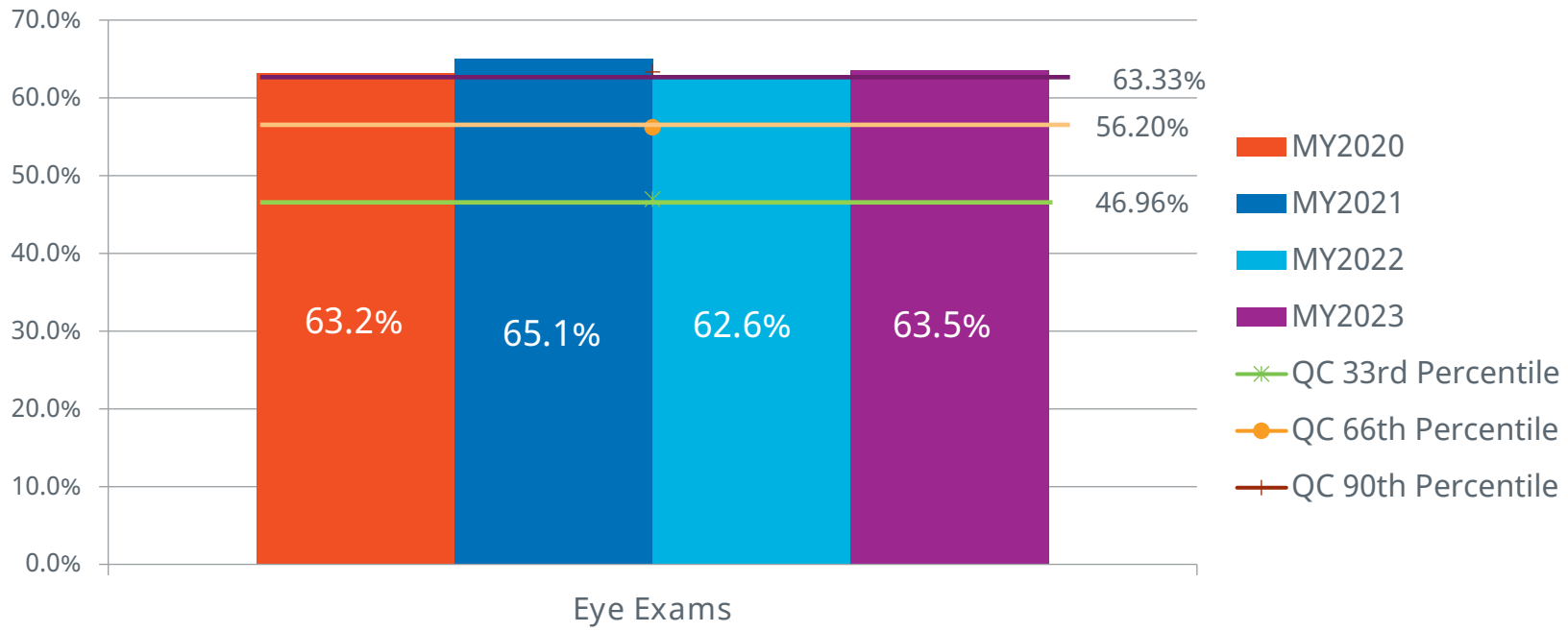
HEDIS MY2023 Results: Medi-Cal

Eye Exam for patient with Diabetes (EED)



* Per HEDIS 2022 Quality Compass Percentile

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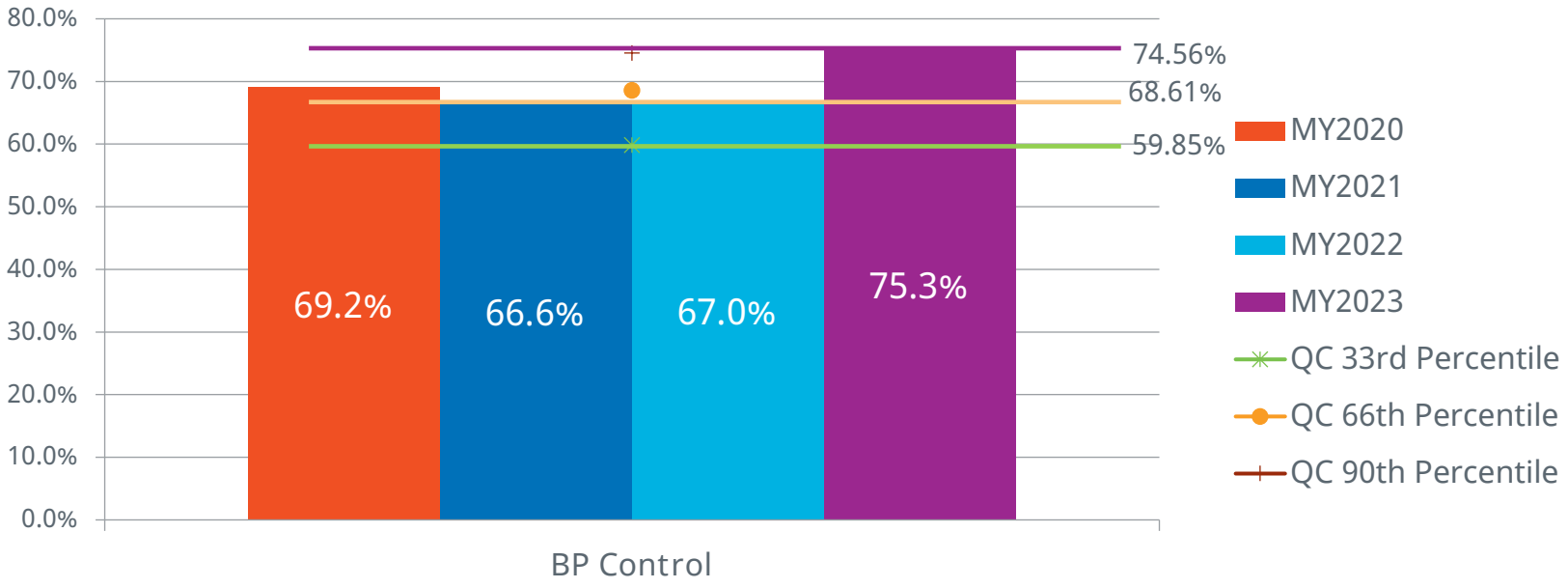
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Blood Pressure Controlled for Patients with Diabetes (BPD)



* Per HEDIS 2022 Quality Compass Percentile

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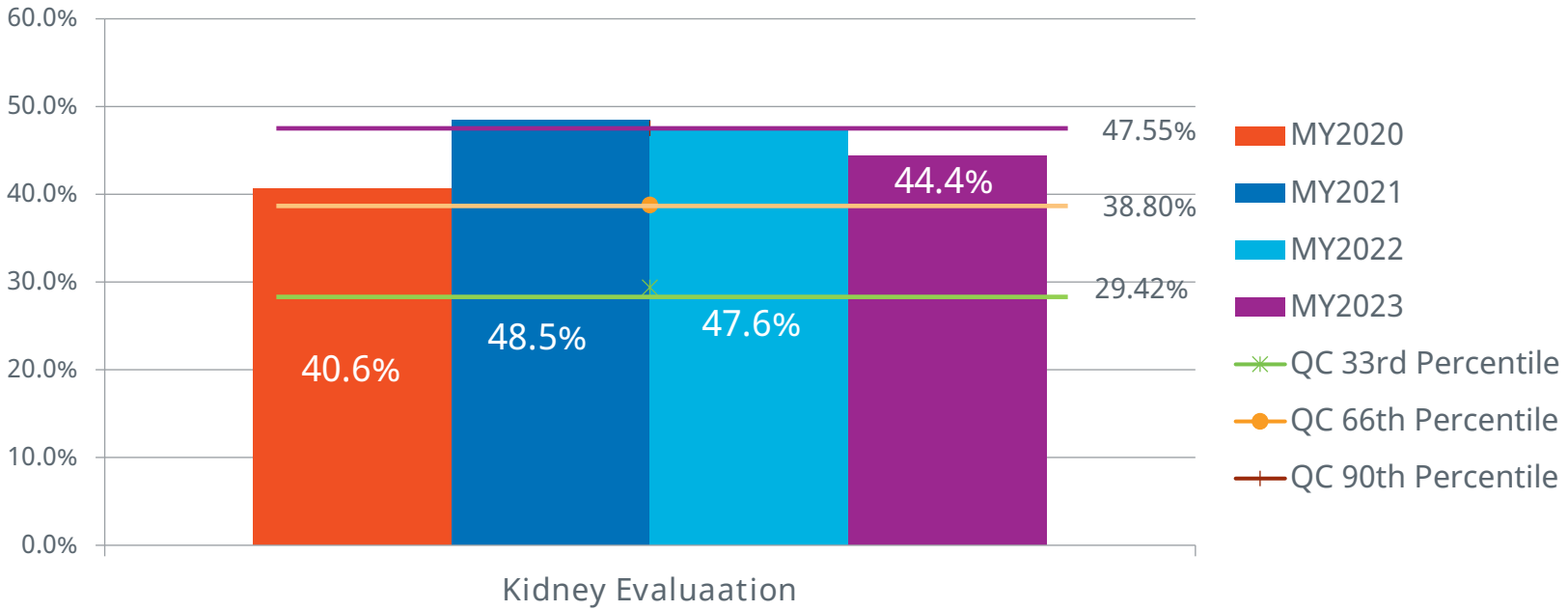
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Kidney Health Evaluation for Patients with Diabetes (KED)



- Per HEDIS 2022 Quality Compass Percentile

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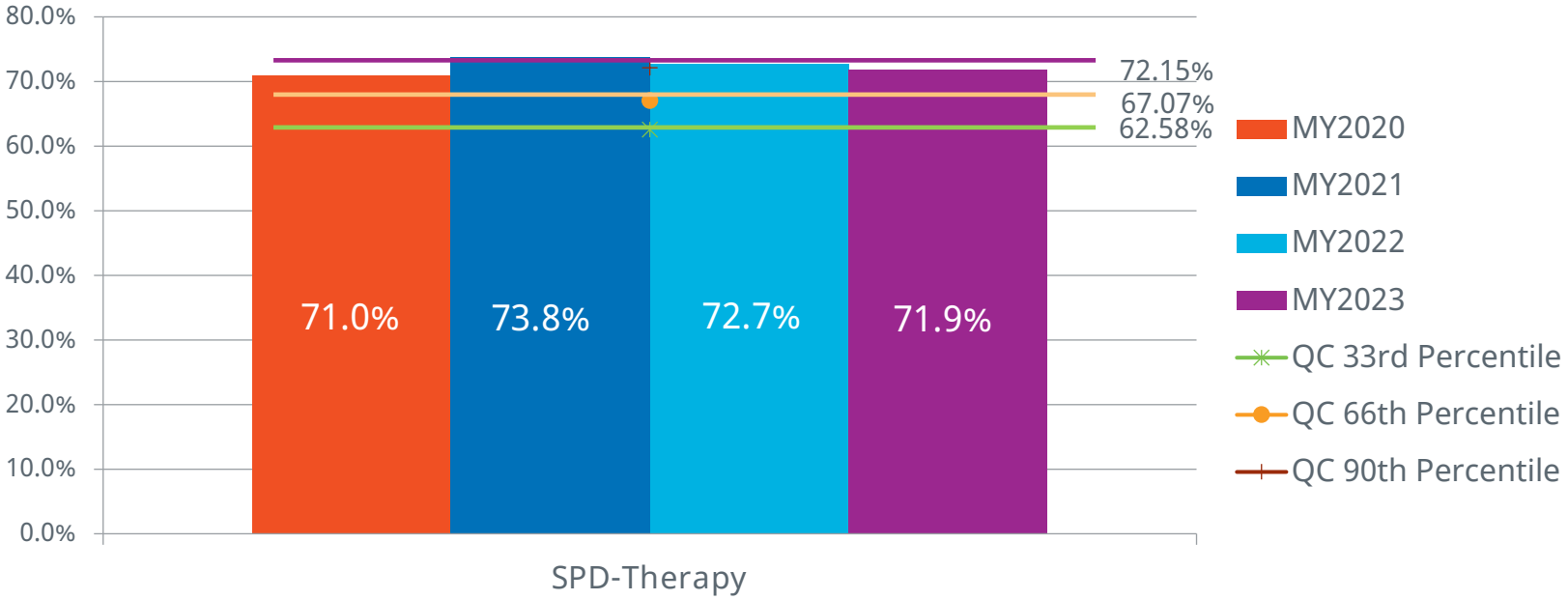
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Statin Therapy for Patients with Diabetes – Therapy (SPD)



* Per HEDIS 2022 Quality Compass Percentile

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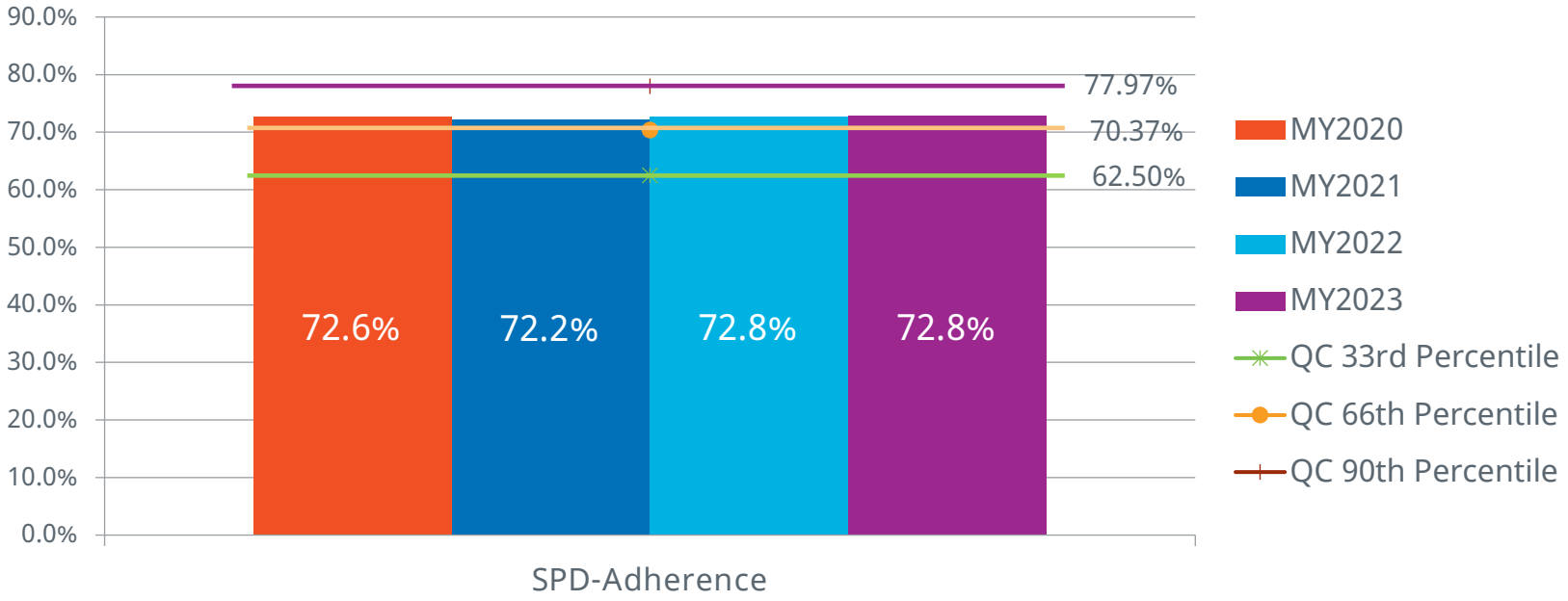
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Statin Therapy for Patients with Diabetes – Adherence (SPD)



* Per HEDIS 2022 Quality Compass Percentile

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CalOptima Health

Cardiovascular Conditions

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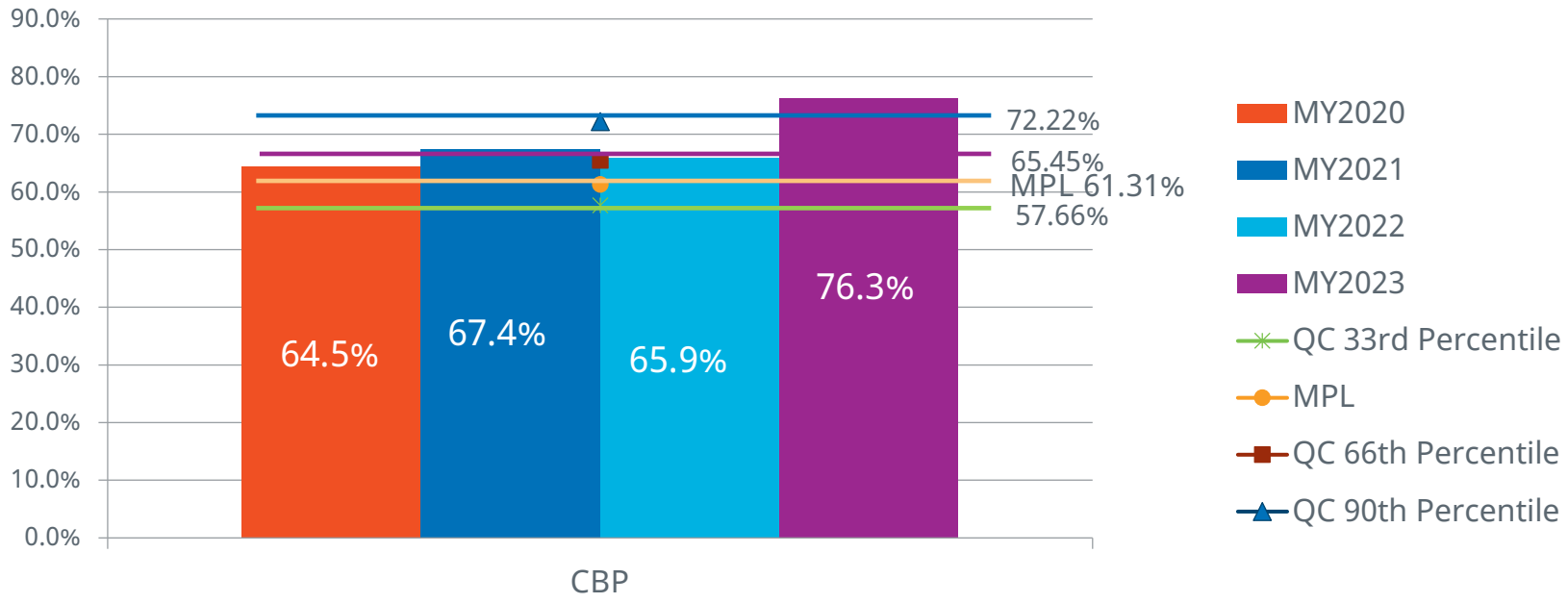
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Controlling High-Blood Pressure (CBP)



* Per HEDIS 2022 Quality Compass Percentile

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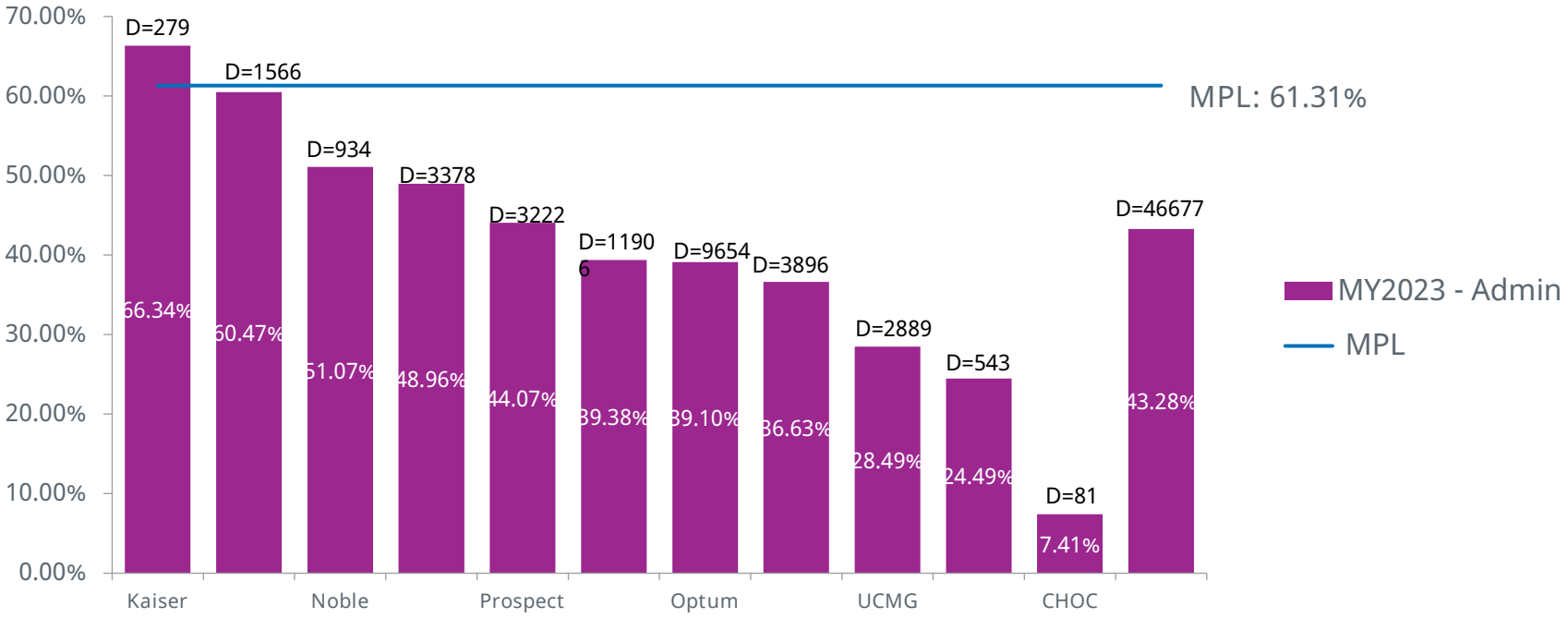
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Controlling High-Blood Pressure (CBP)



* Per HEDIS 2022 Quality Compass Percentile

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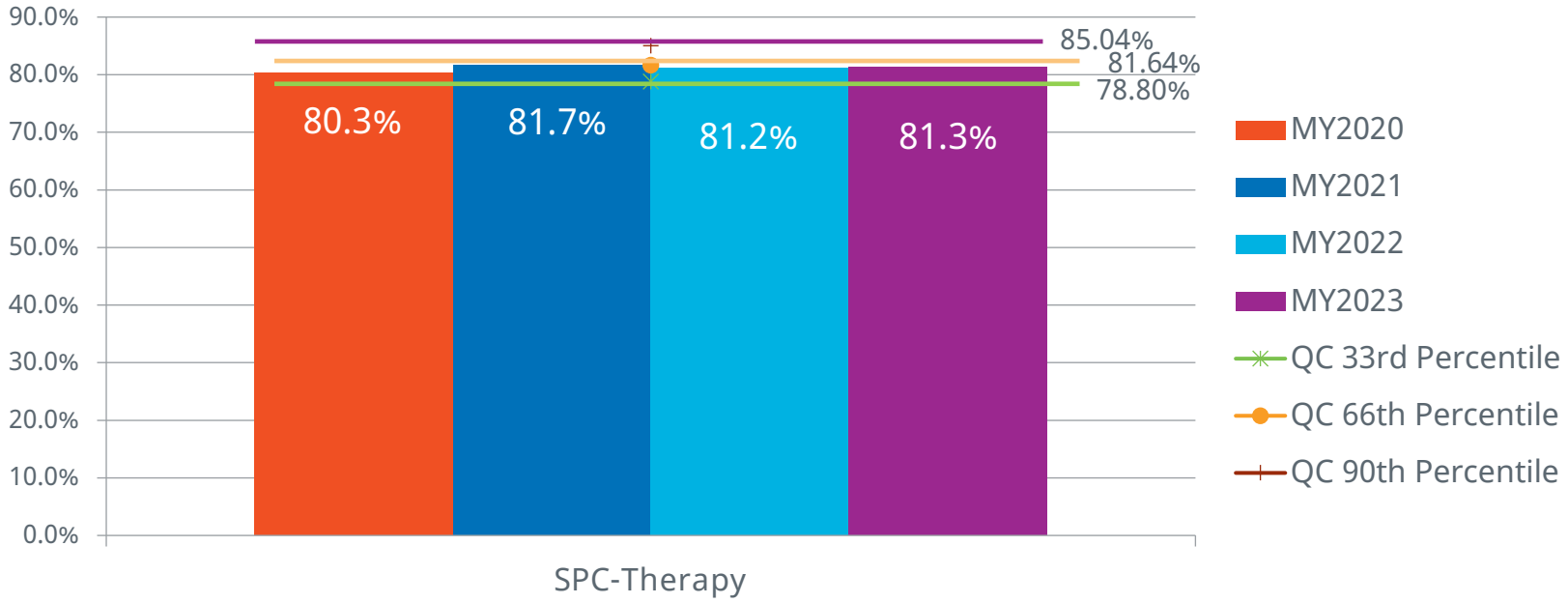
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Statin Therapy for Patients with Cardiovascular Disease – Therapy (SPC)



* Per HEDIS 2022 Quality Compass Percentile

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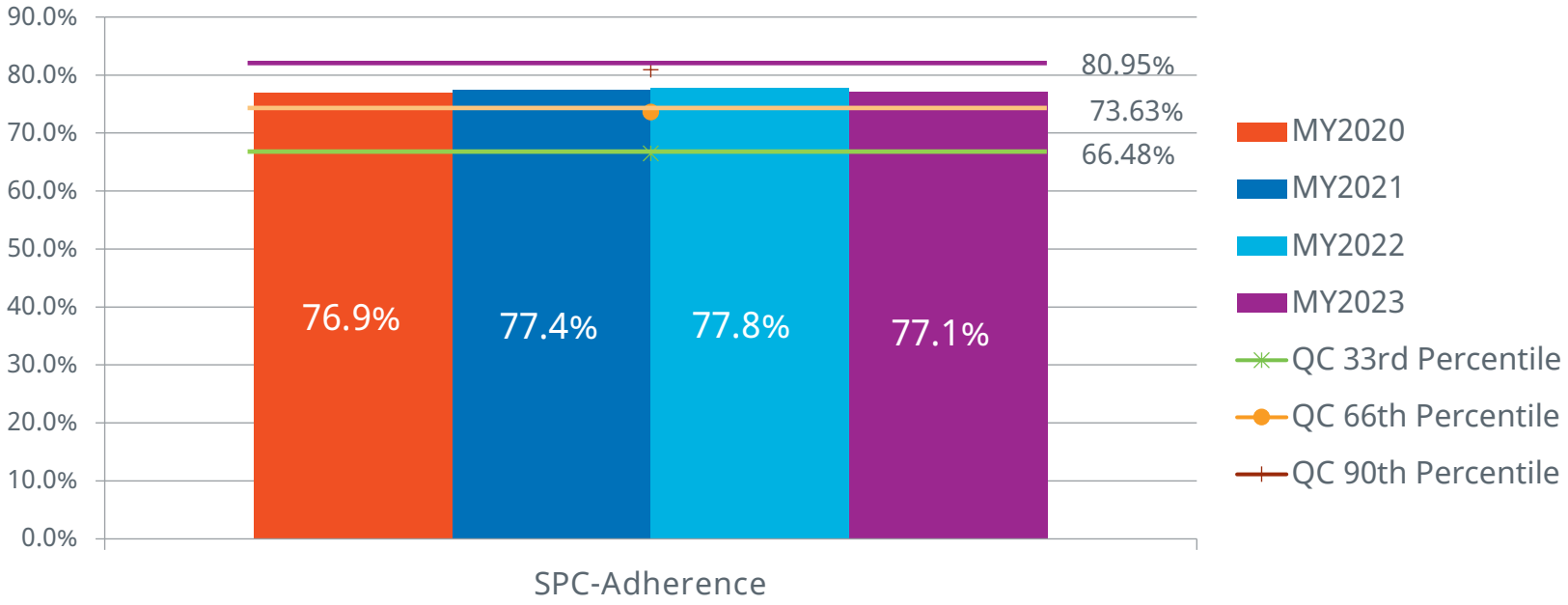
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Statin Therapy for Patients with Cardiovascular Disease – Adherence (SPC)



* Per HEDIS 2022 Quality Compass Percentile

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CalOptima Health

Respiratory Conditions

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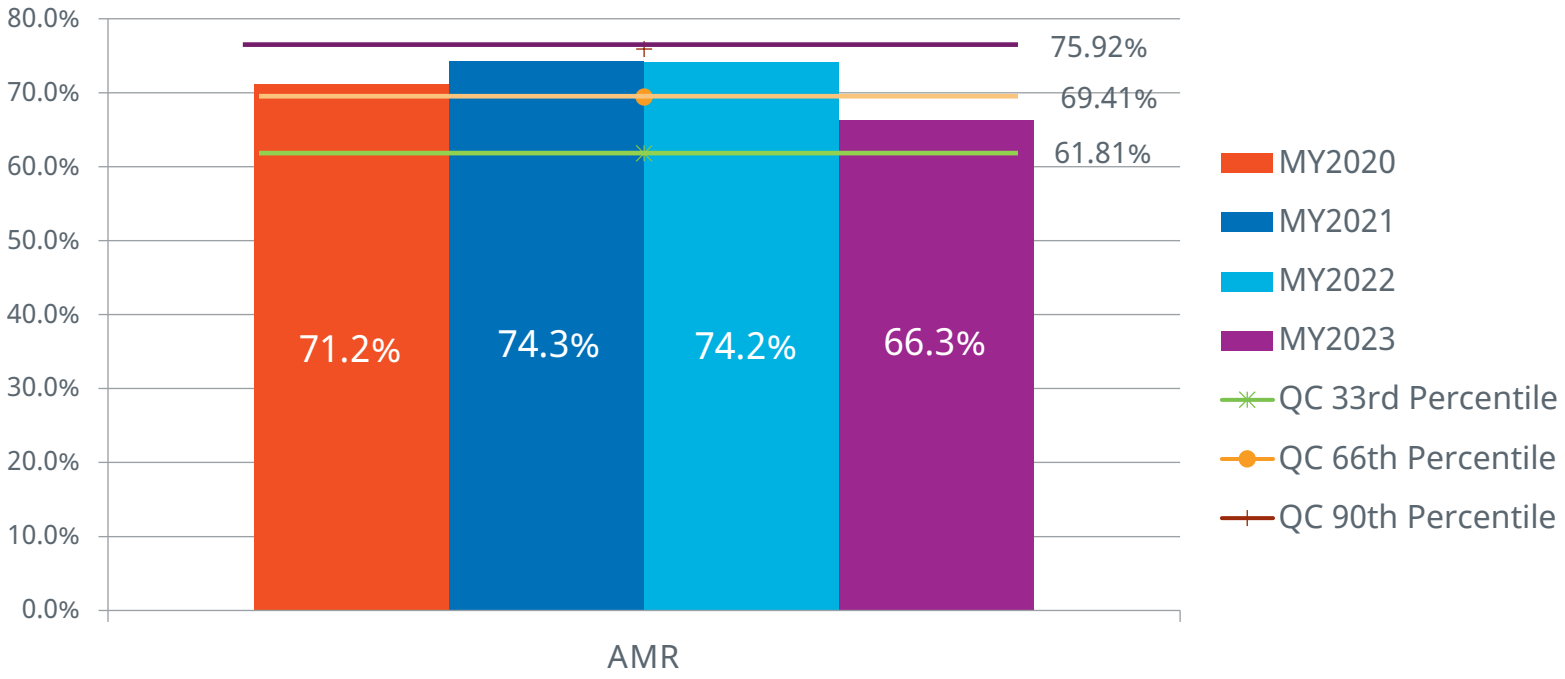
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Asthma Medication Ratio >50% (5-64 years)(AMR)



* Per HEDIS 2022 Quality Compass Percentile

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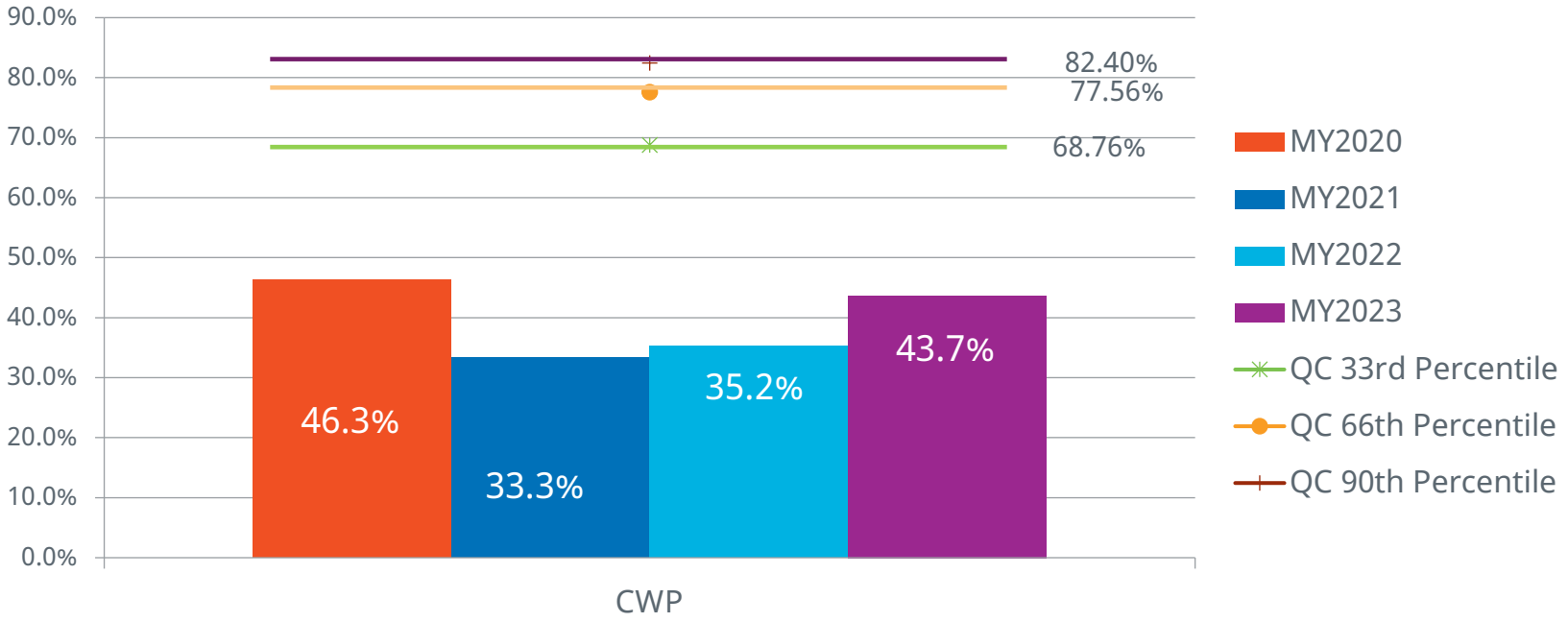
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Appropriate Testing for Children with Pharyngitis (CWP)



* Per HEDIS 2022 Quality Compass Percentile

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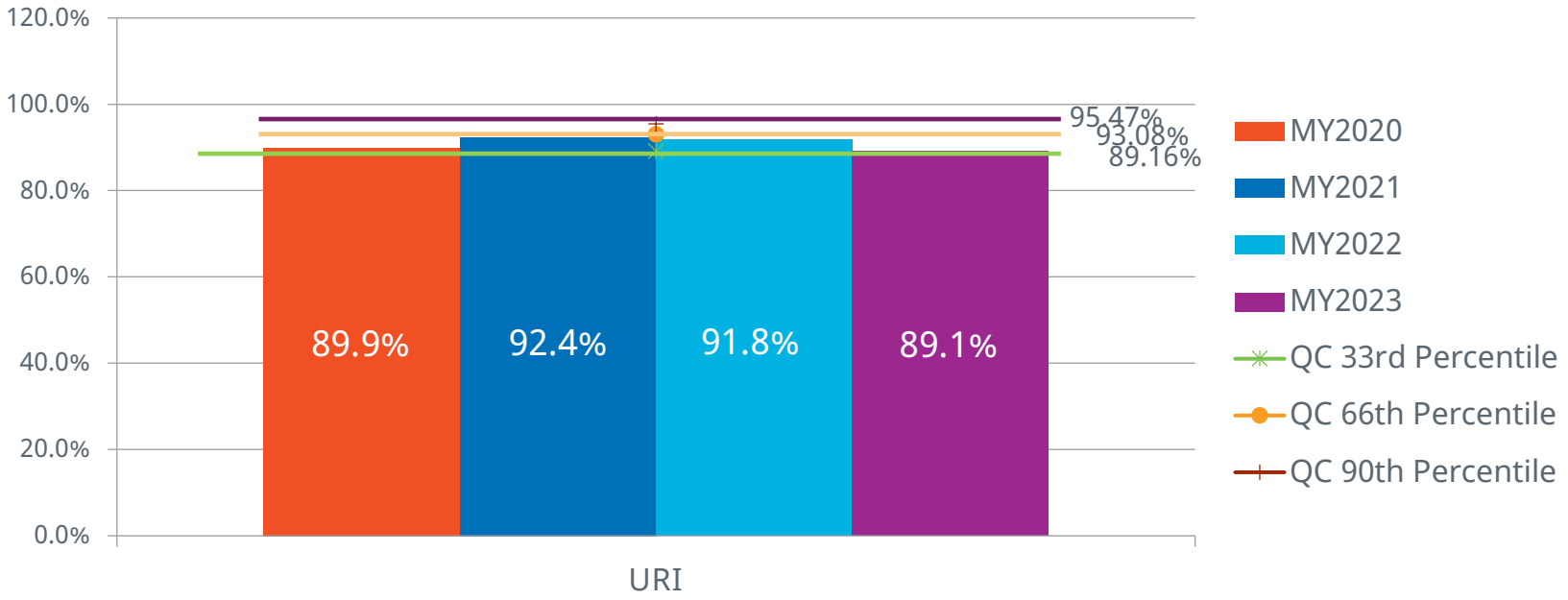
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Appropriate Treatment for Children with Upper Respiratory Infection (URI)



* Per HEDIS 2022 Quality Compass Percentile

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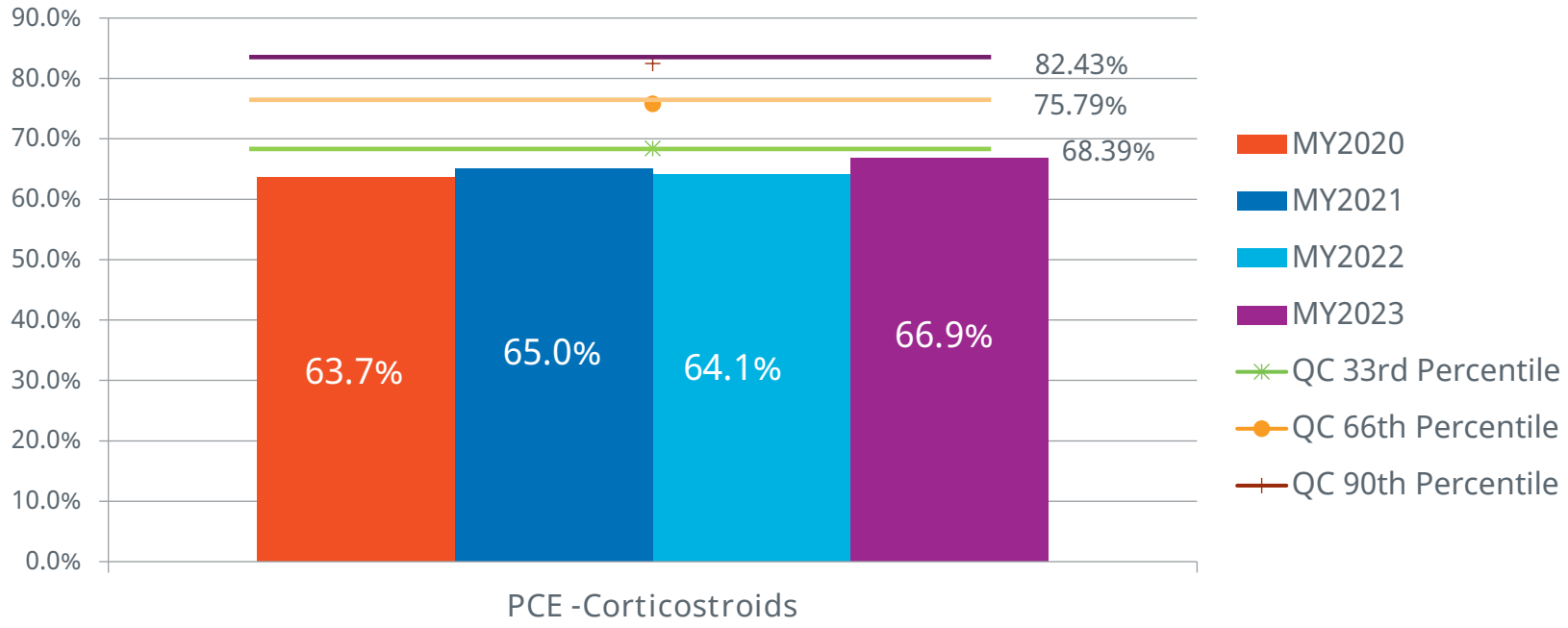
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroids (PCE)



* Per HEDIS 2022 Quality Compass Percentile

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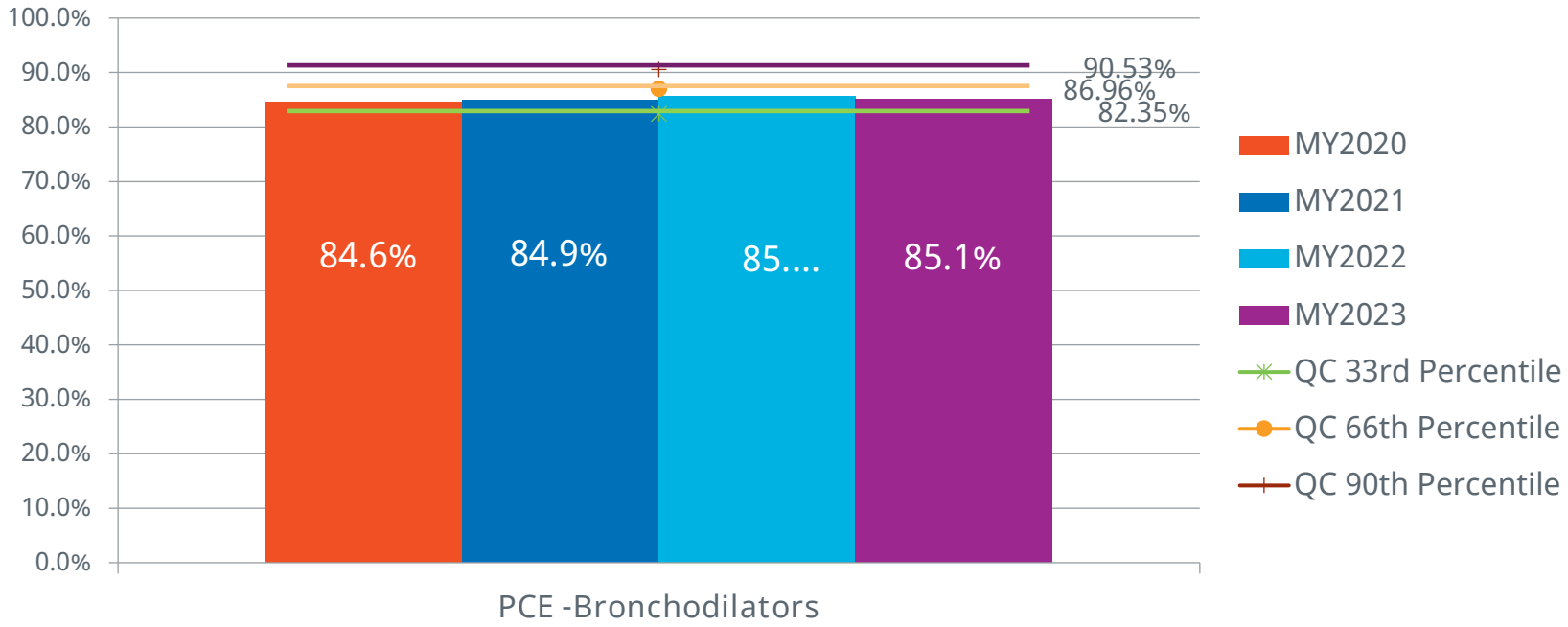
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Pharmacotherapy Management of COPD Exacerbation – Bronchodilators (PCE)



* Per HEDIS 2022 Quality Compass Percentile

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CalOptima Health

Behavioral Health

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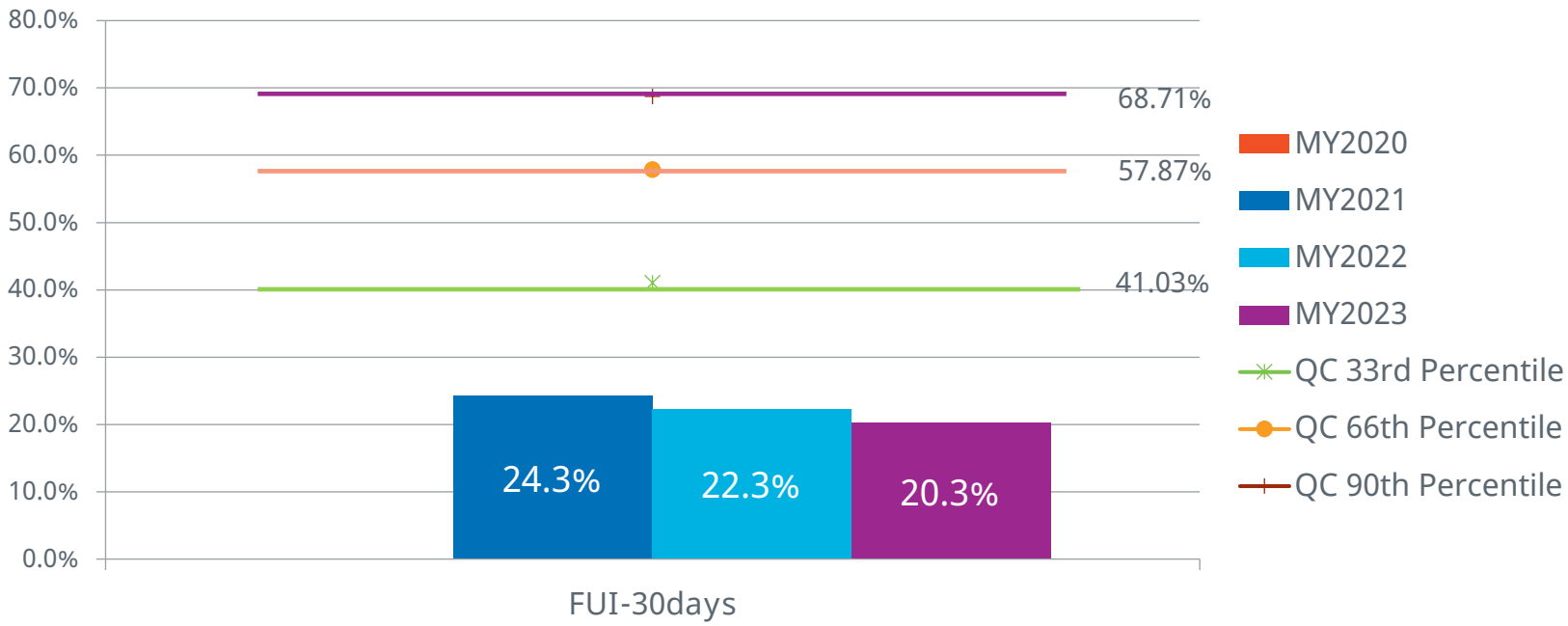
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Follow-Up After High-Intensity Care for Substance Use Disorder – 30 days (FUI)



* Per HEDIS 2022 Quality Compass Percentile

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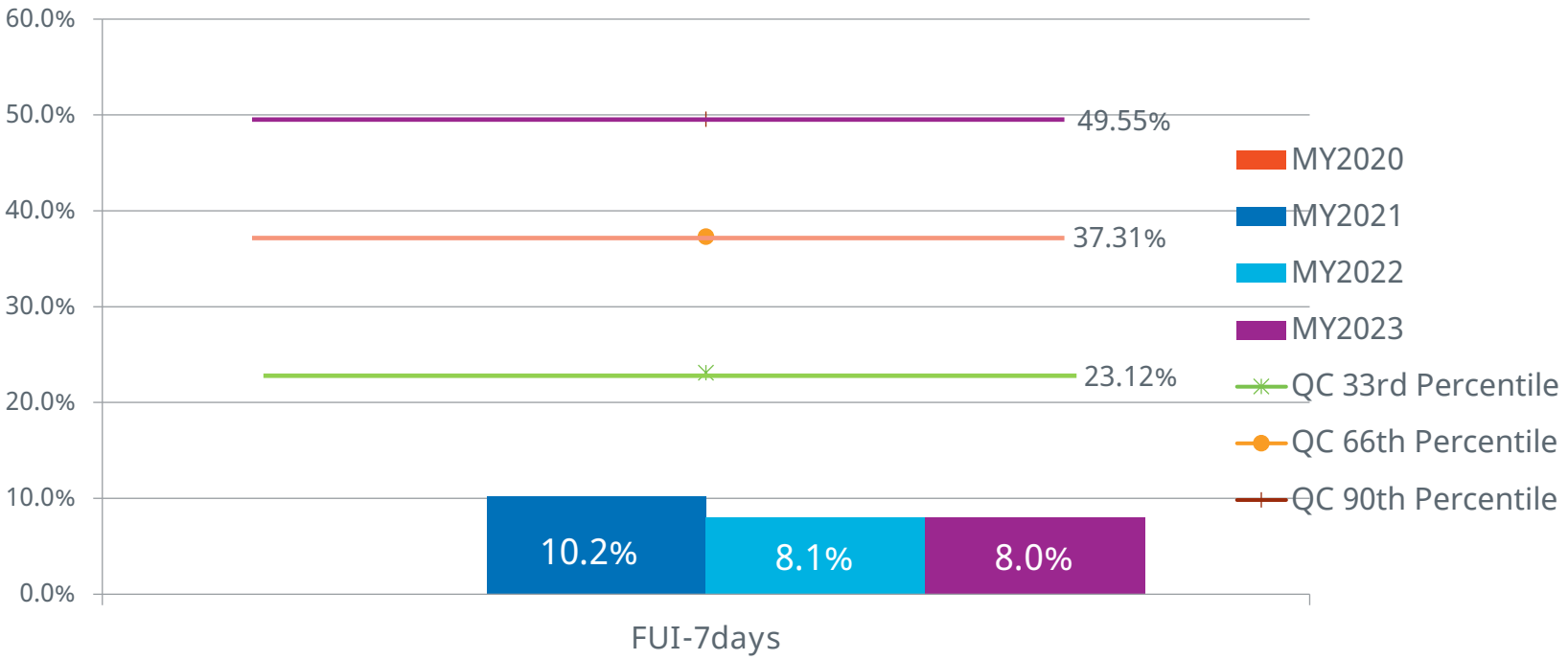
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Follow-Up After High-Intensity Care for Substance Use Disorder – 7days (FUI)



* Per HEDIS 2022 Quality Compass Percentile

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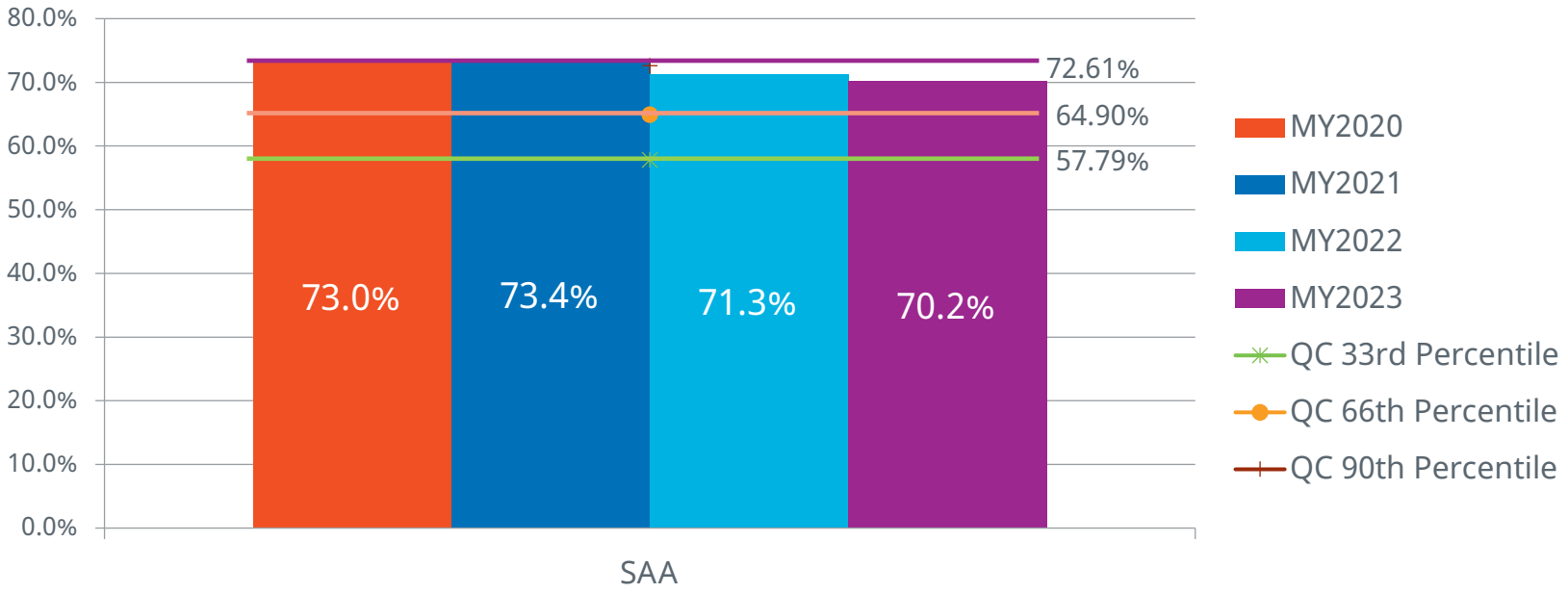
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)



* Per HEDIS 2022 Quality Compass Percentile

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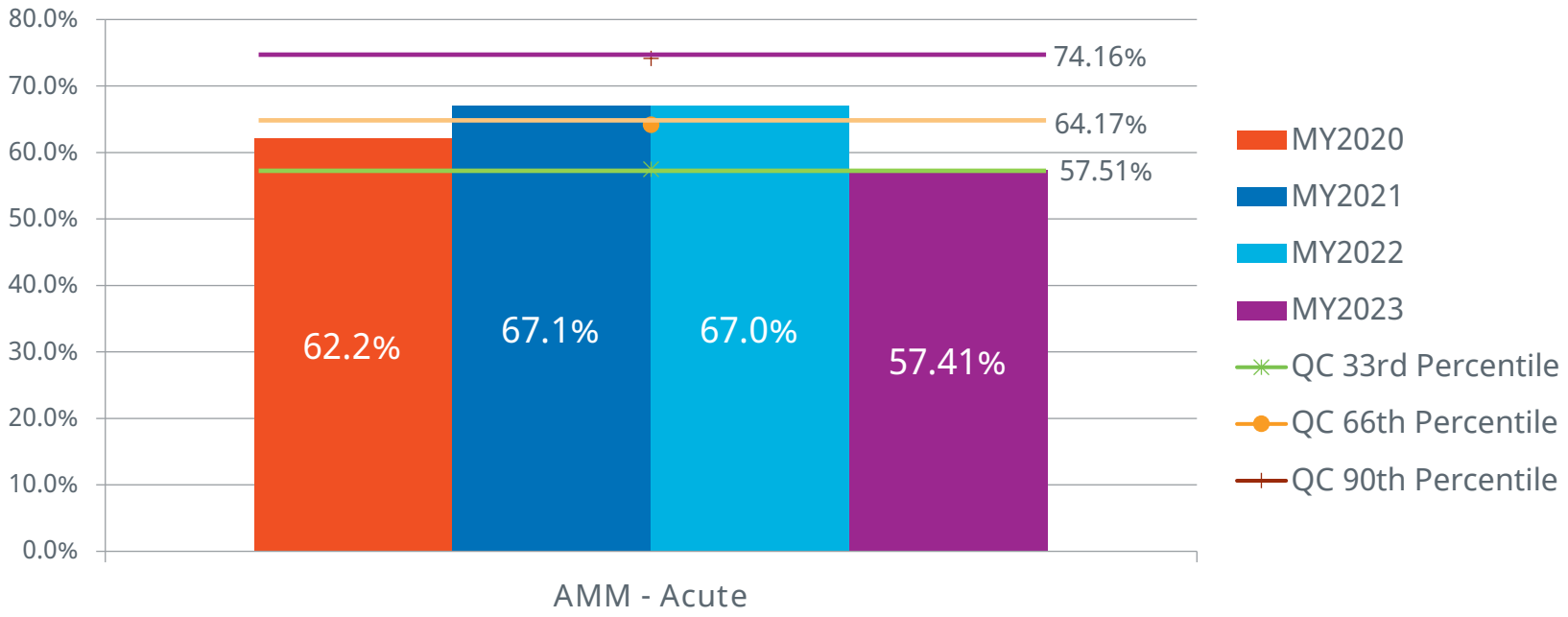
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Antidepressant Medication Management – Acute Phase Treatment (AMM)



* Per HEDIS 2022 Quality Compass Percentile

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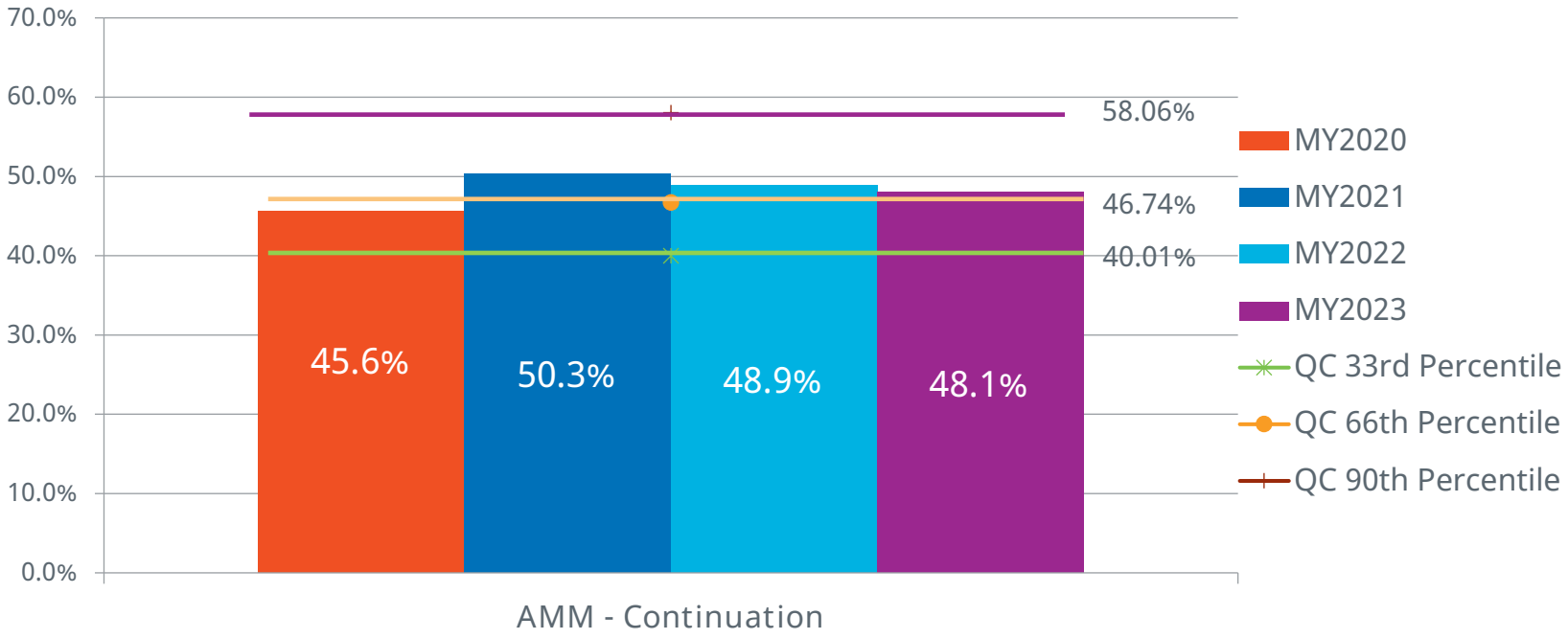
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Antidepressant Medication Management – Continuation Phase Treatment (AMM)



* Per HEDIS 2022 Quality Compass Percentile

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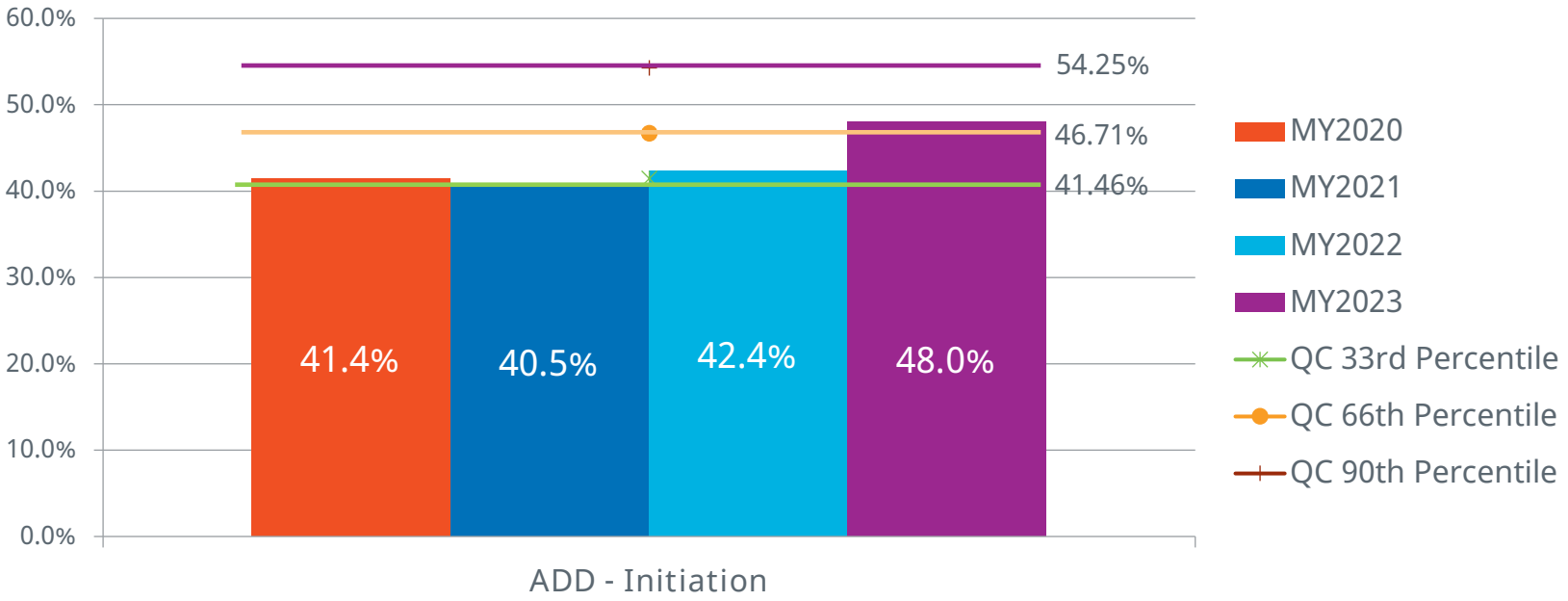
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase (ADD)



* Per HEDIS 2022 Quality Compass Percentile

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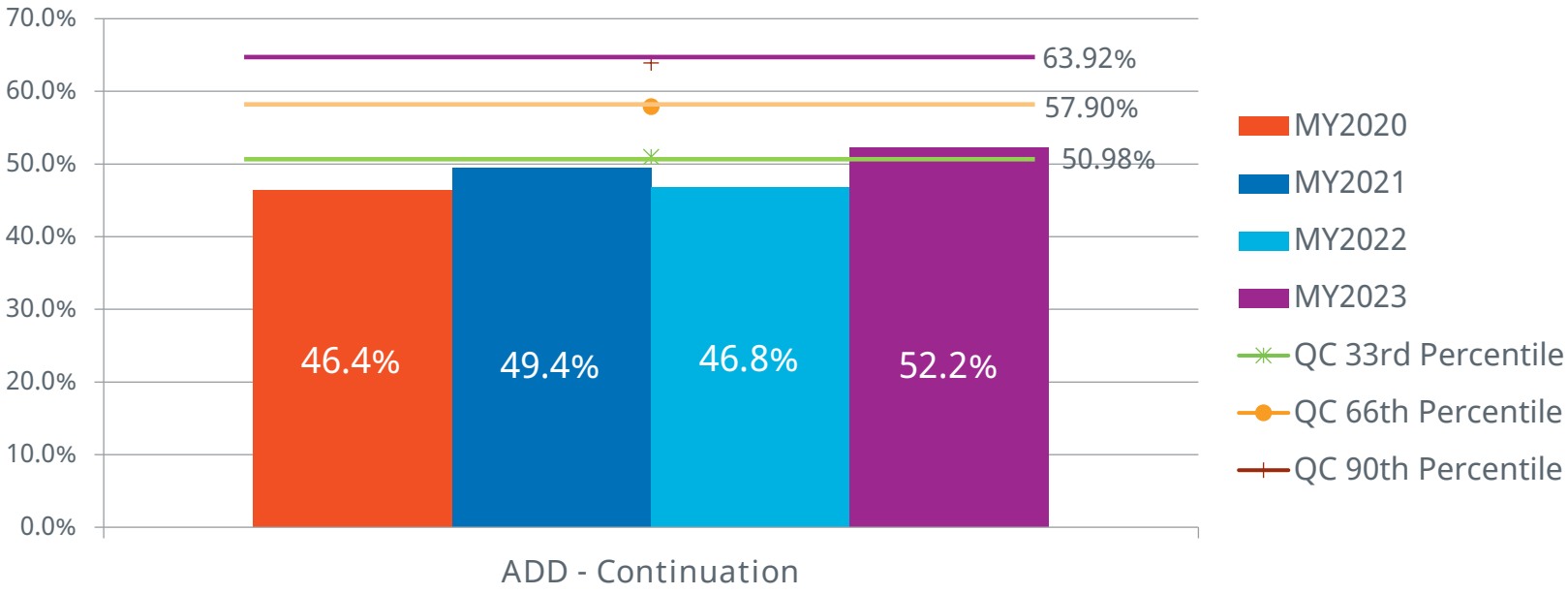
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Follow-up Care for Children Prescribed ADHD Medication – Continuation Phase (ADD)



* Per HEDIS 2022 Quality Compass Percentile

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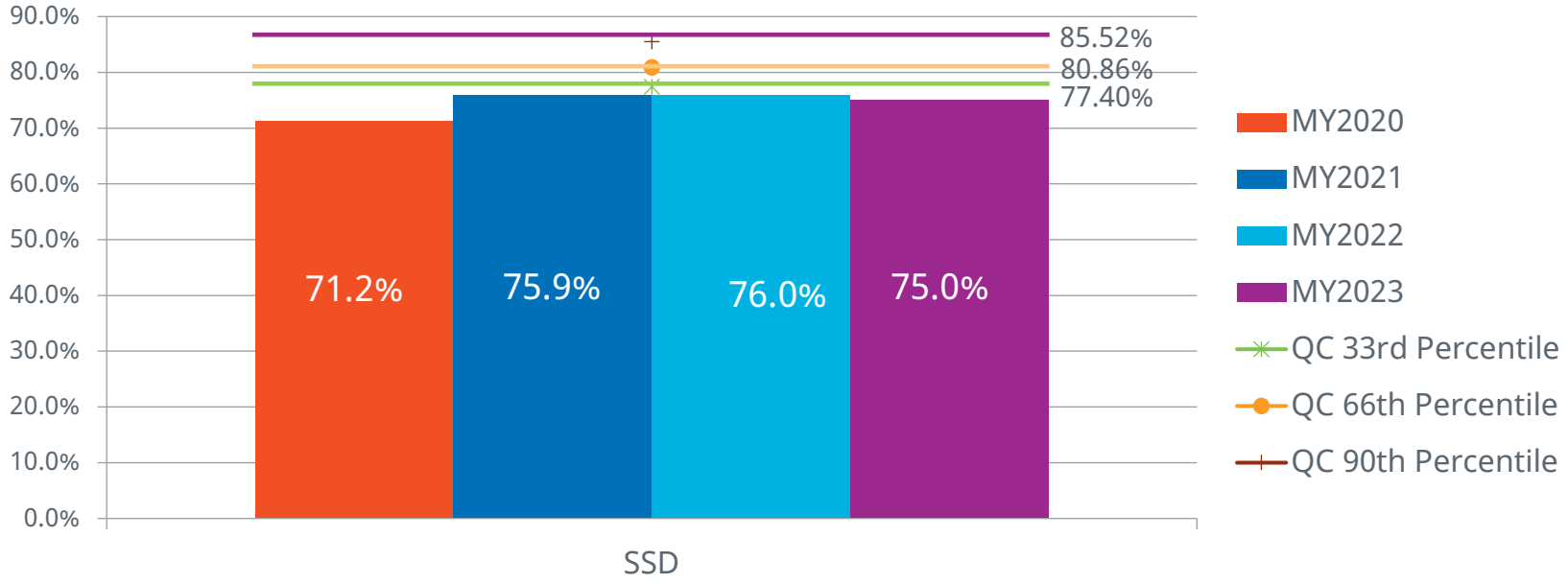
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)



* Per HEDIS 2022 Quality Compass Percentile

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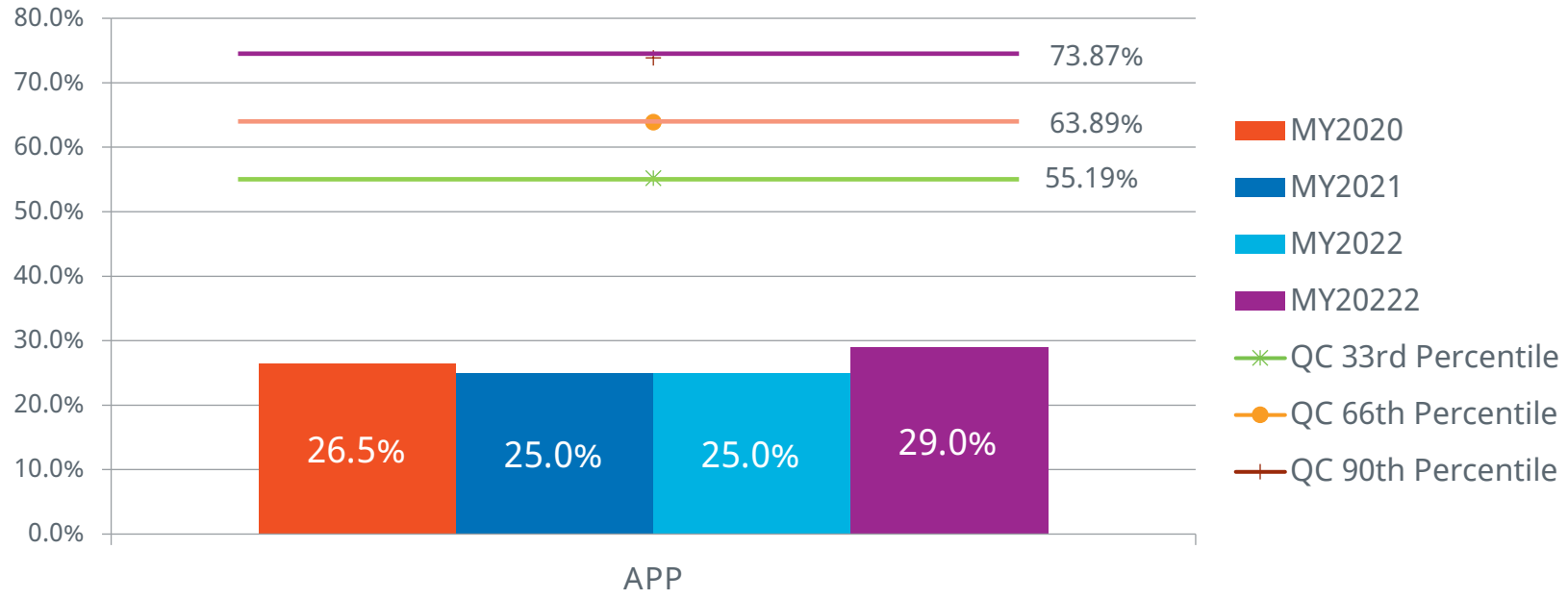
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Use of First-Line Psychosocial for Children and Adolescents on Antipsychotics (APP)



* Per HEDIS 2022 Quality Compass Percentile

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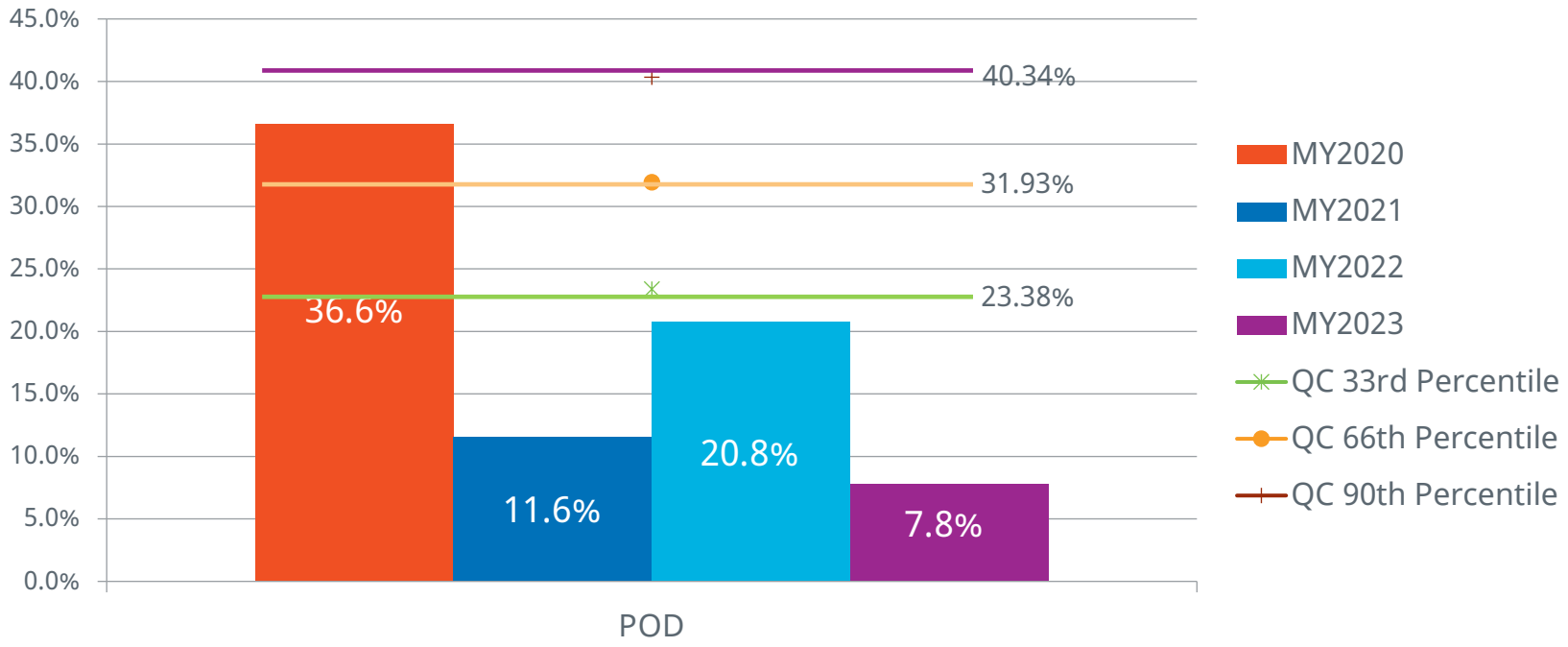
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Pharmacotherapy for Opioid Use Disorder (POD)



* Per HEDIS 2022 Quality Compass Percentile

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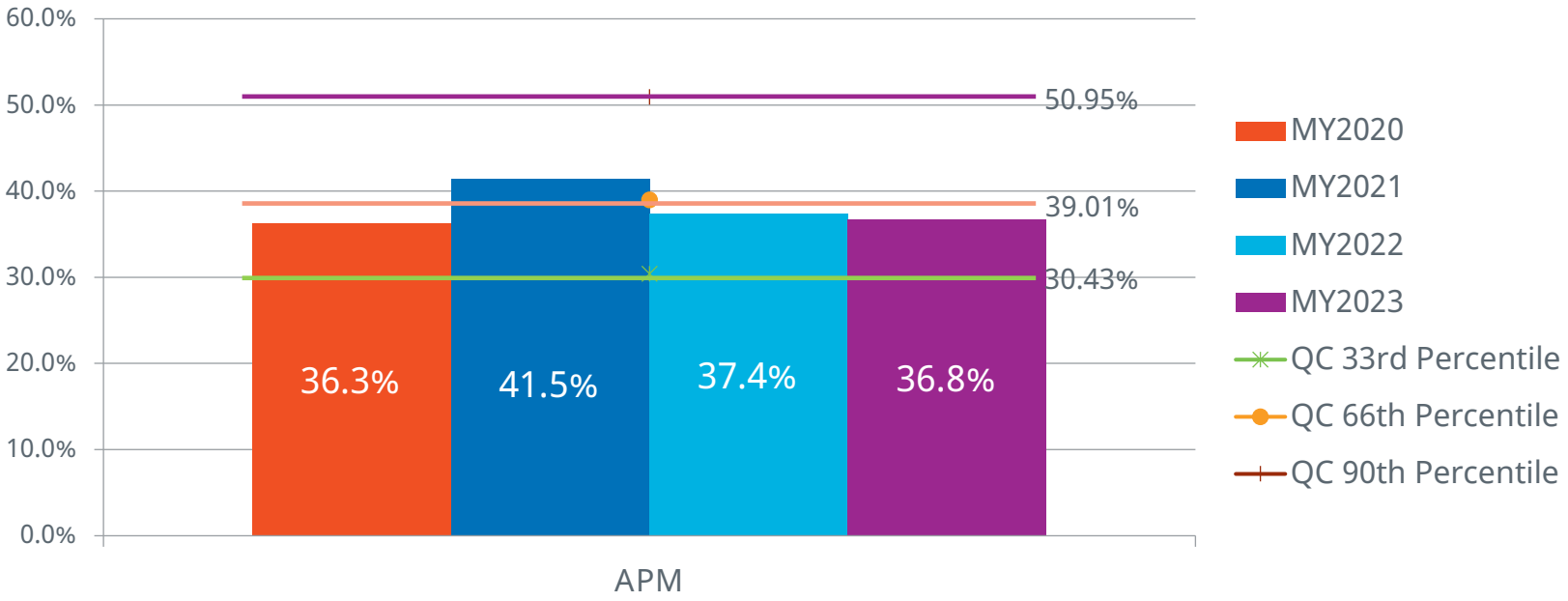
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)



* Per HEDIS 2022 Quality Compass Percentile

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CalOptima Health

Appropriate Utilization

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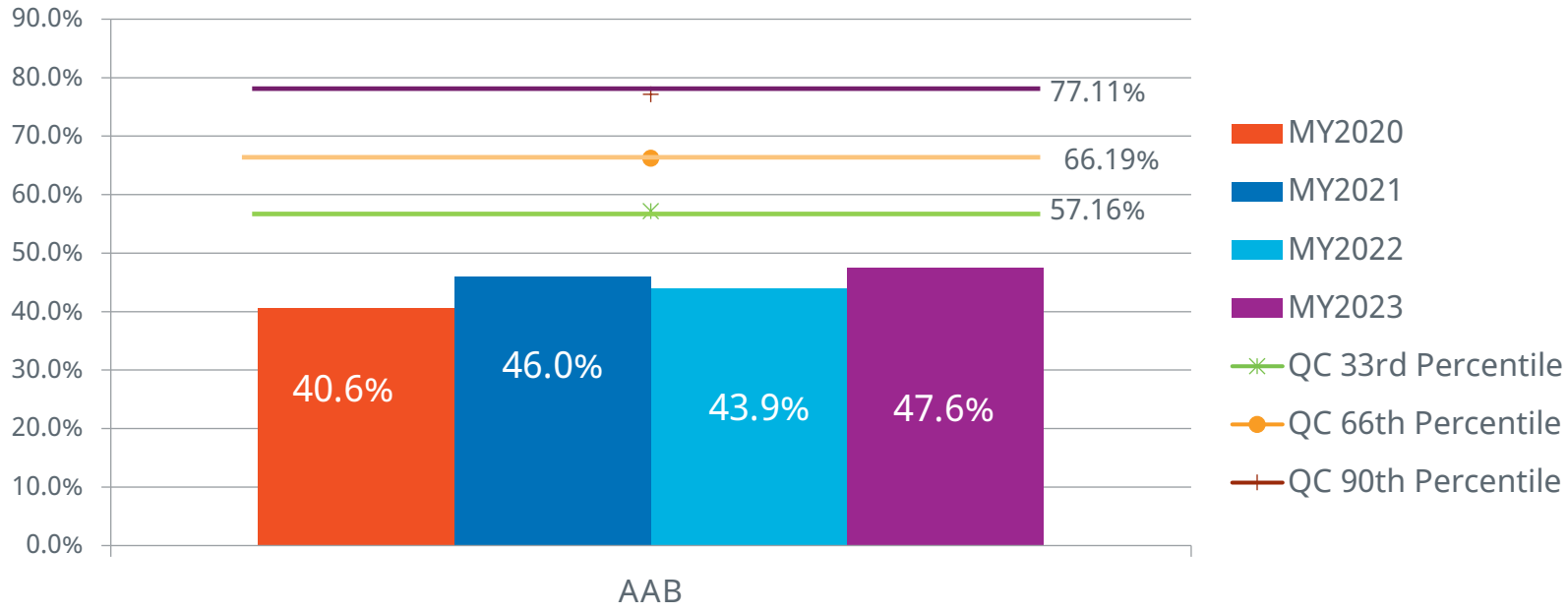
HEDIS MY2023 Results: Medi-Cal

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)



* Per HEDIS 2022 Quality Compass Percentile

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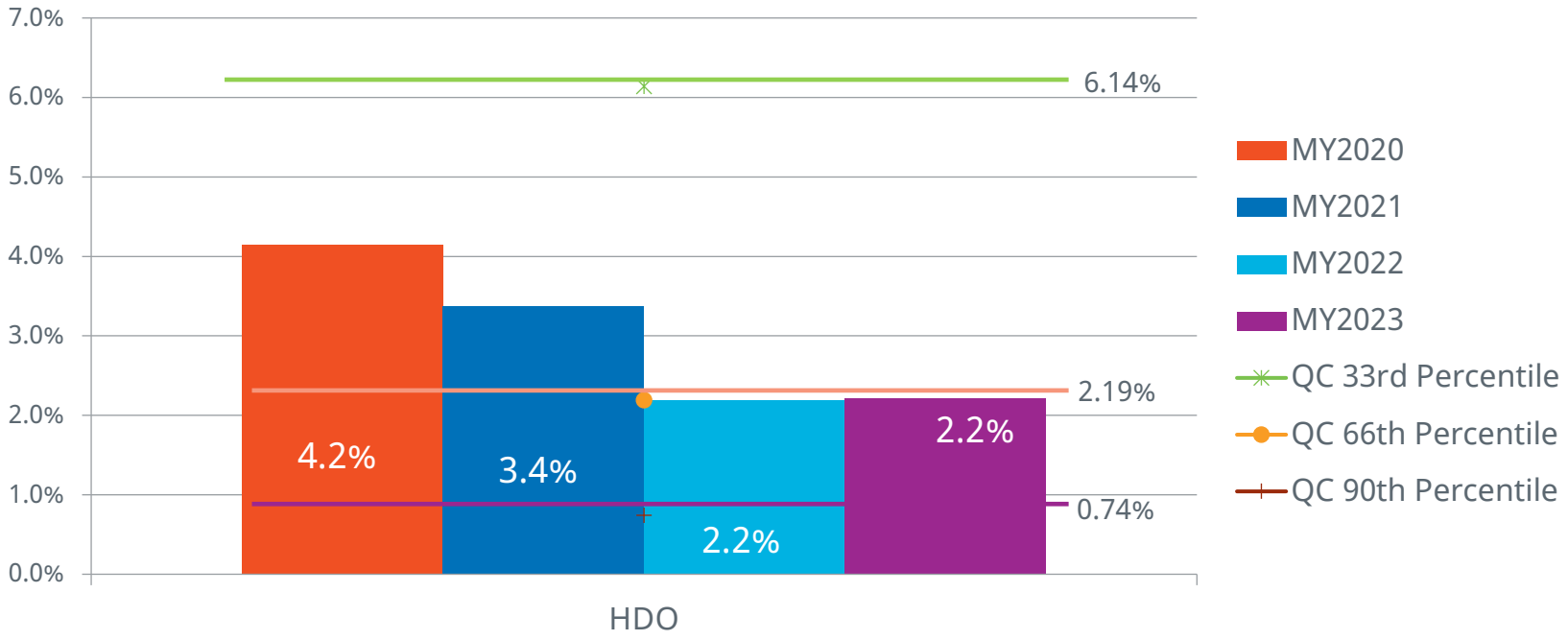
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Use of Opioids at High Dosage (HDO)



- Per HEDIS 2022 Quality Compass Percentile;
- Lower rate is better

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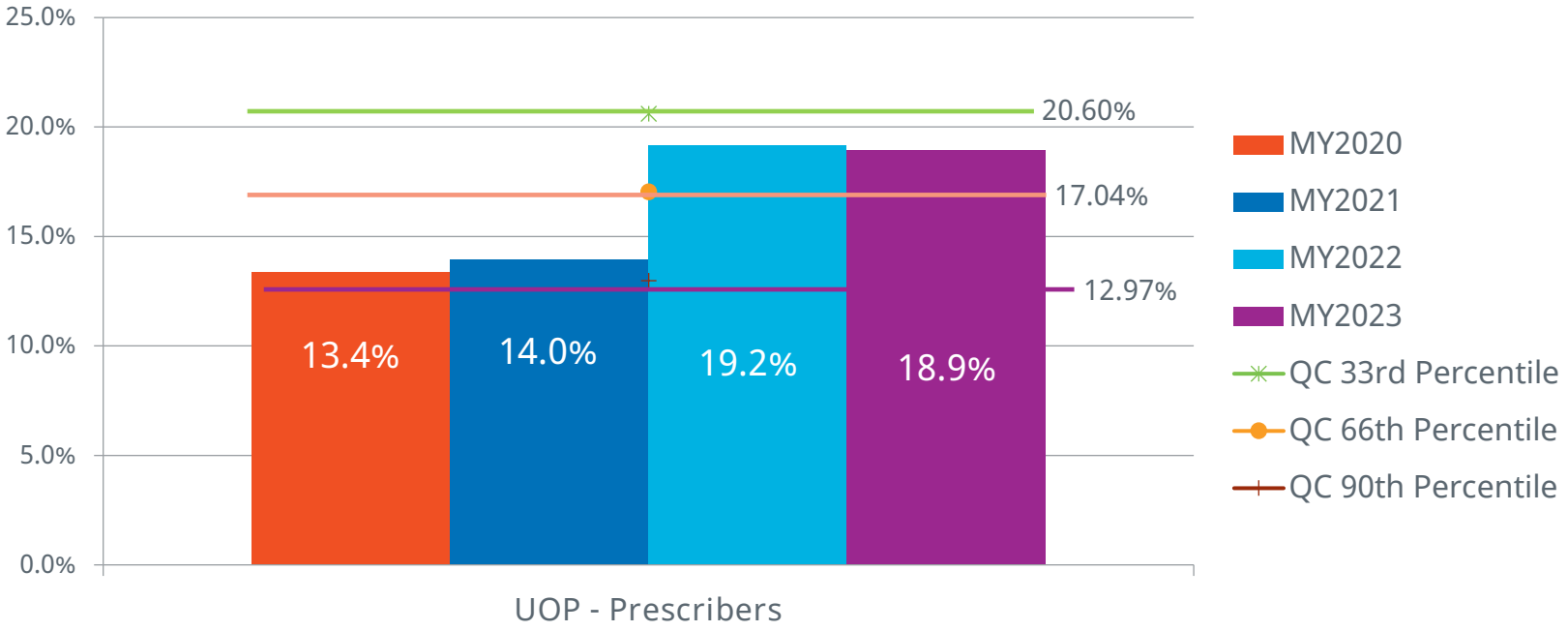
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Use of Opioids From Multiple Providers – Multiple Prescribers (UOP)



- Per HEDIS 2022 Quality Compass Percentile
- Lower rate is better

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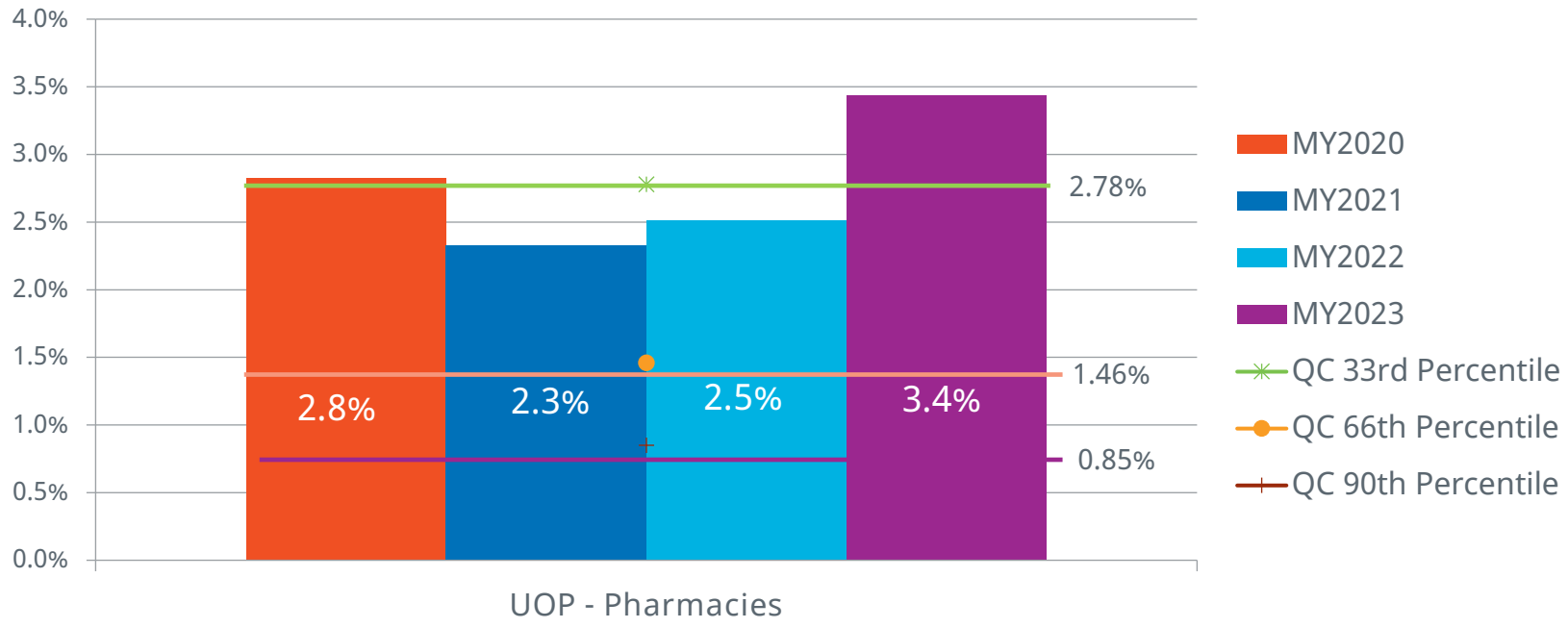
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Use of Opioids From Multiple Providers – Multiple Pharmacies (UOP)



- Per HEDIS 2022 Quality Compass Percentile
- Lower rate is better

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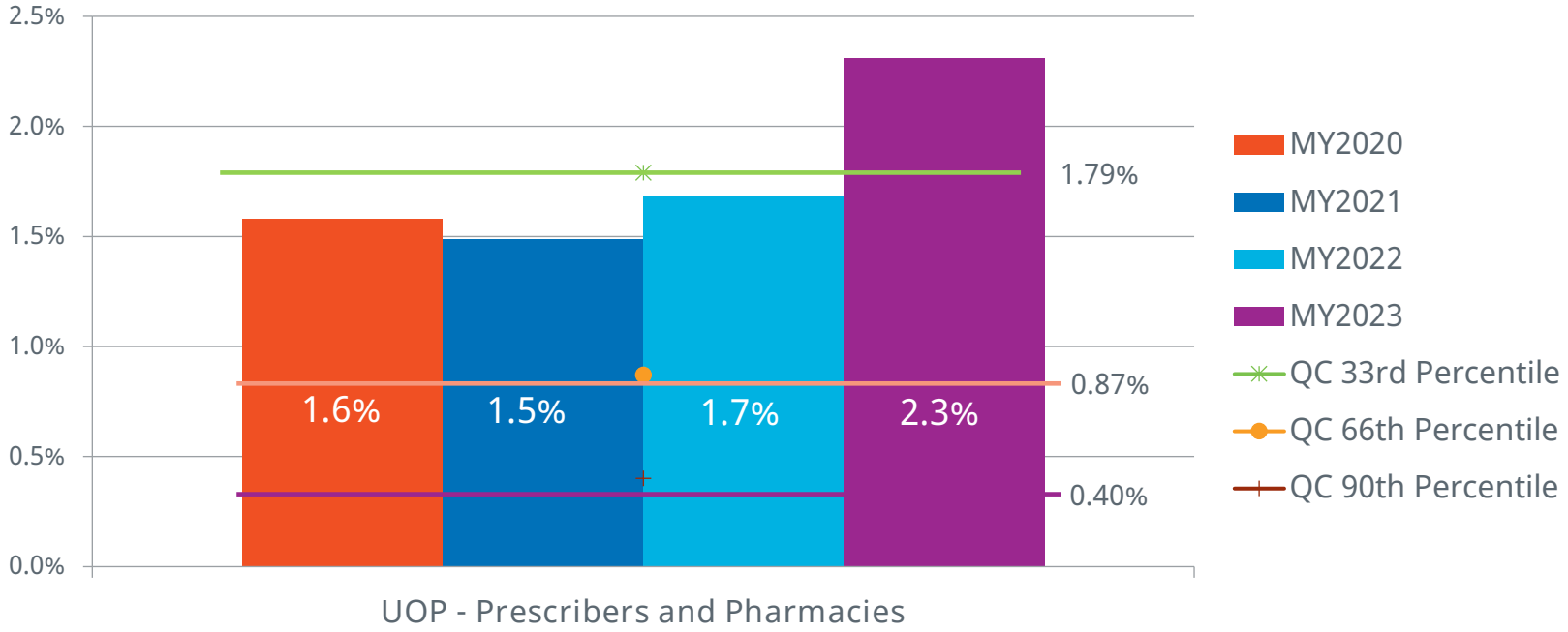
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Use of Opioids From Multiple Providers – Multiple Prescribers and Pharmacies (UOP)



- Per HEDIS 2022 Quality Compass Percentile
- Lower rate is better

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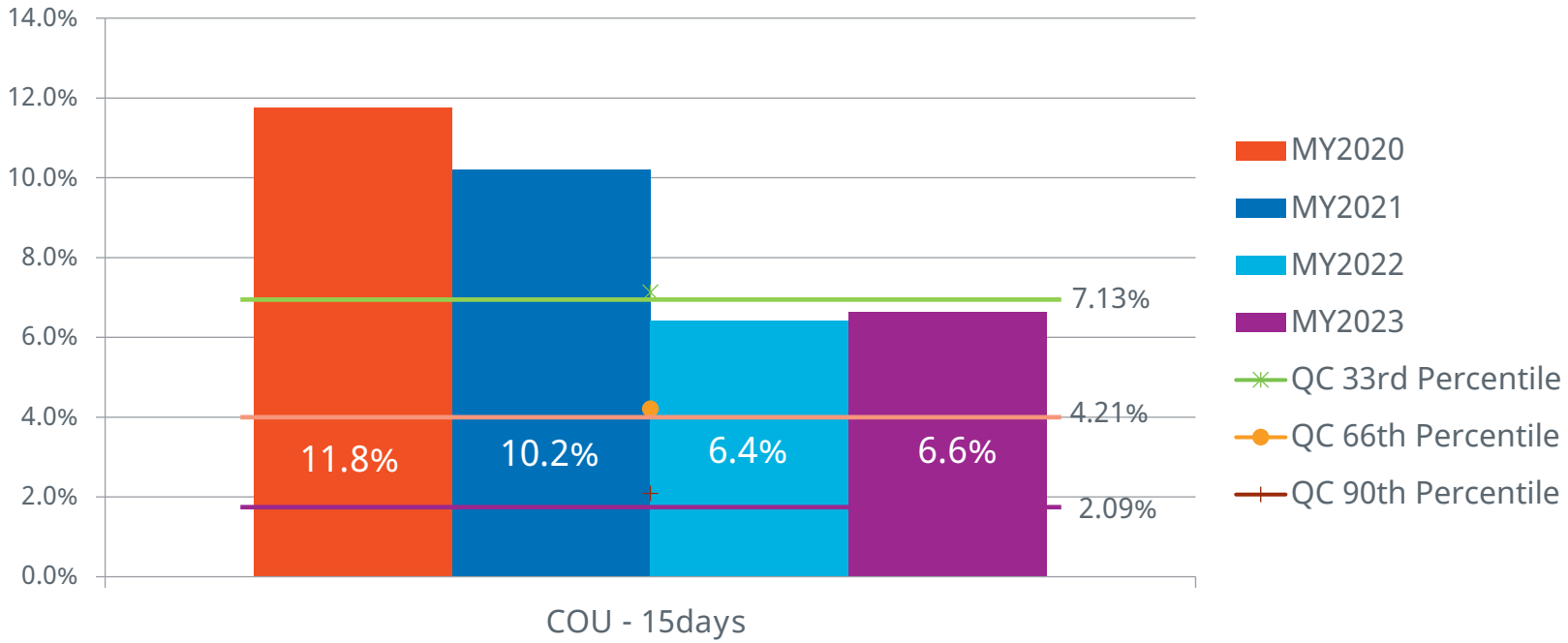
HEDIS MY2023 Results: Medi-Cal

Risk of Continued Opioid Use – 15 days (COU)



- Per HEDIS 2022 Quality Compass Percentile
- Lower rate is better

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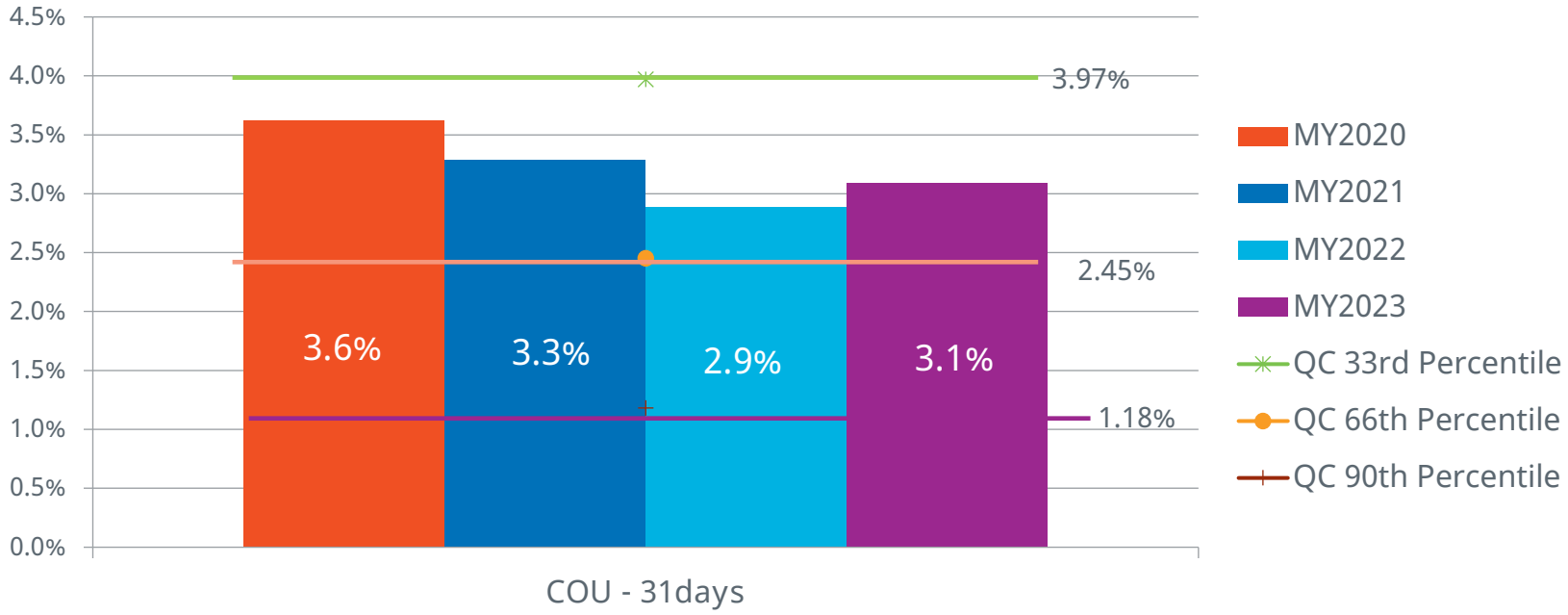
CalOptima Health

HEDIS MY2023 Results: Medi-Cal

Risk of Continued Opioid Use – 31days (COU)



- Per HEDIS 2022 Quality Compass Percentile
- Lower rate is better

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CalOptima Health

Risk-Adjusted Utilization

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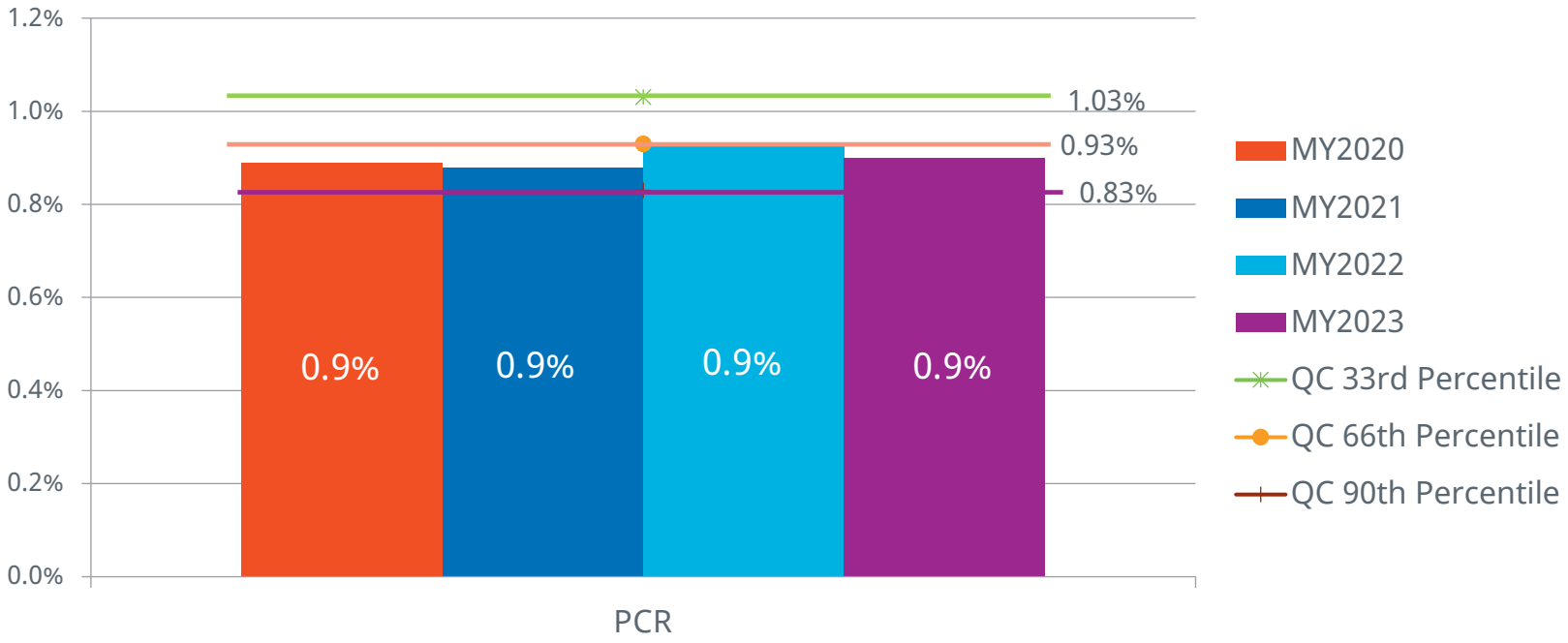
HEDIS MY2023 Results: Medi-Cal

Plan All-Cause Readmissions 18-64 (PCR) – O/E Ratio



- Per HEDIS 2022 Quality Compass Percentile
- Lower rate is better

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CalOptima Health

OneCare (OC) Measures Four Year Trended Results

Benchmarks — NCQA National Medicare HEDIS MY 2022 Percentiles and CMS Medicare 2024 Part C & D Star Ratings Technical Notes 3/13/2024 Update

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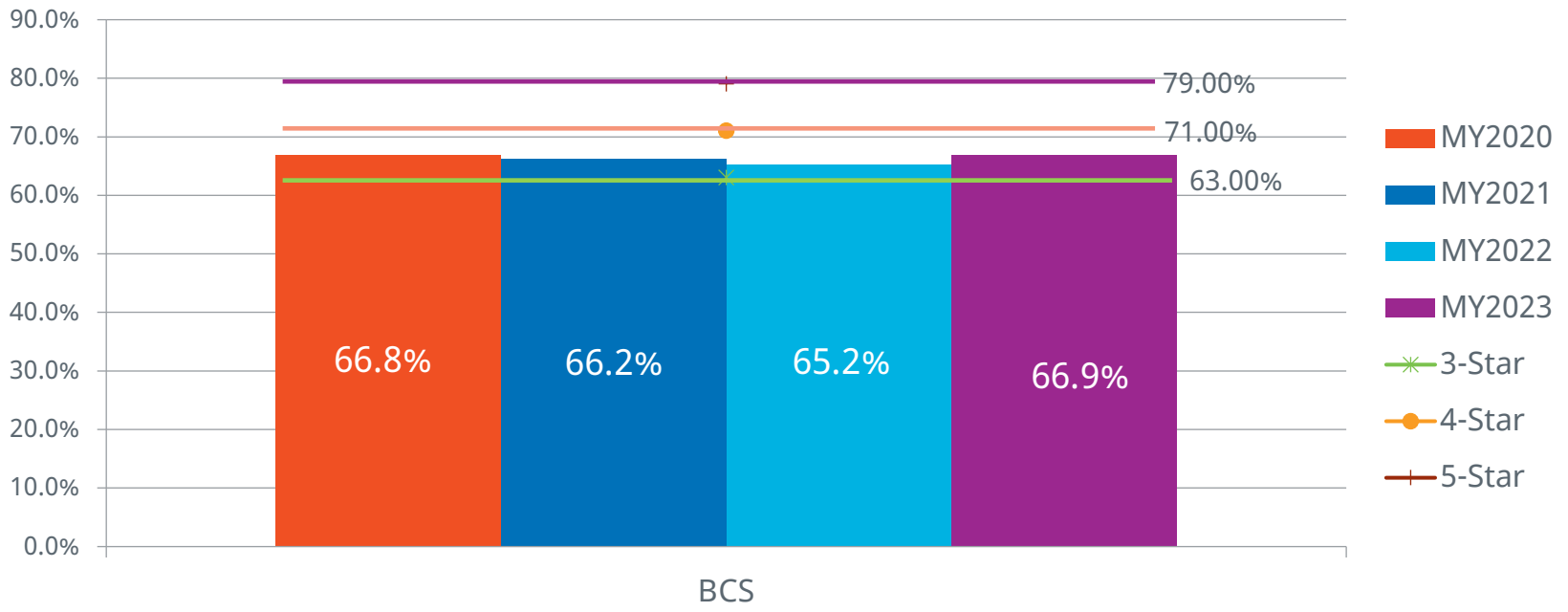
CalOptima Health

HEDIS MY2023 Results: Medicare

Breast Cancer Screening (BCS-E)



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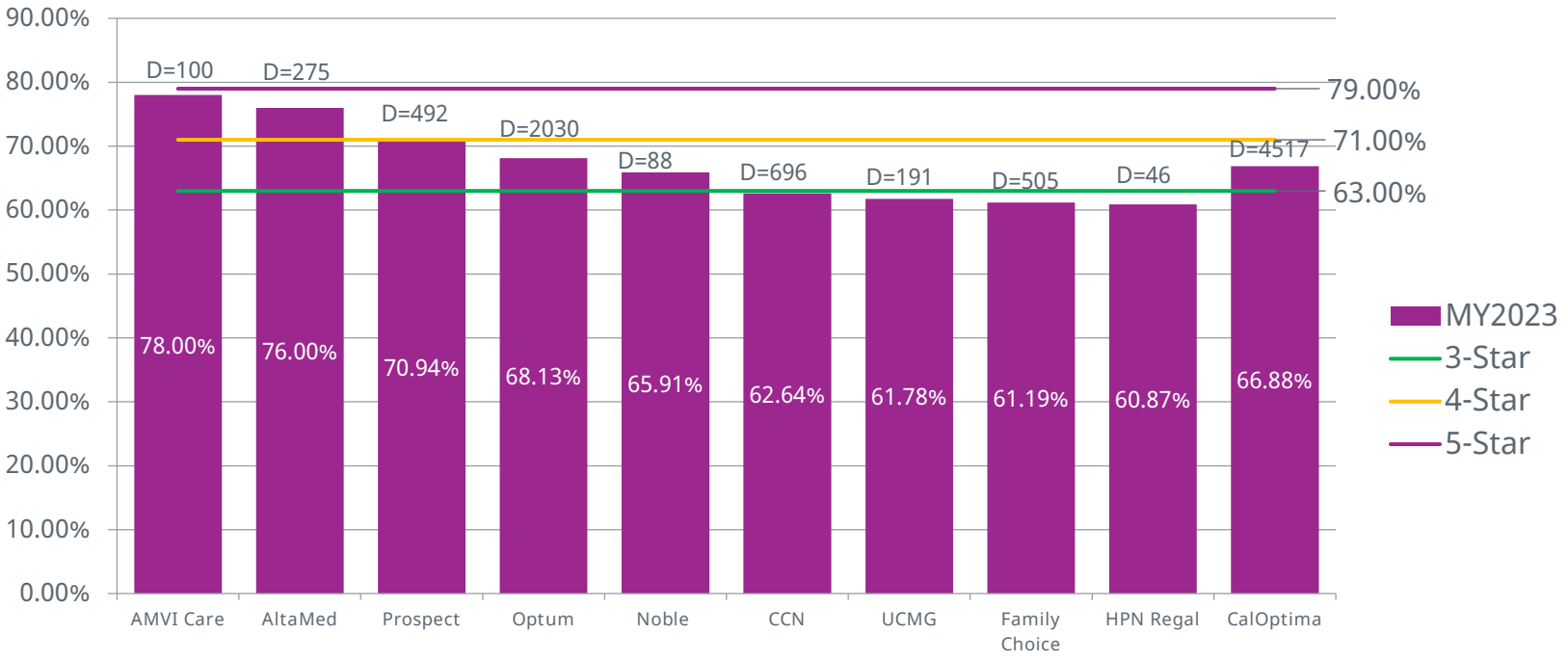
HEDIS MY2023 Results: Medicare

Breast Cancer Screening (BCS-E)



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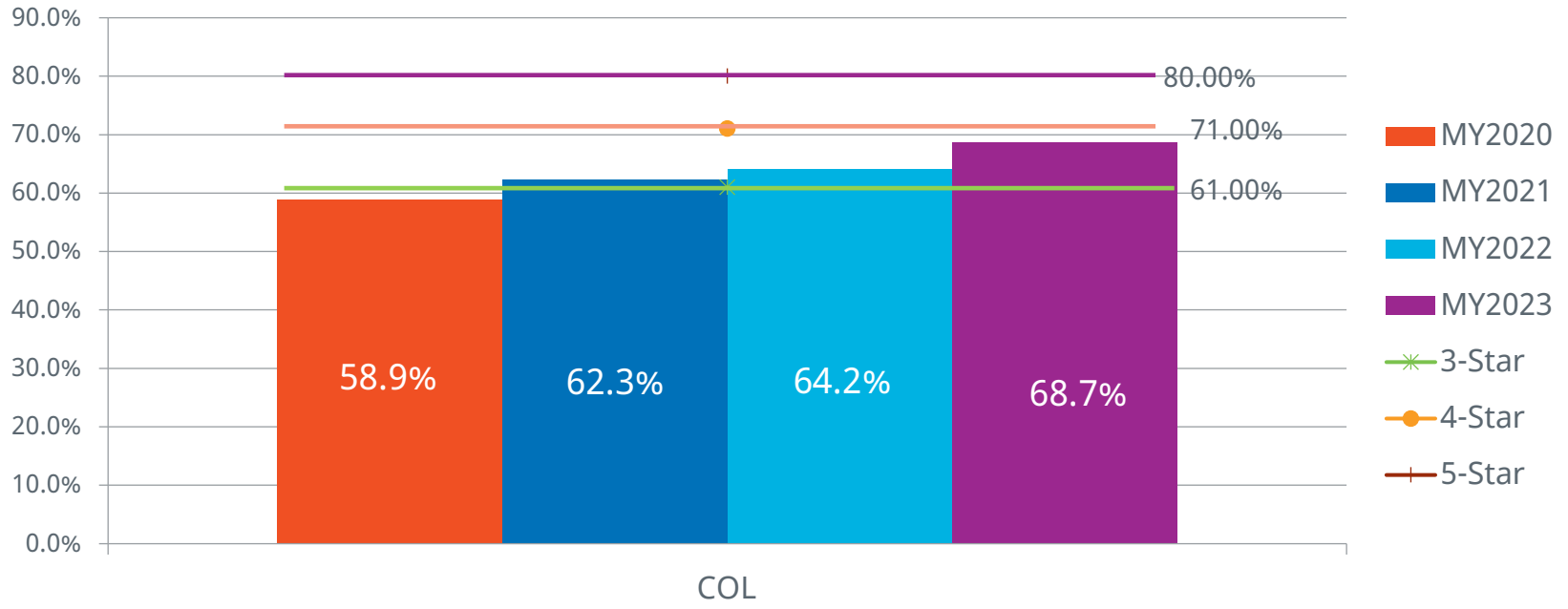
HEDIS MY2023 Results: Medicare

Colorectal Cancer Screening (COL)



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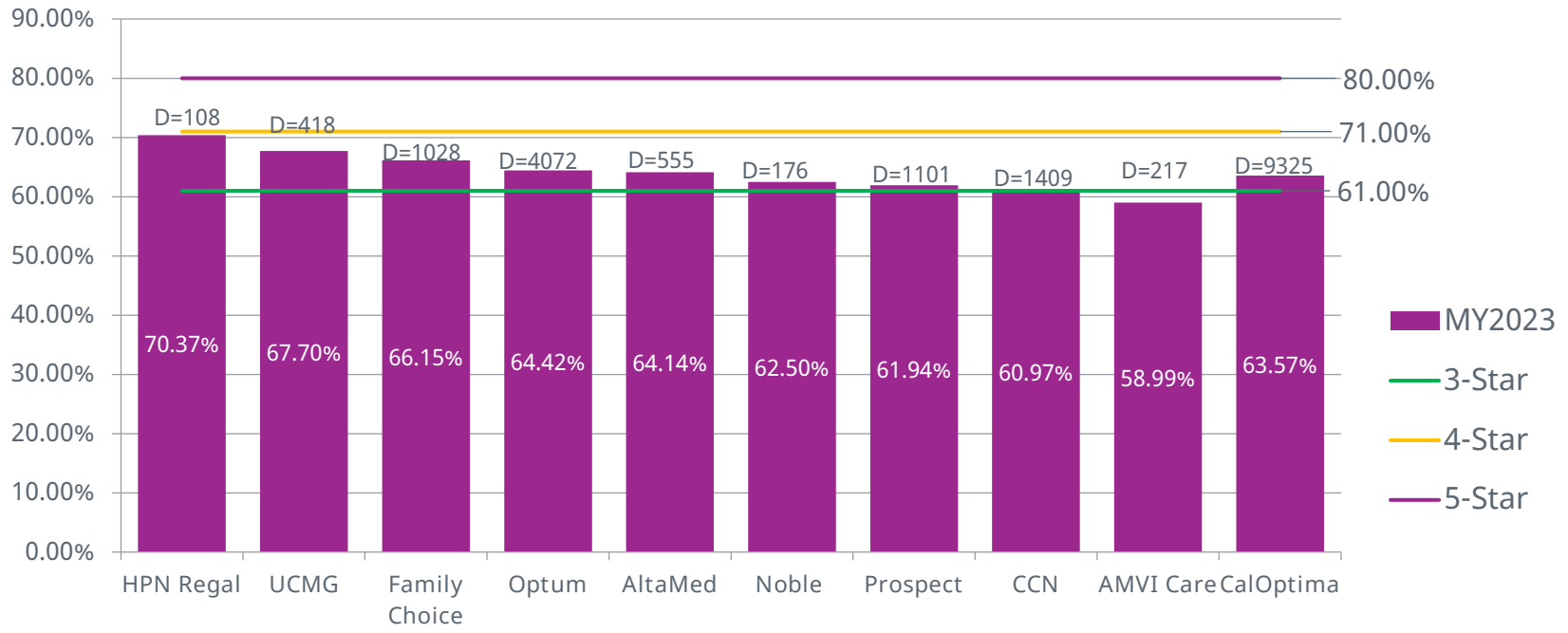
HEDIS MY2023 Results: Medicare
Colorectal Cancer Screening (COL)



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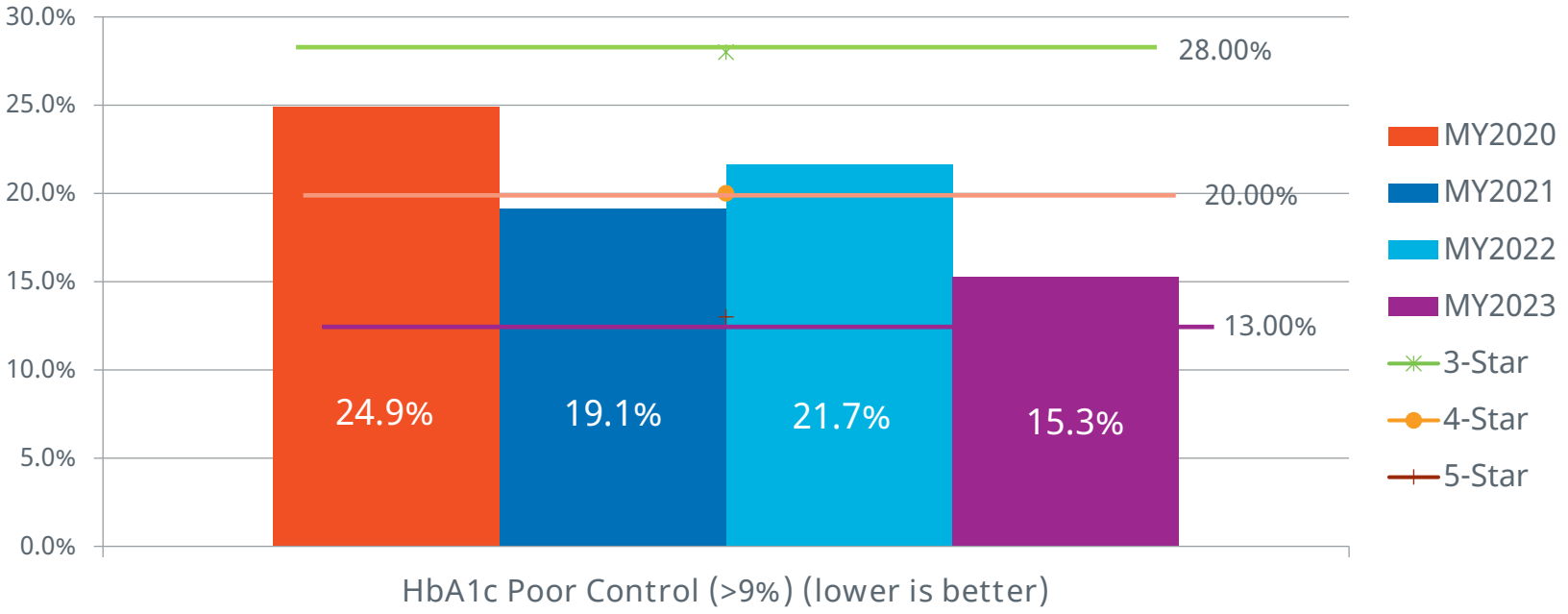
HEDIS MY2023 Results: Medicare

HbA1c Control for patients with Diabetes (HBD)



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HEDIS MY2023 Results: Medicare

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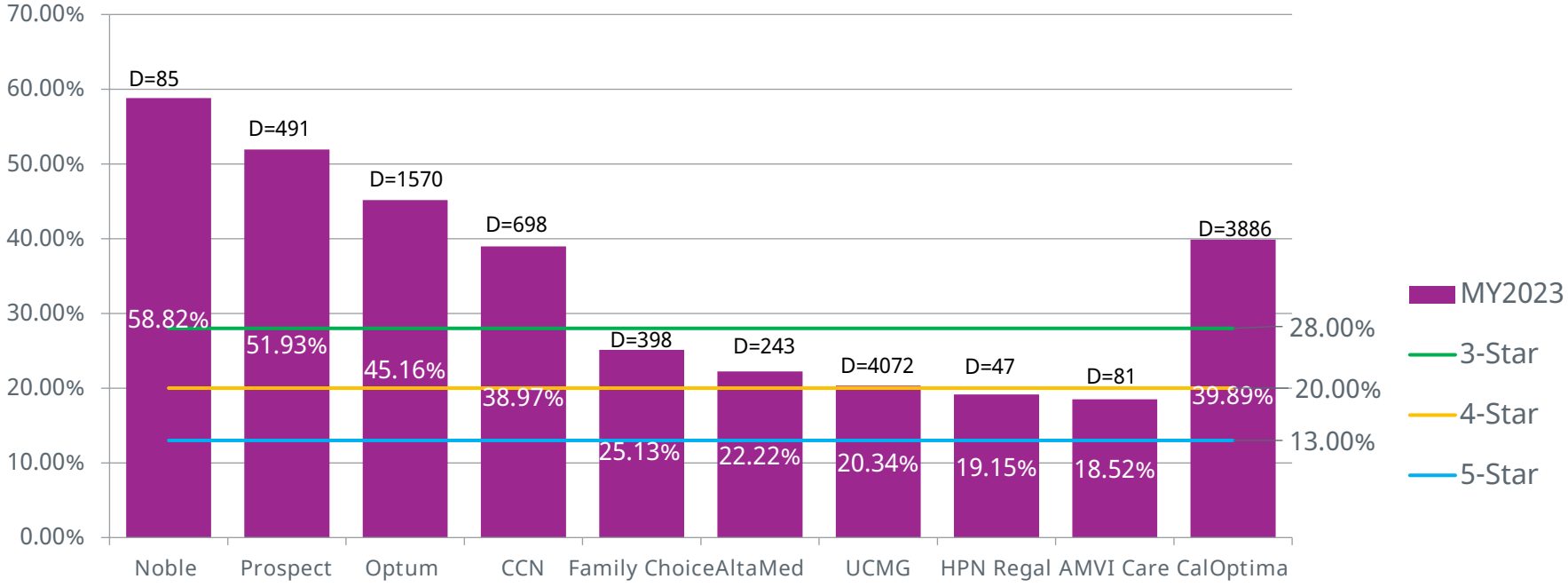

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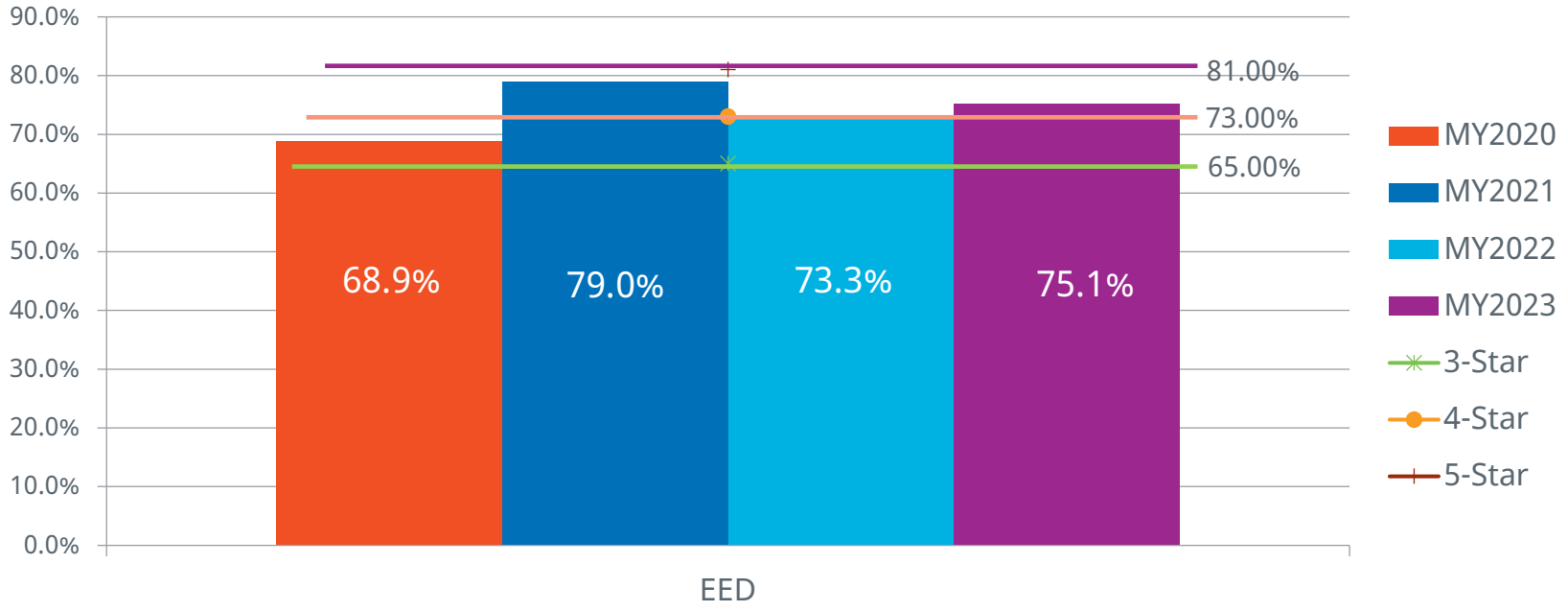
HEDIS MY2023 Results: Medicare

Eye Exams for Patients with Diabetes (EED)



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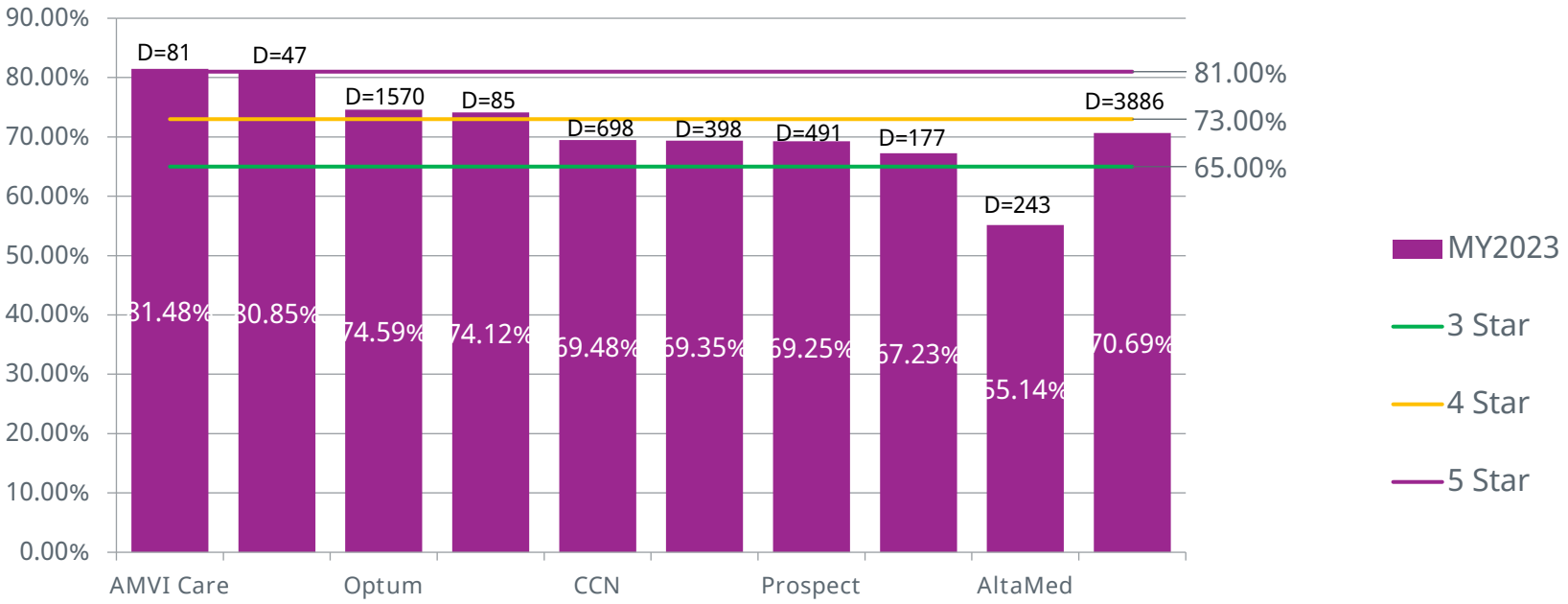
HEDIS MY2023 Results: Medicare
Eye Exams for Patients with Diabetes (EED)



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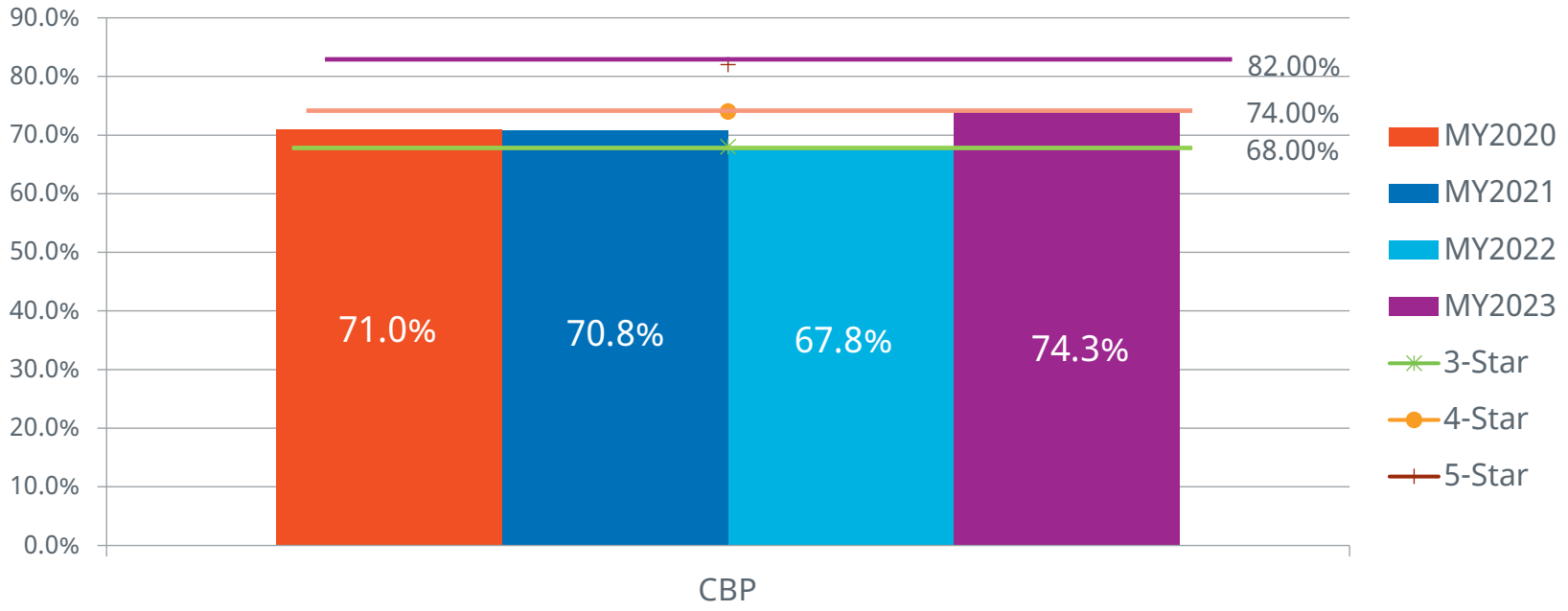
HEDIS MY2023 Results: Medicare

Control High Blood Pressure (CBP)



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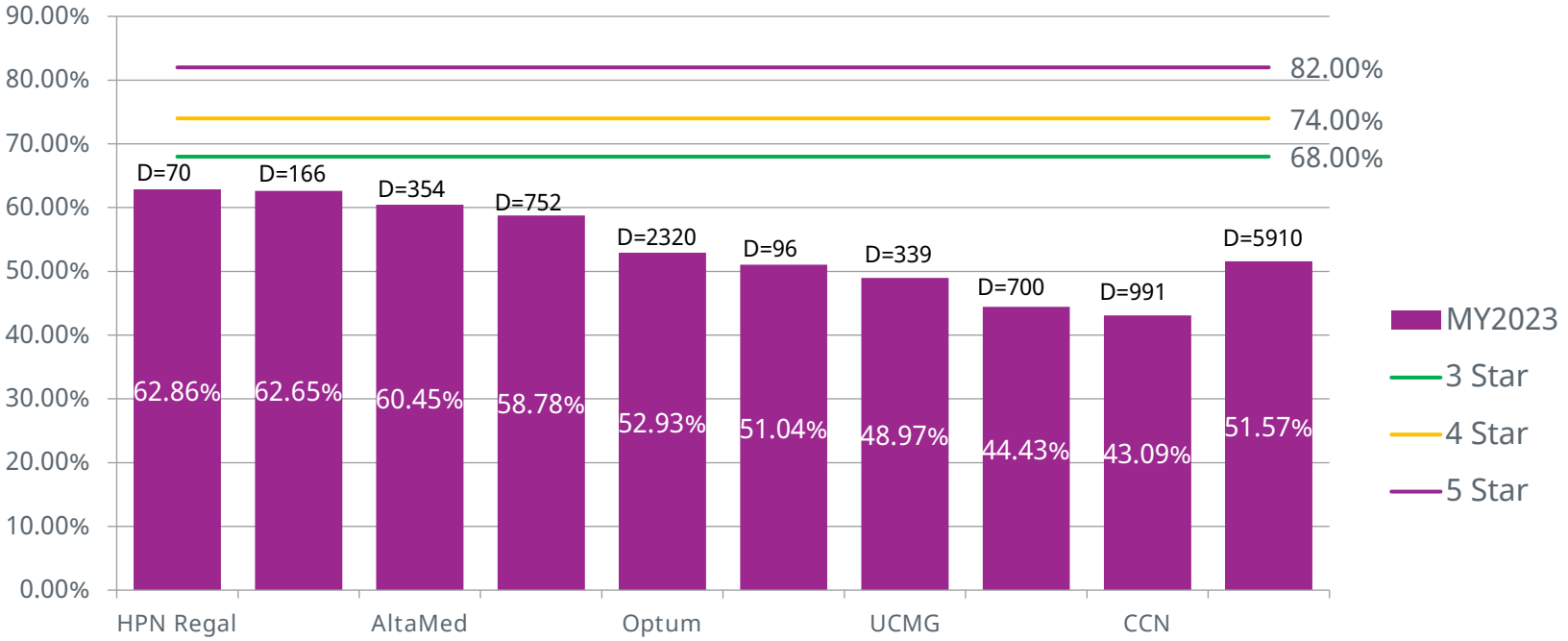
HEDIS MY2023 Results: Medicare
Control High Blood Pressure (CBP)



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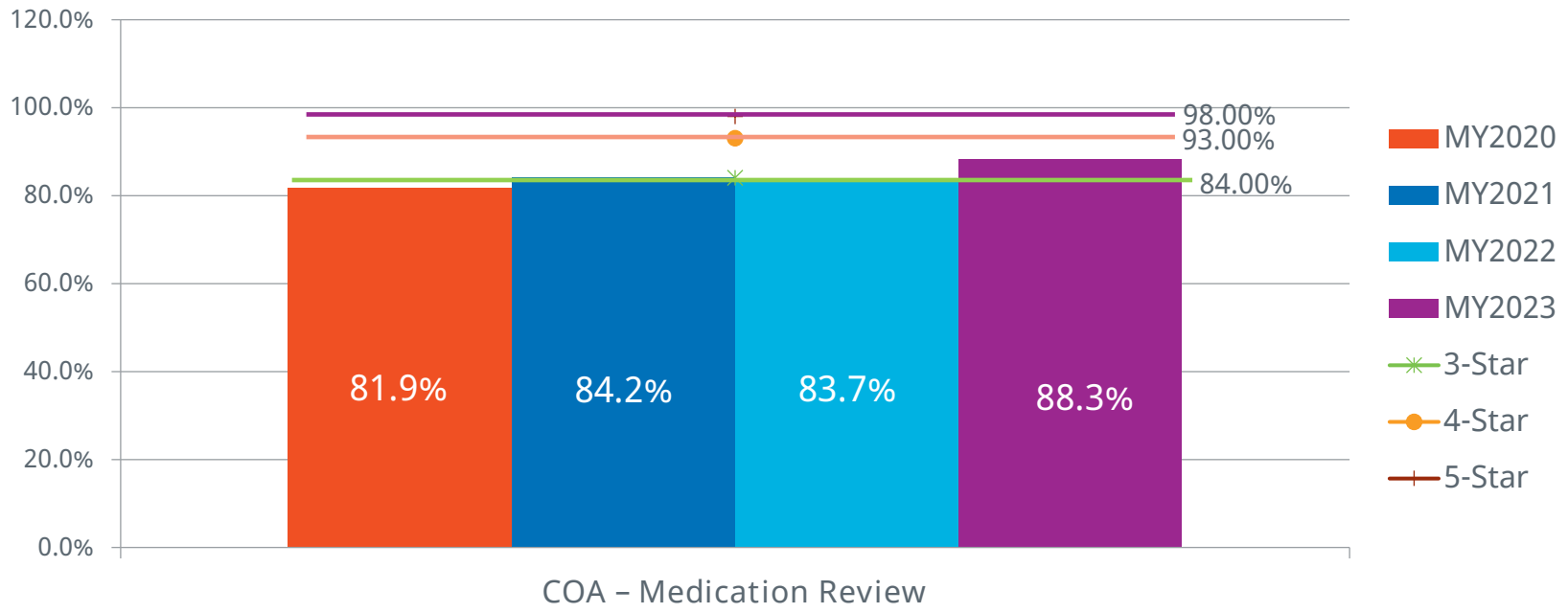
HEDIS MY2023 Results: Medicare

Care for Older Adults (COA)–Medication Review



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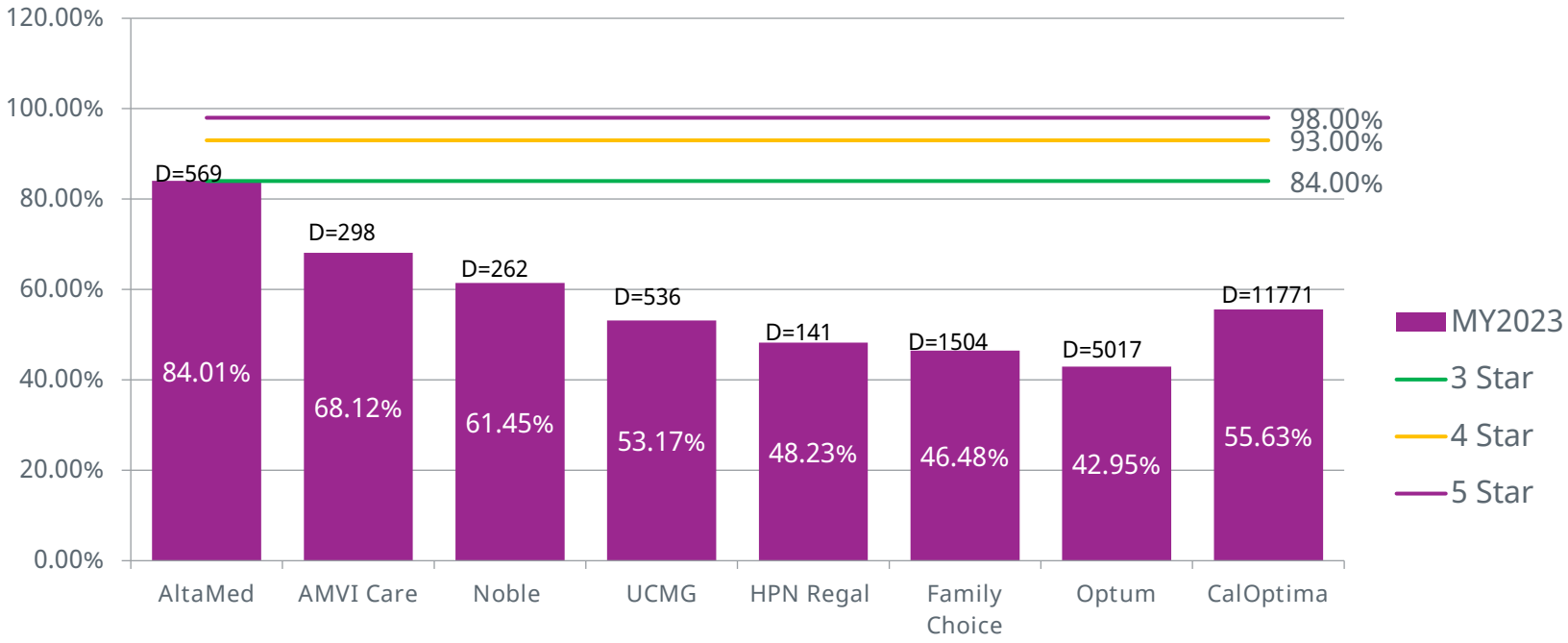
HEDIS MY2023 Results: Medicare

Care for Older Adults (COA)–Medication Review



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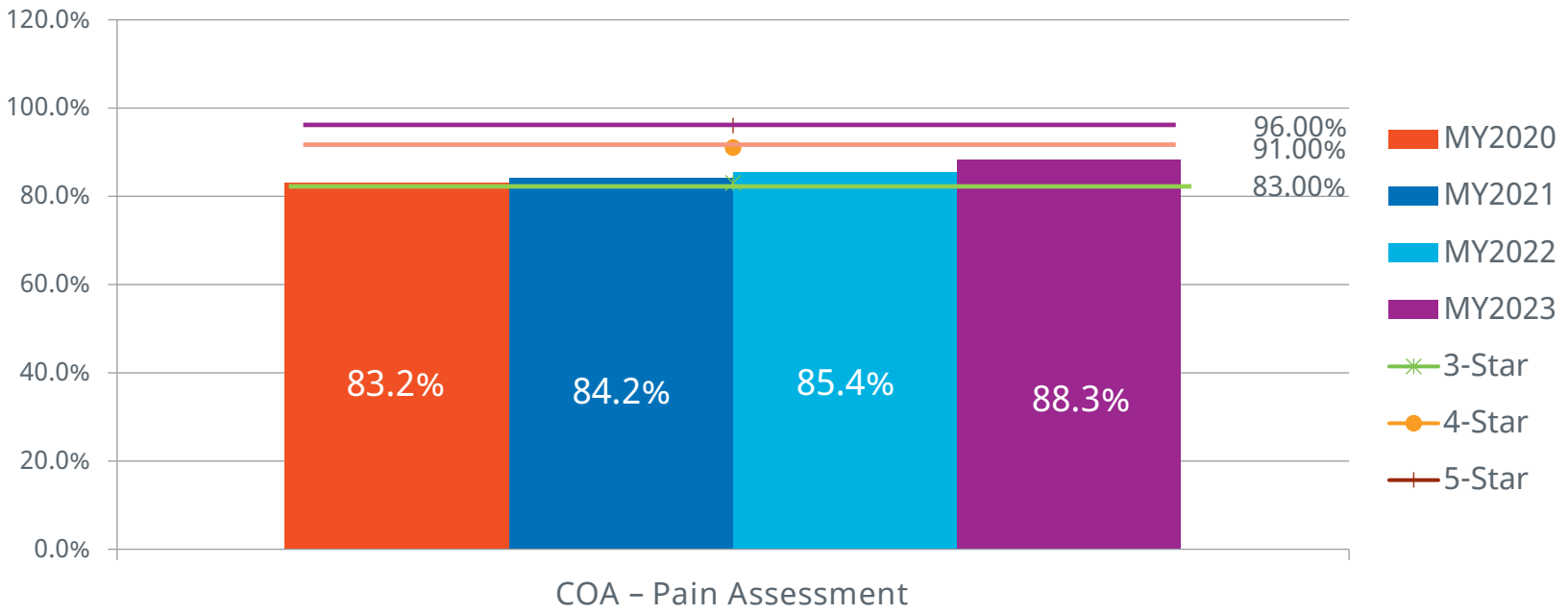
HEDIS MY2023 Results: Medicare

Care for Older Adults (COA) – Pain Assessment



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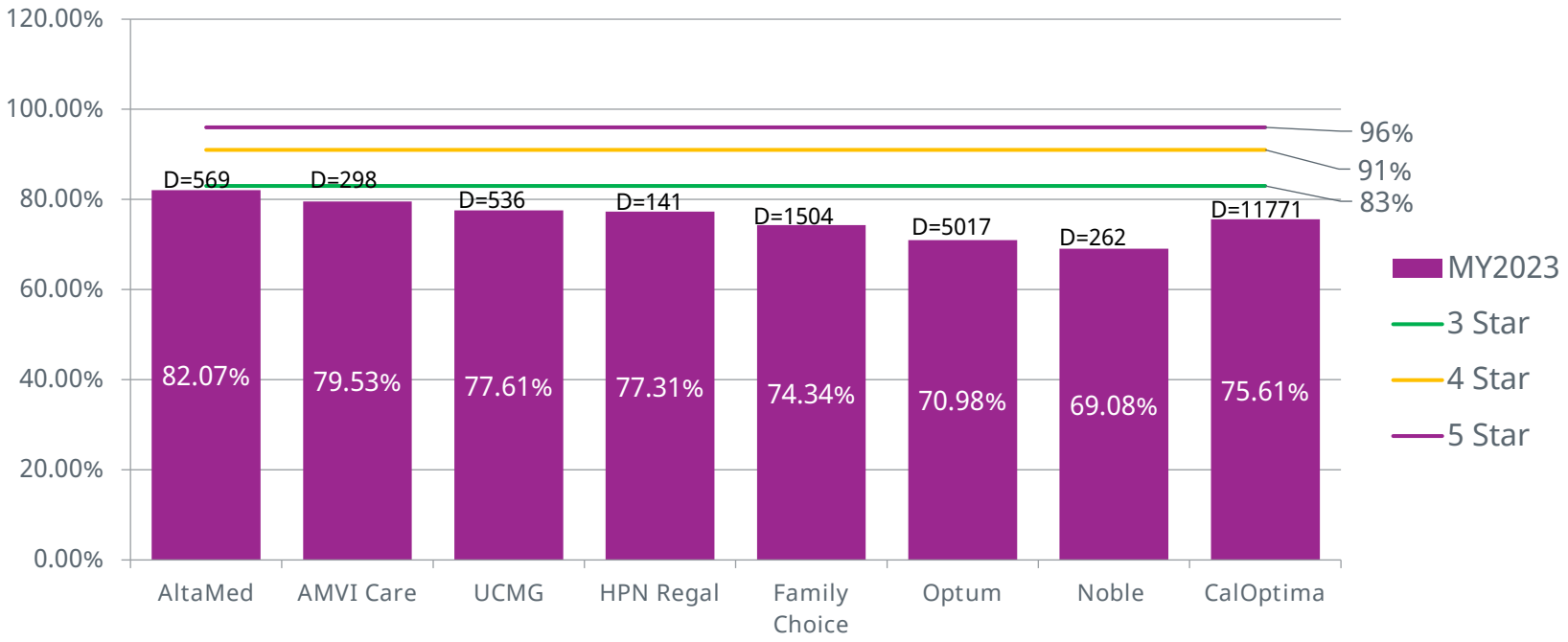
HEDIS MY2023 Results: Medicare

Care for Older Adults (COA)– Pain Assessment



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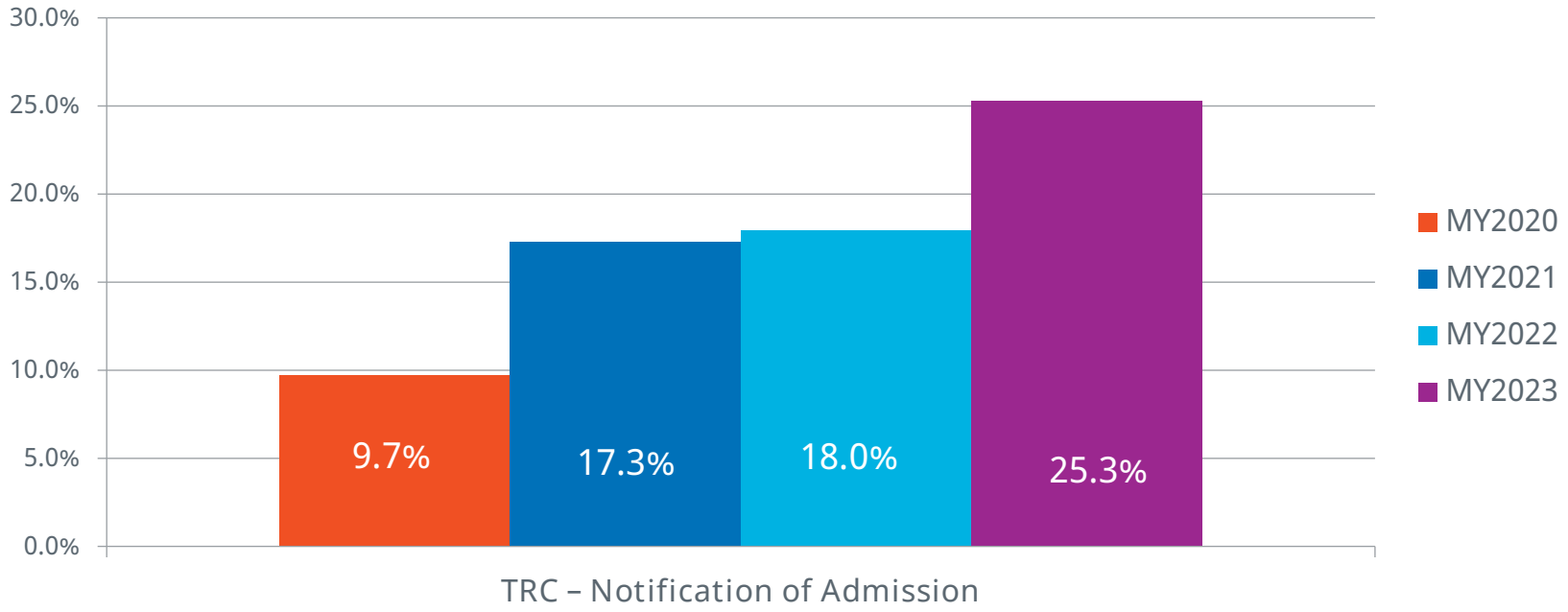
HEDIS MY2023 Results: Medicare

Transition of Care (TRC) – Notification of Admission



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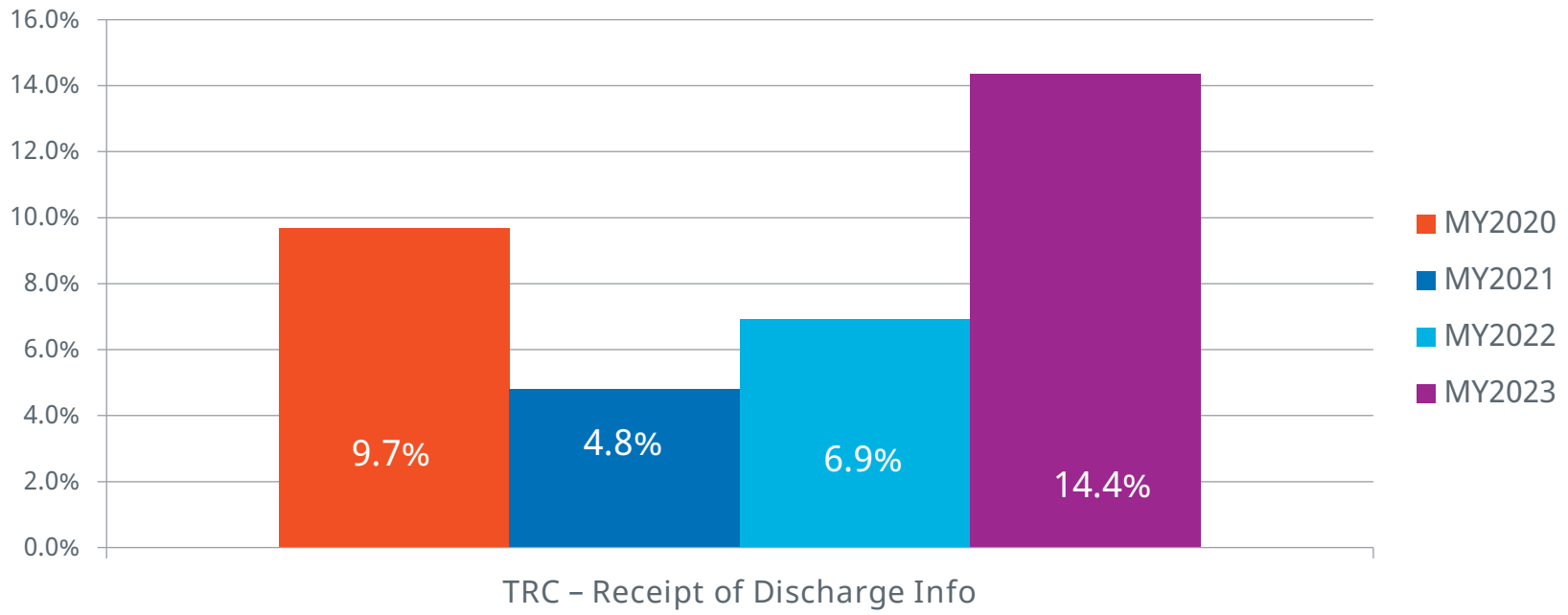
HEDIS MY2023 Results: Medicare

Transition of Care (TRC)– Receipt of Discharge Info



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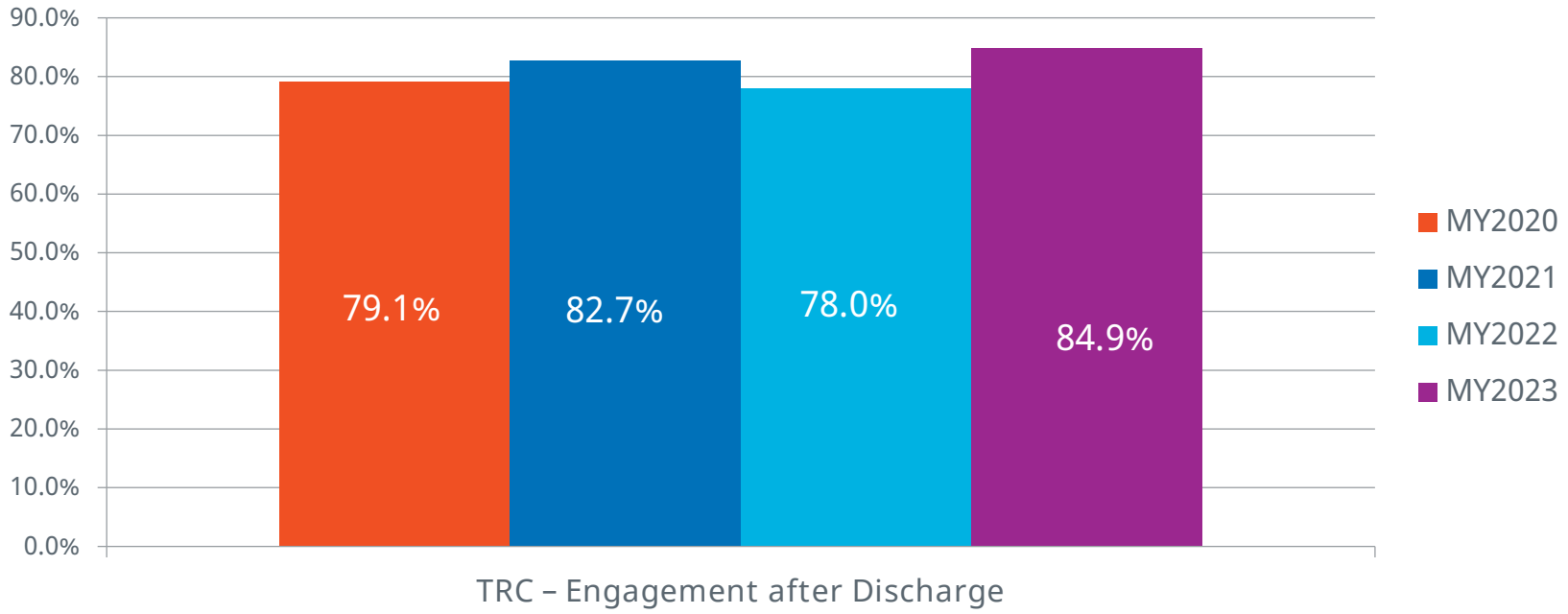
HEDIS MY2023 Results: Medicare

Transition of Care (TRC)– Engagement after Discharge



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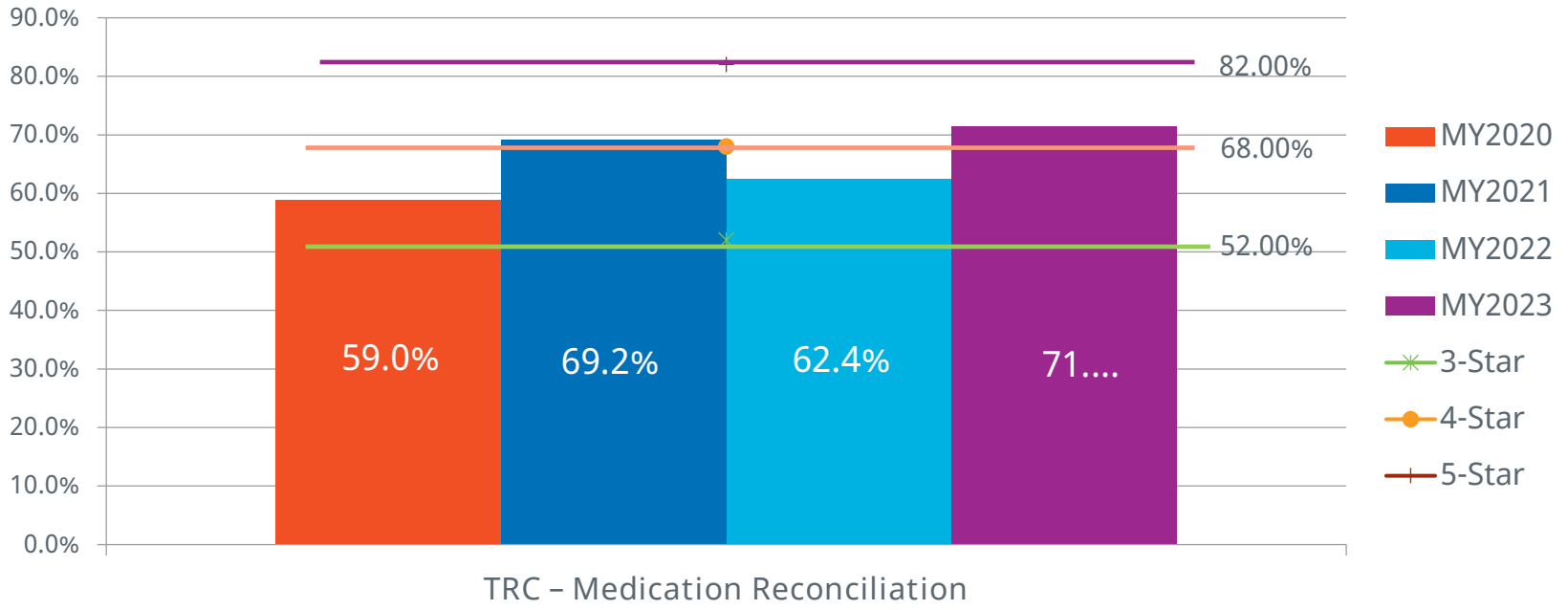
HEDIS MY2023 Results: Medicare

Transition of Care (TRC)– Medication Reconciliation



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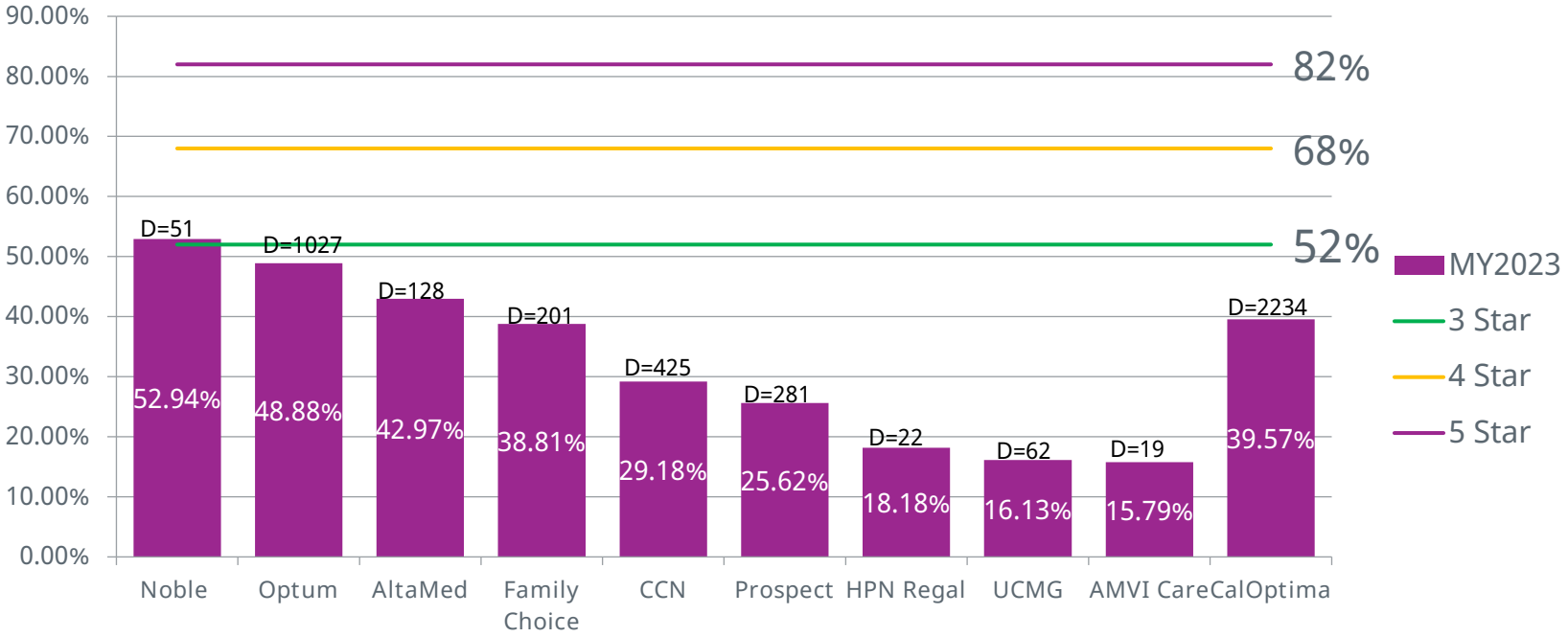
HEDIS MY2023 Results: Medicare

Transition of Care (TRC)– Medication Reconciliation



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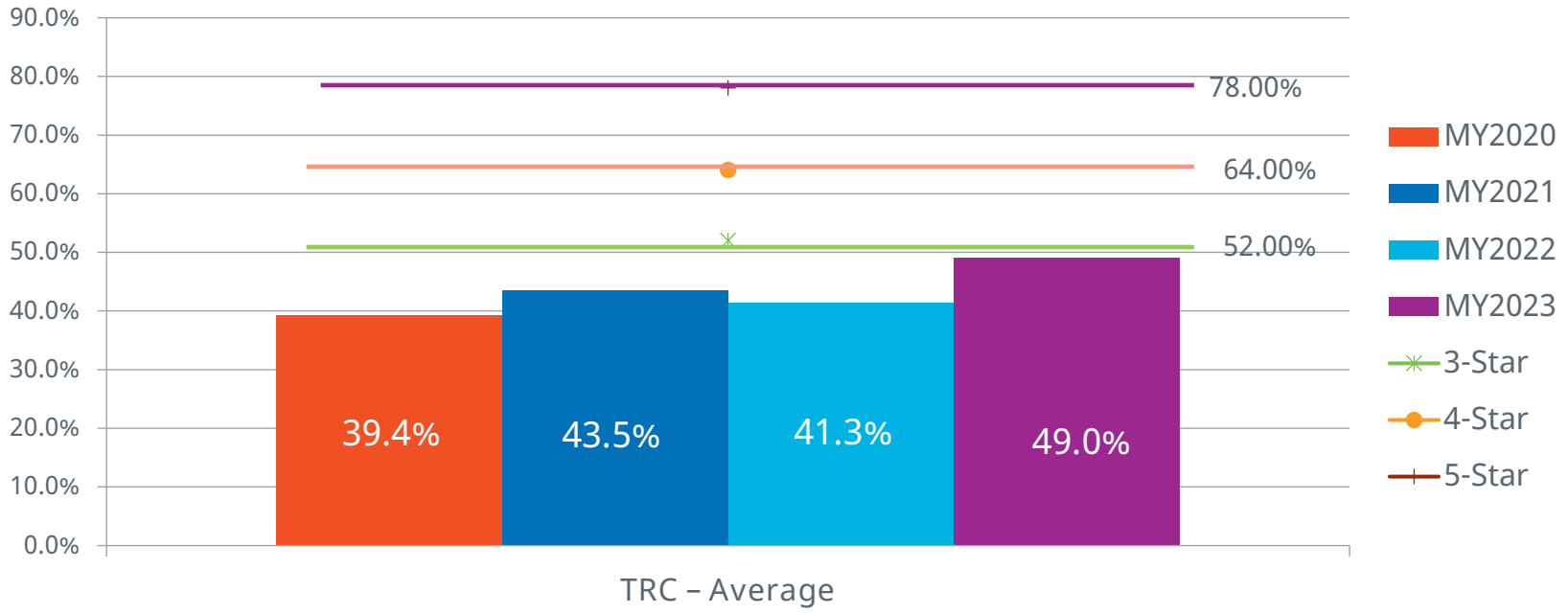
HEDIS MY2023 Results: Medicare

Transition of Care (TRC) - Average



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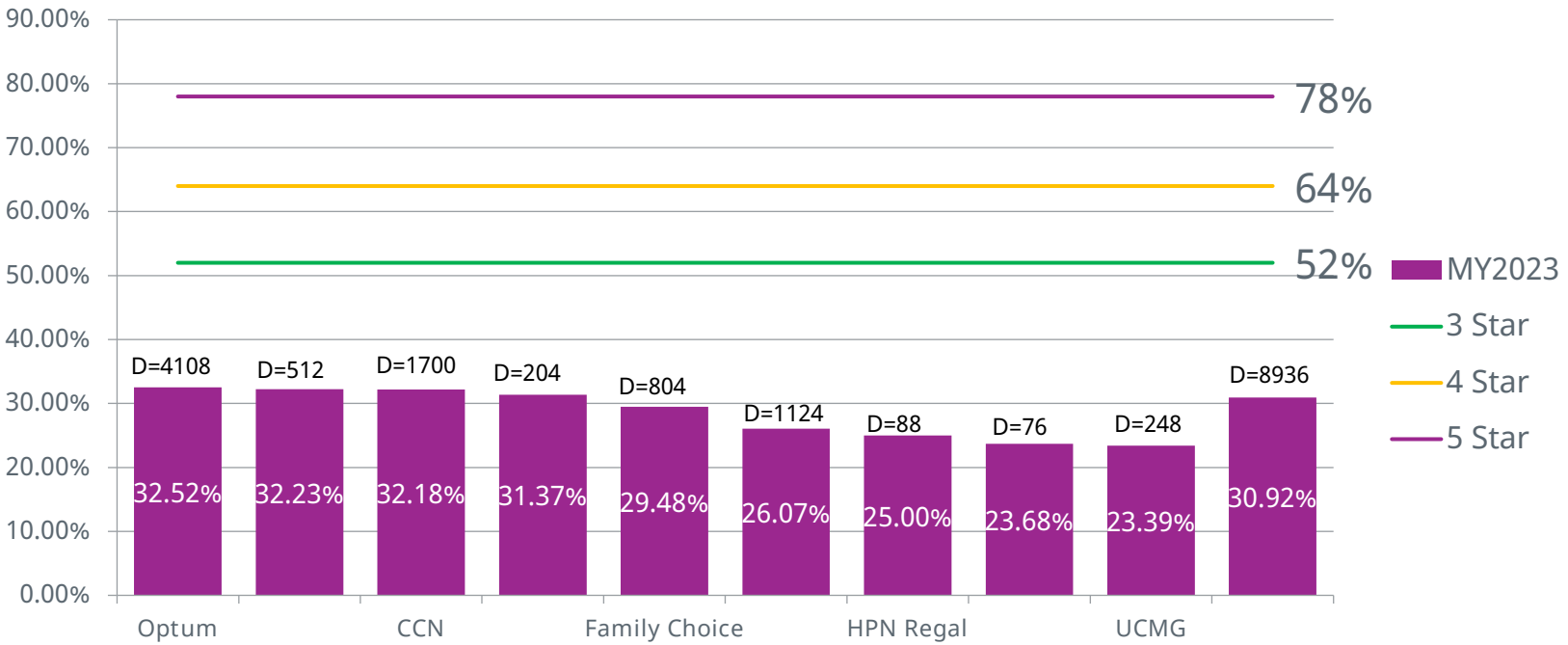
HEDIS MY2023 Results: Medicare

Transition of Care (TRC) - Average



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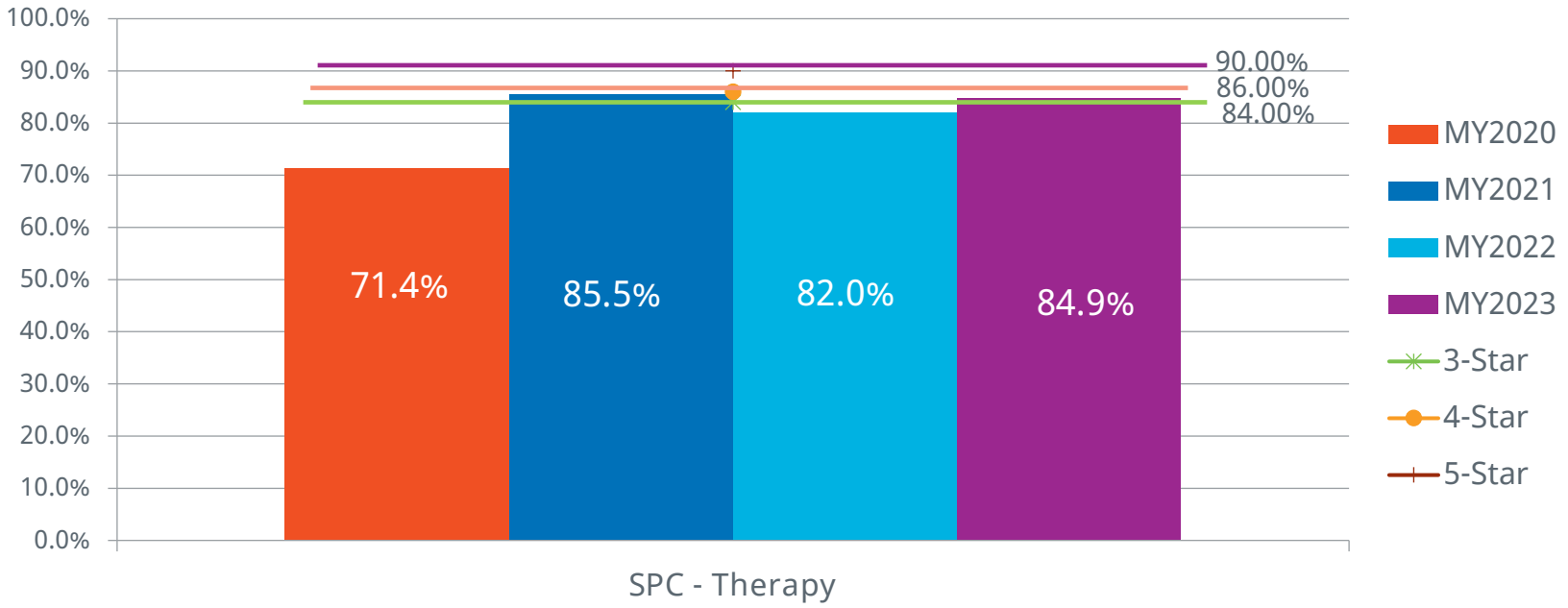
HEDIS MY2023 Results: Medicare

Statin Therapy for Patients with Cardiovascular Disease (SPC) - Therapy



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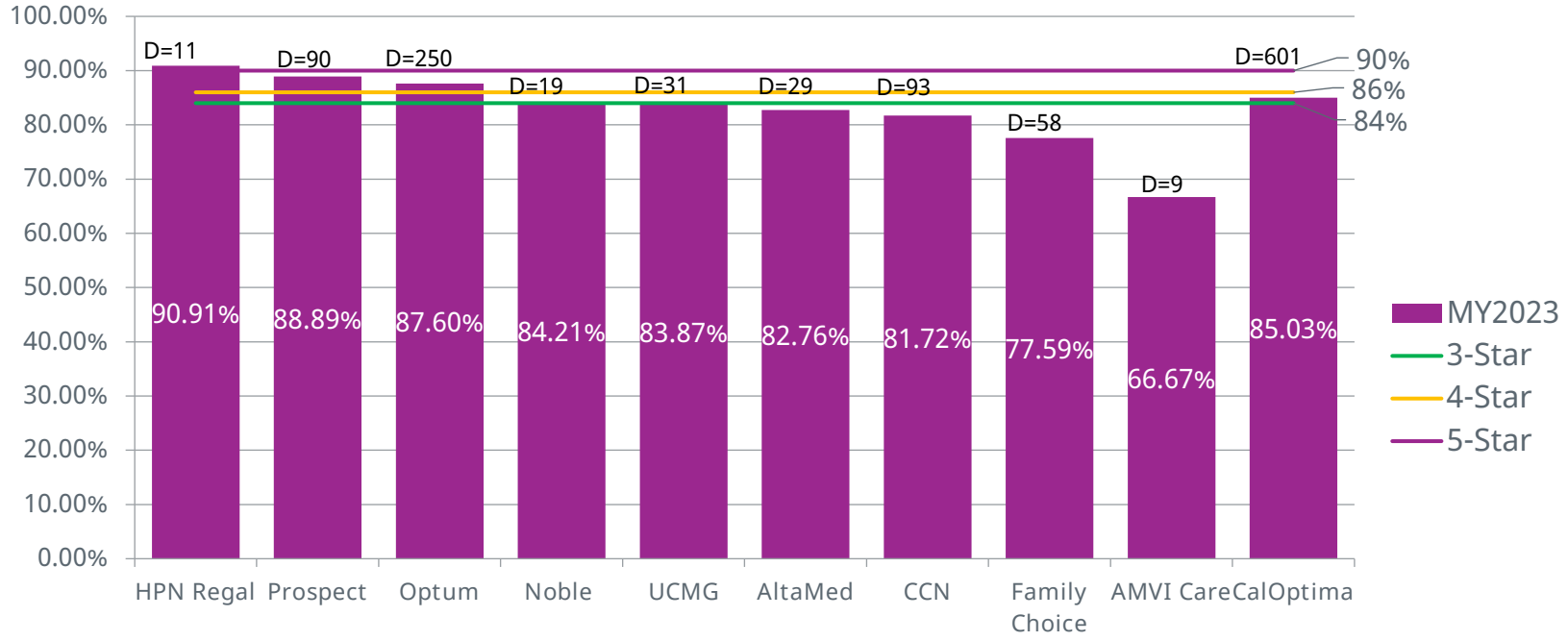
HEDIS MY2023 Results: Medicare - OneCare

Statin Therapy for Patients with Cardiovascular Disease (SPC) - Therapy



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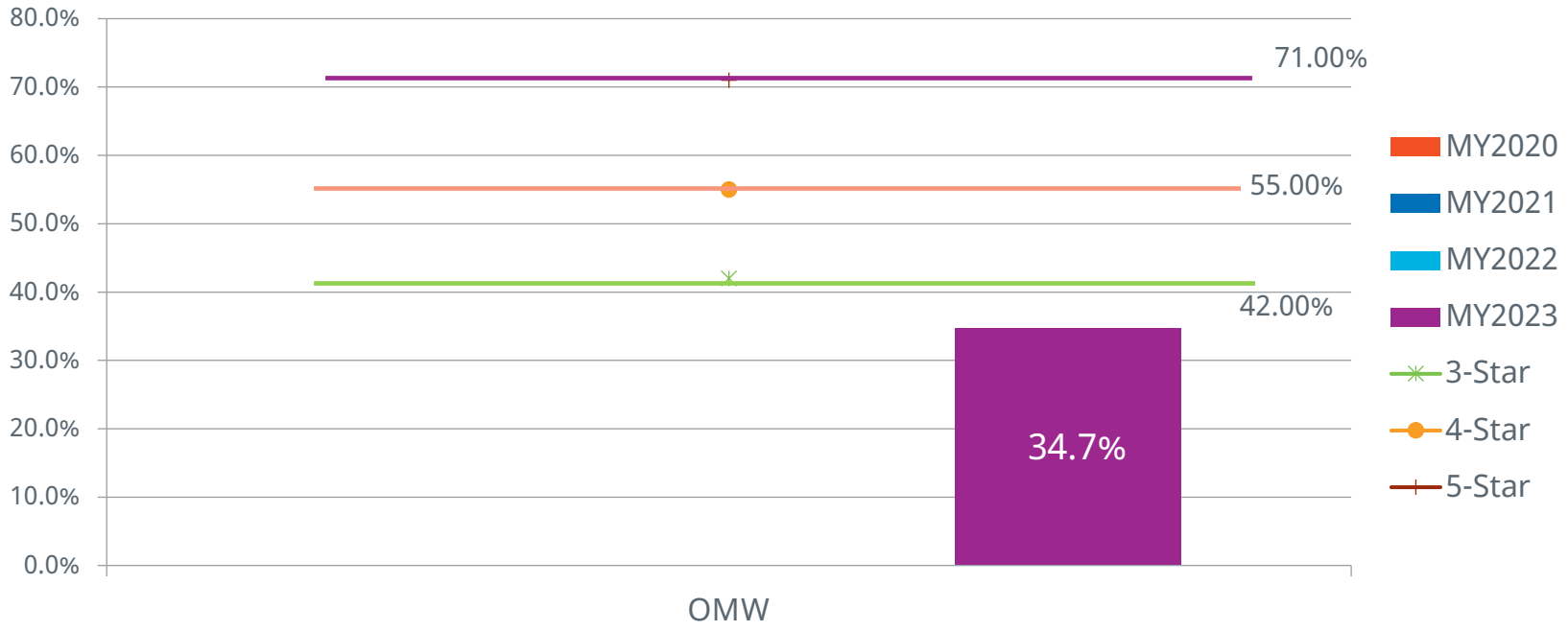
HEDIS MY2023 Results: Medicare

Osteoporosis Management in Women has a fracture (OMW)



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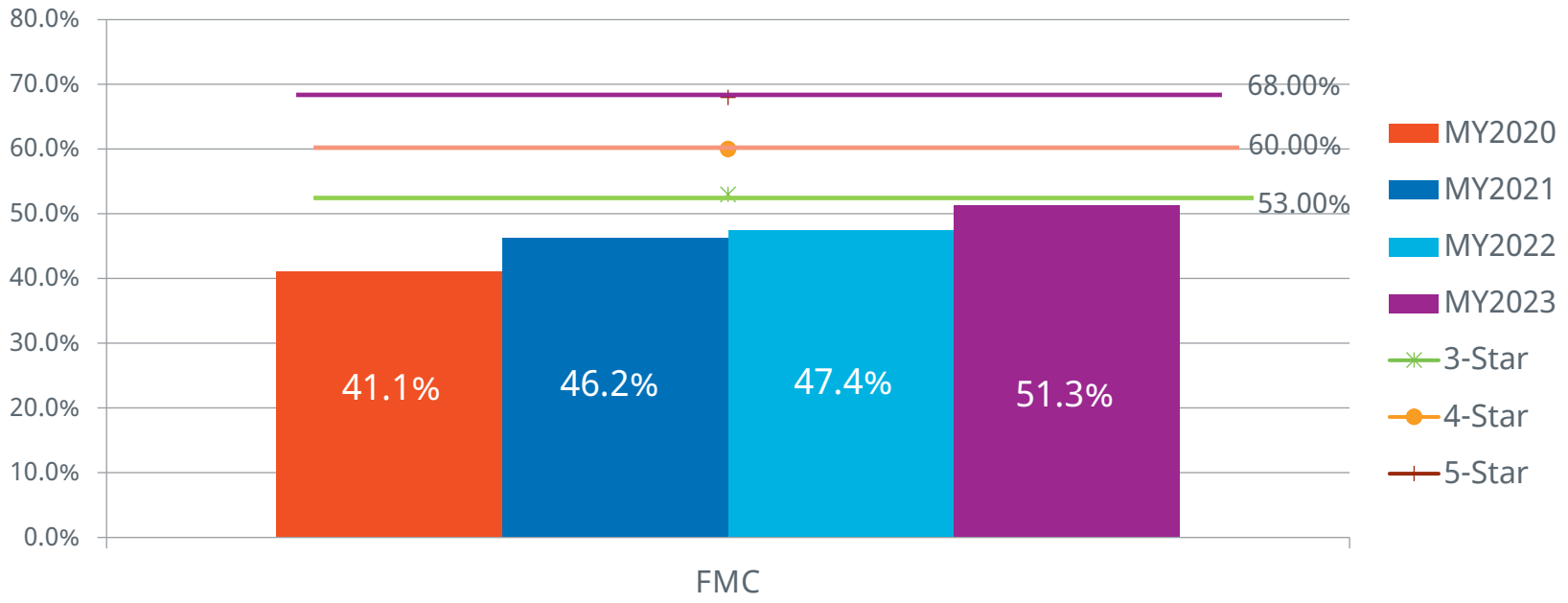
HEDIS MY2023 Results: Medicare

Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)



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HEDIS MY2023 Results: Medicare

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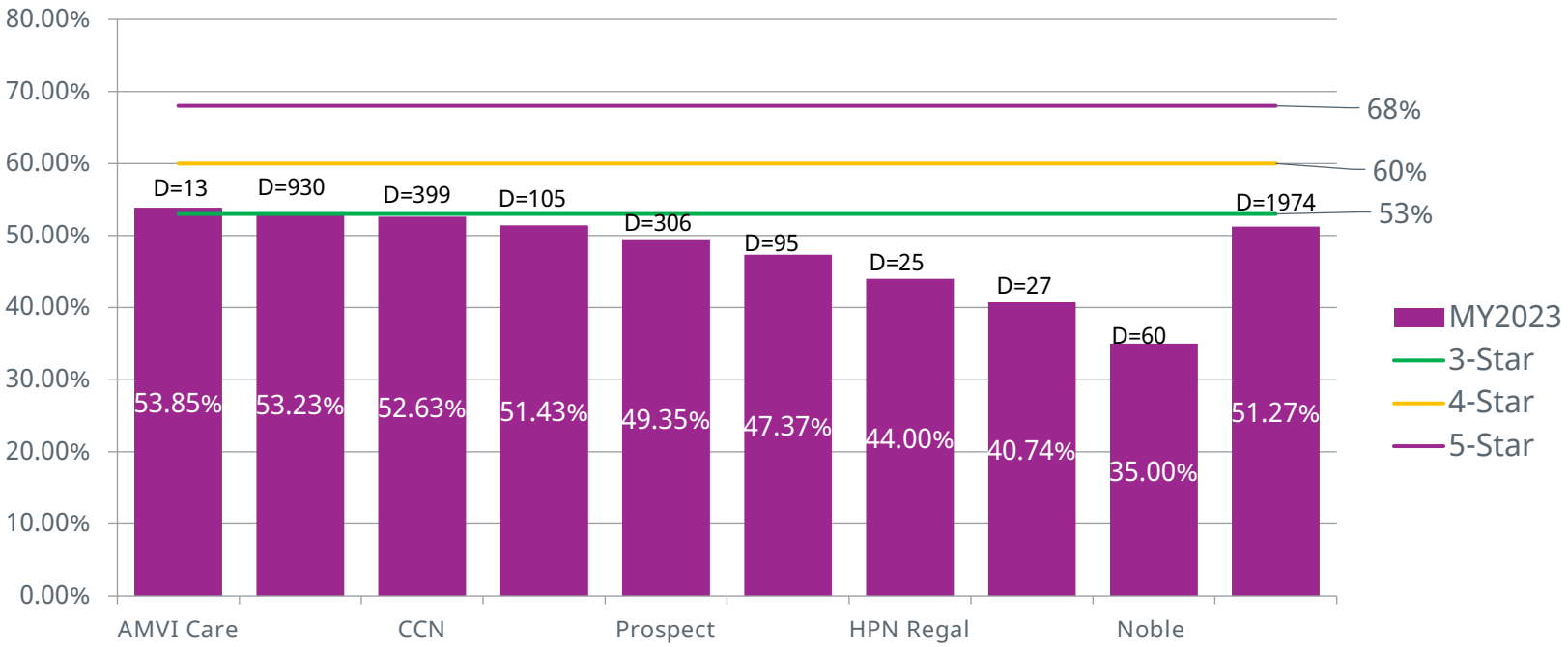

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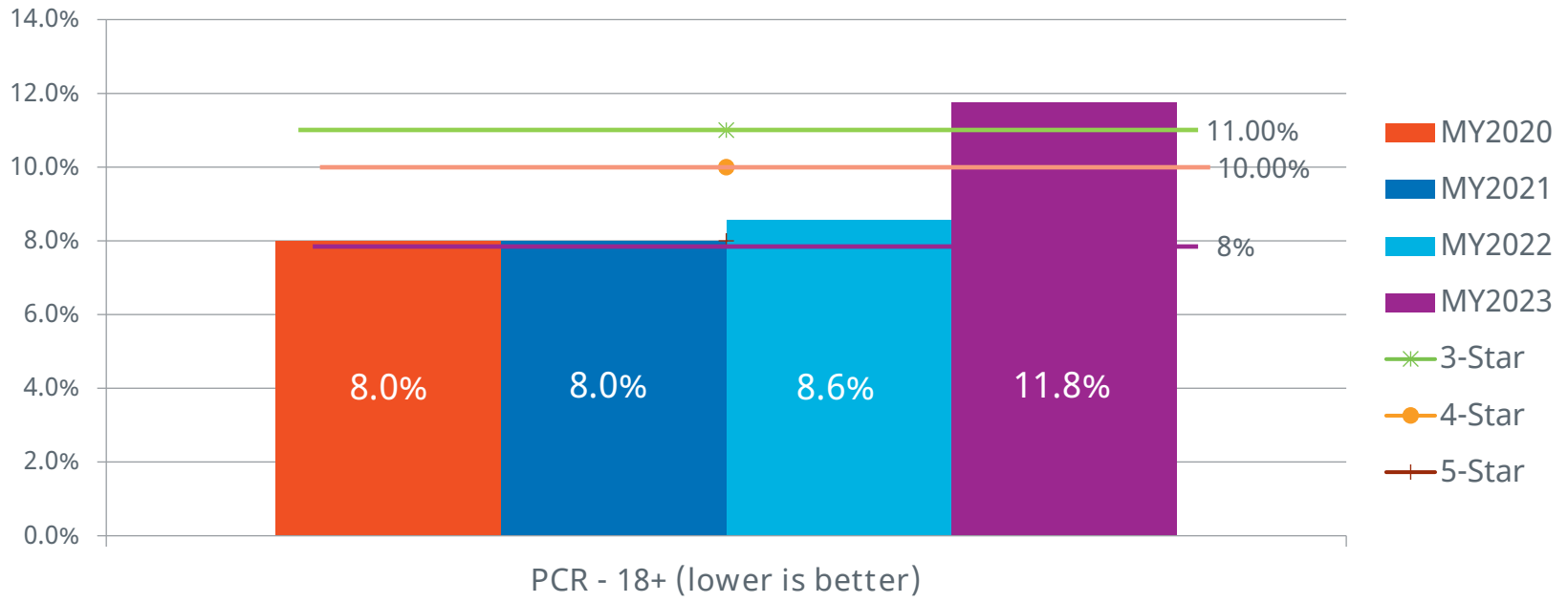
HEDIS MY2023 Results: Medicare

Plan All-Cause Readmissions (PCR) – 18+



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Quality Improvement Grant Program

Quality Assurance Committee Meeting
October 9, 2024

Linda Lee
Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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Quality Improvement Grant Funding Pool

- Grant funds are based on unearned measurement year 2023 Medi-Cal pay for value program dollars
- Total pay for value pool: $79.7 million
- Funds earned based on quality performance: $44.3 million
- Funds unearned and available for grants: $35.3 million
- Funds requested via grant applications: $15.3 million
- Grants awarded: $3 million
- CCN grants applications are still being reviewed
- Remaining funds will be used for quality initiatives led by CalOptima Health: electronic data exchange, health fairs, member satisfaction focus groups, practice site coaching

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CalOptima Health

Quality Grant Program (Medi-Cal)

Goal:	• Utilize the unrealized funds from the MY2023 P4V Program to offer grant opportunities for quality improvement purposes.
High-Level Requirements*:	• Measures of focus must be from the MY2024 P4V Program (see next slide). • Applicants may submit grant applications for individual measures or groups of measures under each domain. • A Health Network that performs below the DHCS MPL must submit a grant application for the measure below the MPL, as part of a corrective action plan. • Grant amounts may range from $50,000 to $250,000 per measure/measure group. • Grant funding is for a 1-year period. • The number and amounts of grants awarded will be contingent upon available funds and determination of acceptable grants. • Funds must be used to provide direct support to improve quality outcomes only for CalOptima Health members.
Eligible:	• Health Networks • Community Clinics • CalOptima Health Community Network (CHCN) Primary Care Providers

*Complete program requirements are outlined in the Notice Of Funding Opportunity

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CalOptima Health

Pay for Value MY 2024: Medi-Cal Measures

Cancer Prevention Measures
Breast Cancer Screening (BCS-E)
Cervical Cancer Screening (CCS)
Children's Health Measures
Child and Adolescent Well-Care Visits: Total (WCV)
Childhood Immunization: Combo 10 (CIS)
Development Screening in the First Years of Life (DEV CMS)
Immunization for Adolescents: Combo 2 (IMA)
Lead Screening in Children (LSC)
Topical Fluoride in Children (TFL CMS)
Well-Child Visits in the First 30 Months of Life: First 15 Months (W30)
Well-Child Visits in the First 30 Months of Life: 15 Months – 30 Months (W30)
Reproductive Health Measures
Chlamydia Screening in Women: Total (CHL)
Prenatal and Postpartum Care: Prenatal Care (PPC)
Prenatal and Postpartum Care: Postpartum Care (PPC)

Behavioral Health Measures
Follow-Up After ED Visit for Mental Illness: 30 days (FUM)
Follow-Up After ED Visit for Substance Abuse: 30 days (FUA)
Chronic Disease Management Measures
Asthma Medication Ratio (AMR)
Controlling Blood Pressure (CBP)
Glycemic Status Assessment for Patients with Diabetes: Poor Control (GSD)
Member Experience (CAHPS Survey) Measures
Coordination of Care
Getting Care Quickly
Getting Needed Care
Rating of Health Care
Rating of Health Network
Rating of Personal Doctor
Rating of Specialist Seen Most Often

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CalOptima Health

Quality Grant Timeline

Action	Medi-Cal
Application Release	7/22/2024
Informational Meeting	8/1/2024
Application Deadline	8/23/2024 at 5pm
Internal Review	August – September 2024
Announcement of Approved Grants	9/23/2024

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CalOptima Health

Activities To-Date

- Notice of funding released on 7/22/2024 to qualified providers
- Conducted virtual Question and Answer session on 8/1/2024
- CalOptima Health received 82 grant applications
- A grant review team has conducted preliminary review and made initial funding recommendations
- A second-level grant review team made final determinations on 9/16/2024
- Health Network grant funding notices were released on 9/23/2024 with 17 grants issued totaling $3 million.
- CCN grant applications are being reviewed

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MY2023 Awarded Grants

Health Network Grantee	Grant Focus Area	Approved Grant Amount
AltaMed Health Services	Preventive Care Support Program (Cancer Screening and Women's Health)	$63,180.00
AltaMed Health Services	Enhanced Well-Child Visit (WCV) Outreach and Preventive Care Support Program	$63,180.00
AltaMed Health Services	Enhancing Chronic Disease Management through Clinical Pharmacy Services	$188,325.00
CHOC Health Alliance	Controlling Blood Pressure and Diabetes	$162,000.00
CHOC Health Alliance	Follow-Up After Visit for Mental Illness: 30 days (FUM) Follow-Up After Visit for Substance Abuse: 30 days (FUA)	$166,500.00
CHOC Health Alliance	Improving Development Screening in the First Years of Life	$94,500.00
CHOC Health Alliance	Improving overall TFL and LSC metrics	$240,000.00
CHOC Health Alliance	Quality Assurance and Training - Customer Service	$84,000.00
Noble Mid-Orange County	Behavioral Health Measures Improvement	$39,000.00

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MY2023 Awarded Grants

Health Network Grantee	Grant Focus Area	Approved Grant Amount
Noble Mid-Orange County	Cancer Prevention Measures Improvement	$184,000.00
Noble Mid-Orange County	Children's Health Measures Improvement	$126,600.00
Noble Mid-Orange County	Chronic Disease Management and Improvement	$108,010.00
Noble Mid-Orange County	Reproductive Health Measures Improvement	$53,625.00
Optum	Post ED Discharge Continuity of Care Calls	$174,199.98
Prospect Medical	Health Navigator Proposal	$75,000.00
Prospect Medical	Lead Screening POC Machine Initiative	$24,000.00
Prospect Medical	Mobile Mammography Proposal	$30,000.00

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Behavioral Health (BH) Mental Health Incentive Program Update

Quality Assurance Committee Meeting

October 9, 2024

Carmen Katsarov, LPCC, CCM, Executive Director

Behavioral Health Integration

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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Background:
BH Pay-for-Value (P4V)Program

Presented at QAC March 2024
Board Approved May 2024
Start Date – Jan 2025

BHI Leadership conducted listening sessions with various BH Providers

Program design internally reevaluated for better provider experience, capabilities, and expectations

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CalOptima Health

BH P4V Program Elements

	Category	Program Element	Weigh t
1	Quality Process	Timely Follow-up After BH/SUD ED visit	2%
2	Capacity/Growth	Capacity/Panel Growth	1.5%
3	Quality Process	Follow–up After Initial Visits	2%
4	Quality Process	Effective Ongoing Care	1.5%
5	Care Effectiveness	Quality Monitoring of Essential Labs and Diagnostics	1%
6	Care Effectiveness	Clinical Measurement of Care	1%
7	Care Experience	Care Experience (Member satisfaction)	1%
		TOTAL	**10%**

**Each measure that meets or exceeds the target earns 100% of the incentive allocation for that measure.*

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CalOptima Health

BH P4V Program Measurement and Scoring

- Measurement Set
  - Use industry standard measures aligned with product regulatory requirements i.e. Department of Health Care Services (DHCS), Managed Care Accountability Set (MCAS) and Centers for Medicare and Medicaid Services(CMS) Star measurement sets
  - Aligning with Department of Managed Health Care (DMHC) timely access standard
  - Clinical industry best practice related
- Data Collection
  - 7 Program Elements
- Measurement & Scoring Methodology
  - Semi-annually
    - Data will be captured by various methods including claims/encounter data, provider attestation forms, and digital surveys

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CalOptima Health

Program Measurement and Payout Period

- Providers will be able to earn up to 10% additional payment on claims during the payout period by achieving any or all the program elements in the measurement period.

6 - month Measurement Period	Payout Period
Jan – Jun 2025	Jan – Jun 2026
July – Dec 2025	Jul – Dec 2026
Jan – Jun 2026	Jan – Jun 2027
July – Dec 2026	Jul – Dec 2027

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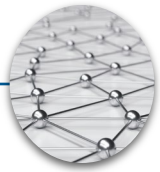
Next Steps

Conduct an introduction and training webinar for the BH providers (Nov/Dec 2024)



Continue to work closely with ITS and Financial Analysis to complete the programming needs

Ensure providers have access to the provider portal

Continue to coordinate with other internal business units as necessary

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CalOptima Health Board of Directors'

Quality Assurance Committee Meeting

October 9, 2024

Quality Improvement Health Equity Committee (QIHEC) Second Quarter 2024 Report

QIHEC Summary		
QIHEC Chair(s)	Quality Medical Director Chief Health Equity Officer	
Reporting Period	Quarter 2, 2024	
QIHEC Meeting Dates	April 9, 2024; May 14, 2024; and June 11, 2024	
Topics Presented and Discussed in QIHEC during the reporting period	• Chief Medical Officer updates • Access and Availability • Adult Wellness and Prevention • Behavioral Health Integration (BHI) • Blood Lead Screening • California Advancing and Innovating Medi-Cal (CalAIM) • CalOptima Health Comprehensive Community Cancer Screening Program • Care Management and Care Coordination • Chronic Conditions Management • Clinical Practice Guidelines • Continuity & Coordination of Care (Behavioral Health) • Credentialing and Recredentialing • Cultural and Linguistic • Customer Service • Diabetes Care • Delegation Oversight	• National Committee for Quality Assurance (NCQA) Accreditation • OneCare Model of Care • Pediatric Wellness and Prevention • Performance Improvement Projects • Policies • Population Health Management (PHM) • Potential Quality Issues (PQIs) • Prenatal and Postpartum Care • Preventive and Screening Services • Maternal Care • Quality Compliance Report • Quality Improvement Health Equity Transformation Program (QIHETP) and Work Plan (WP) • Quality Metrics

	• Encounter Data Review • Facility Site Review (FSR)/Medical Record Review (MRR)/Physical Accessibility Review Survey (PARS) • Grievance & Appeals Resolution Services • Health Education • Healthcare Effectiveness Data and Information Set (HEDIS) • Initial Health Appointment • Medicare Advantage Star Program Rating/Consumer Assessment of Healthcare Providers and Systems (CAHPS) • Member Experience	• Skilled Nursing Facility and Community Based Adult Services (CBAS) • Transitional Care Services • Utilization Management Program and Activities • Whole Child Model

QIHEC Actions in Quarter 2, 2024

QIHEC Approved the Following Items:

- March 12, 2024, QIHEC Meeting Minutes
- April 9, 2024, QIHEC Meeting Minutes
- May 14, 2024, QIHEC Meeting Minutes
- Monitoring of Performance Improvement Project (PIP) in the Quality Improvement Work Plan to ensure CalOptima Health call center standards are compliant.
- 2024 QIHETP Description with 2024 QI Work Plan, Pay Value Program, Population Health Management Strategy, and Cultural and Linguistics Appropriate Services (CLAS) Program
- 2024 Medical Director Review of Clinical Practice Guidelines and 2024 Proposed Clinical Practice Guidelines. Going forward, ownership of the Clinical Practice Guidelines Policy GG.1204 will be responsibility of Medical Management/Utilization Management.
- 2023 Utilization Management Program Evaluation
- 2024 Utilization Management and Case Management Integrated Program Description
- Accept Board-Certified Consultants 2024
- HEDIS Goal Setting Methodology for Measurement Year 2024
- 2024 QIHETP Updated 4.1.24 (Redline)
- 2024 QIHETP Updated 4.1.24 (Clean)
- 2024 QI Work Plan Updated 4.1.24
- 2024 Culturally and Linguistic Appropriate Services Program Description (Clean)

Policies:

- GG.1132 Medi-Cal Annual Wellness Visit

QIHEC Actions in Quarter 2, 2024

- GG.1620 Quality Improvement and Health Equity Committee
- GG.1608 Full Scope Site Reviews
- GG.1603 Medical Records Maintenance
- GG.1651 Assessment and Re-Assessment of Organizational Providers

Accepted and filed the following items:

- Grievance and Resolutions Services Committee Meeting Minutes: February 14, 2024
- Member Experience Committee Meeting Minutes: November 28, 2023, and March 4, 2024
- Member Experience Committee Charter 2024
- Population Health Management Committee Meeting Minutes: February 29, 2024
- Population Health Management Committee Charter 2024
- Utilization Management Committee Meeting Minutes: February 22,2024
- Whole Child Model Clinical Advisory Committee Meeting Minutes: February 20, 2024
- Whole Child Model Clinical Advisory Committee Charter 2024
- 2024 QI Work Plan Q1

Committee Membership Updates:

- Dr. Alan Rodriguez termed with University of California (UCI). Their last QIHEC meeting was April 2024.

QIHEC Quarter 2 2024 Highlights

- Chief Medical Officer updated the committee on the following:
  - California Department of Health Care Services (DHCS) audit was completed and anticipate a preliminary report in June.
  - CalOptima Health is preparing for a mock CMS audit with focus on OneCare and utilization.
  - CalOptima Health is drafting a response to a Corrective Action Plan (CAP) received from DHCS after the Prime facility onsite evaluation to ensure the following after the Prime terminations:
    - A licensed physician is available seven days a week 24-hours a day to authorize medically necessary post stabilization care services and coordinate transfer
    - There is appropriate communication with out of network facilities
    - CalOptima Health subcontracts comply with the CAP requirements.
  - Pertussis increased across the United States and the committee members were asked to share CDC's recommendation around whooping cough vaccination.
- The 2024 QIHETP and Annual Work Plan were updated to include the Cultural and Linguistics Appropriate Services (CLAS) Program (added to appendix of the QIHETP).
- The QIHETP Work Plan was updated to include the following:
  - CLAS workplan elements
  - Monitoring Maternal and Adolescent Depression Screening.
  - A CAP to improve a Key Performance Indicator (KPI) for customer service.

QIHEC Quarter 2 2024 Highlights

- CalOptima Health was preparing for the NCQA Health Plan Accreditation Re-survey. CalOptima Health staff worked diligently to finalize documents for the April 30, 2024, submission date and prepare for the June 17 and 18, file review sessions.
- In May, staff reported to QIHEC a noncompliance regarding timely Fax Recipient Acknowledgements after 3,409 faxes were found to not have evidence of acknowledgement by the provider. Staff was conducting a barrier analysis to identify a root cause and identify options for remediation. Staff will provide a status update to QIHEC.
- Staff reported that the issue of noncompliance related to Whole Child Model (WCM) Health Needs Assessment (HNA) outreach and collection timeliness previously reported to QIHEC on April 9, 2024, has been resolved.
- CalOptima Health conducted annual Health Network audits and issued 12 CAPs for Family Choice Medical Group in the quarter. Utilization trends around timeliness of UM notification, processing of claims and outdated templates were identified.
- Cultural and Linguistic
    - Developed a Sexual Orientation Gender Identity (SOGI) Survey to collect members SOGI data. Survey will be loaded to the member portal and be mailed to members. CalOptima Health's claims system, FACETS, will store this data when collected.
    - Experienced an increase in requests for interpreter and translation services from both members and providers with Spanish being the language most requested.
    - BH telehealth provider support increased utilization of face-to-face interpreter services and expect the increase to continue.
- CalOptima Health reviewed Medi-Cal and OneCare Encounter data from Health Networks and no CAPs were issued for encounter data.
- CalOptima Health Comprehensive Community Cancer Screening and Support Program
    - A notice of funding opportunity was released on February 7, 2024, and closed on March 29, 2024.
    - Received 27 Community Grant applications for activities to increase screening and decrease late-stage discovery of breast, cervical, colorectal and lung cancer. The applications will be reviewed and scored and selected applications will be presented to the Board of Directors meeting.
- When comparing to last year's Star cut-off values, HEDIS Star measures have improved overall.
    - Five-star measures may receive a higher Star Rating.
    - The Plan All-Cause Readmissions (PRC) measure may receive a lower Star Rating.
    - HEDIS rates were not finalized but the administrative data refresh and medical record review for hybrid measures were completed. Next step was Medical Record Review Validation (MRRV), and final rates review and approval by auditors.

QIHEC Quarter 2 2024 Highlights

  - All Managed Care Accountability Set (MCAS) measures may not meet DHCS minimum performance levels (MPLs) and particularly measures related to Follow-Up After Emergency Department Visit are at risk.

- For OneCare, HEDIS 2024 Star rating results, based on 2023 dates of service, were slightly lower than they were the same time last year. There are nine measures at-risk for not meeting 3 Stars. Two measures have recently increased to a 3- and 4-Star rating. CalOptima Health Part D medication measures are at the 3 Star rating except for Medication Adherence for Cholesterol (Statins). CAHPS surveys were being collected through June and Call Center Monitoring for the TTY and Interpreter availability calls began in February and continue through May.
- CalOptima Health is expected to meet the Blood Lead Screening (BLS) MPL where the preliminary rate shows almost 60%, with the MPL at about 63%. BLS initiatives for 2024 include Member Health Rewards, text campaign, and a live-call campaign.
- Student Behavioral Health Incentive Program (SBHIP) met the program timelines. The last bi-quarterly report was submitted to DHCS in December 2023, received approval in March 2024 and will receive full funding for that period. CalOptima Health's Utilization Management department is working with the schools for additional support for access to Applied Behavioral Analyst services.
- Behavioral Health Integration reported low prospective rates for five BHI HEDIS quality measures related to Follow-Up After Emergency Department Visit, Diabetes Screening and Monitoring for People with Schizophrenia or Bipolar Disorder and Metabolic Monitoring for Children and Adolescents on Antipsychotics. These measures are at risk for not meeting the HEDIS MY2024 goals. Follow-Up Care for Children Prescribed ADHD medication (ADD) and Antidepressant Medication Management (AMM) are on target to meet goals. Interventions to address low performance include text message campaigns, member health rewards, member outreach and communications, and a new BH Pay-For-Value program.
- Customer Service: There was an increase in Medi-Cal call volume during Q1 2024 due to Kaiser Permanente and Optum Health transition affecting CalOptima Health's adult membership. There was a slight increase in the volume of OneCare member calls.
  - CalOptima Health's internal goal for abandonment rate for OneCare and average speed of answer for both Medi-Cal and OneCare were not met. Additional staff was hired to help with the increase in the volume of calls. A new contact center NICE will be implemented in Q3, 2024. Customer Services Department has also secured a customer relationship management platform to enhance the existing member portal.
- Special Needs Plan (SNP) Model of Care (MOC): As of 5/8/24, MY2024 Health Risk Assessment member completion was at 30.09% (goal 65%) and staff continues to focus on collecting HRAs.
- Maternal and Child Health
  - Rates for Prenatal and Postpartum Care: The rate for Timeliness of Prenatal Care (PPC) has improved compared to the same time last year. However, the Timeliness for Postpartum Care (PPC) is slightly lower compared to the same time last year.

QIHEC Quarter 2 2024 Highlights

- CalOptima Health contracted with seven doula providers. Doula providers could be found on CalOptima.org website on the Provider Directory. CalOptima Health provides education and guidance for doulas interested in contracting with CalOptima Health to provide services.

- Preventive and Screening Services
  - When reviewing 2024 prospective rates, the following measures performed better compared to the same time last year: Breast Cancer Screening (BCS) and Colorectal Cancer Screening (COL) for Medi-Cal and OneCare. However, Cervical Cancer Screening (CCS) has a lower rate when comparing the rate at the same time last year.
- Clinical Performance Improvement Projects (PIPs) Medi-Cal
  - Well-Child visits in the first 15 months – Call campaign to help improve the rate among Black/African American population began in May 2024. Calls are utilized to remind members to get well child visits and to gather data on barriers to address health disparities for this population.
- Facility Site Review Medical Record Review and Physical Accessibility Review
  - Compliance was 96% and 100% on the assessment of adult and pediatric comprehensive history and Physical and Member Risk Assessment.
  - Compliance on assessment of Blood Lead Screening was 64%. Common recurring deficiencies in the FSR and MRR review were shared with the Committee. The Committee focused on the deficiency with California Immunization Registry (CAIR) utilization recommending additional education and training to providers on regulatory requirements to enroll in CAIR.

QIHEC Subcommittee Report Summary in Quarter 2, 2024

Credentialing and Peer Review Committee (CPRC)

- CPRC met on 01/25/2024, 01/29/2024 (ad Hoc), 02/22/2024, and 03/28/2024.
- Approved the following:
  - Policy GG.1651: Assessment and Reassessment of Organizational Providers
  - Newly recognized board, American Board of General Practice in Credentialing.
  - CPRC charter to include DCMO and Manager Quality Improvement, and specified voting vs. non-voting members
  - The Potential Quality Issues (PQIs) Cases and Trend Reports, the Credentialing Clean Lists, and the Credentialing Record Closing Lists each month.
- With help from QI team, Jiva QPI module by ZeOmega launched May 20, 2024.
- Five providers were in Fair Hearing process.
- Reviewed PQI and credentialing cases. One PQI was recommended for an administrative termination and one physician was referred to Fraud, Waste & Abuse.
- A total of 341 providers were credentialed. CalOptima Health has met all Turn-Around-Times (TAT) for credentialing and recredentialing applications but continues not meeting the initial credentialing for Behavioral Health Practitioners, who must be credentialed in 60 days. To help

QIHEC Subcommittee Report Summary in Quarter 2, 2024

with that process a Credentialing Verification Organization (CVO) vendor was implemented on 6/13/2024.

- A total of 70 FSRs and 50 MRRs were conducted.
  - 89% of completed FSR audits met the TAT. MRR audit TAT is dependent upon FSR. Two providers failed FRS audits, and five providers failed their MRR.
  - 31 CAPs were issued for critical elements and 22 for FSR. One PCP was terminated per APL 22-017. Barriers were identified and staff conducts regular provider office staff training.
- Reviewed Long Term Services and Supports, Community-Based Adult Services, and Multipurpose Senior Service Incident Reporting data.
- No new Provider Preventable Conditions (PCCs) were identified in Q1 2024.

Grievance & Appeals Resolution Services Committee (GARS)

- GARS Committee met on 5/14/2024.
- Q1 2024 trends by line of business.
- Reviewed Q1 2024 trends along with remediation activities.
- Medi-Cal Grievances: There was a decrease in grievances from the previous quarter. Areas of focus for grievances are: CCN, delays in referrals, wait time for appointments, and non-medical transportation (NMT).
- Medi-Cal Appeals: There was a decrease in appeals from the previous quarter with an overturn rate of 32%. Many of the appeals were related to CCN and Optum Healthcare: additional records received, medical criteria applied at the appeal level to support the requests and missing information received at the time of appeal
- OneCare Grievances: There was an increase in grievances from the previous quarter. Areas of focus for grievances are: Optum Healthcare, quality of services issues related to providers refusing care, NMT services where CalOptima Health transitioned NMT services to a new vendor.
- OneCare Appeals: There was a decrease in appeals from the previous quarter with an overturn rate of 48%. Many of the appeals were related to Optum Healthcare: out of network specialty care. Staff reached out to Optum Healthcare and resolved many of the issues.
- There were 11 state fair hearings requested and 1 overturned.
- Several departments took actions to remediate issues related to grievances:
  - Claims was conducting a claim sweep to adjust claims previously processed in error leading to grievance.
  - Network Operations was providing education to Health Networks on proper denials and assigning a new fax number so that authorization is properly and timely received.
  - Medical Management was providing education to providers on ABA denials and better coordination with HN contacts on discharges.

QIHEC Subcommittee Report Summary in Quarter 2, 2024
• Non-Compliance: Member Appeals had five cases submitted late due to high Nurse Specialist caseload. Staff created a report for clinical manager tracking and is being monitored daily to ensure that all denial cases are being submitted timely. • Member Grievances – In 2023 100% of all discrimination cases were closed timely. However, only 60% were sent to DHCS within the regulatory timeframe and in Q1 2024 two additional cases were submitted late. Late submission was due to reporting details not available however staff created a detail reporting to allow for proper monitoring.
Member Experience Committee (MemX)
• MemX met on 5/22/2024. • Approved updates to their charter. • BH member experience survey results – Medi-Cal member responses increased in 2023 from the previous year For Medi-Cal, the overall satisfaction rate decreased for Medi-Cal Mental Health population from 75% to 67% and increased in the Medi-Cal ABA population from 81% to 84%. 2023 was the first year OneCare members were surveyed for mental health experience. OneCare Mental Health overall satisfaction was 65%. The goal for the surveys was set at 85%, and all populations surveyed did not meet their target goal. • Reviewed status of the 2022 Timely Access survey CAPS where 117 CAPs were issued, and 11 CAPs were issued to the HNs. Staff provided a status on the 2023 Timely Access survey fielded from September to December of 2023 and rates to be available in June 2024. • Discussed results of the 2023 Annual Network Certification (ANC) and Subcontracted Network Certification (SNC) submissions including status of CAPs for health networks related to SNC. CalOptima Health continues to work with the HNs on improving the following areas: Mandatory Provider Types for licensed/certified midwives, provider to member ratios for specific provider type and time and distance for specific zip codes. OneCare met standards for network adequacy. • Introduced the Network Adequacy Validation (NAV) audit and provided update on progress; Virtual session scheduled for July 2024. • CAHPS status on fielding was provided. Final plan results will be available in Q3 2024.
Population Health Management (PHM) Committee
• PHM Committee met February 29, 2024, and May 16, 2024 • PHMC approved PHM Committee Charter, reviewed regulatory requirements and KPIs. • While Initial Health Appointment rates increased from 17% to 50%, most health networks are at risk of not meeting the goal. • Included pediatricians as providers for Maternal Health Depression for the PHM Strategic goal. • Shape Your Life informational flyer for the Health Education Program was shared. • Presentation to PHMC by OCHCA on Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP).
Utilization Management Committee (UMC) • **Benefits Management Subcommittee (BMSC)**

QIHEC Subcommittee Report Summary in Quarter 2, 2024
• **Pharmacy and Therapeutics Committee (P&T)**

• UMC met on May 23, 2024.
• The Committee took the following actions:
  o Reviewed 2023 Utilization Metrics for 4th Quarter: Over and under-utilization rates against goals (Admits/PTMPY, Days/PTMPY, ALOS, Readmit %), identified an increase in rates for Long Term Care population and an increase in readmissions for most populations.
  o Reviewed Inpatient TAT - Compliant since November 2023.
  o Reviewed Prior Authorization TAT – Compliant for all measures.
  o Approved the 2024 UMC Charter revisions.
  o Set target goals for Bed Day and Readmits and created a Bed Day's Reduction workgroup to review data for inpatient Bed Days and Admits and to assist with improvements needed.
  o Approved 2024 Board Certified Consultants
  o Approved the 2024 Utilization Management Goals
• The following quality improvement actions were implemented:
  o Reported to QIHEC that a system error caused fax receipt acknowledgement issue after the JIVA migration. Created a sub workgroup to analyze the list of outstanding fax acknowledgements and create interventions with a report on resolution.
• Benefit Management Subcommittee was held on 2/28/24, 3/13/2024 and 3/27/2024.
  o 145 codes were reviewed and determined whether a prior authorization is required, not required or removed from the list.
  o 2024 Benefit Management Subcommittee Charter reviewed and approved.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

• WCM CAC met on May 20, 2024.
• Approved WCM CAC Charter updates.
• Accepted Dr. Wyman Lai's resignation and added Dr. James Chu, pediatric cardiologist at CHOC Health Alliance as his replacement.
• Unanimously voted to keep meeting virtual.
• Reviewed WCM DHCS Assessment Report.
• WCM membership continues to decrease. Largest enrollment was 15–19-year-olds.
• WCM network adequacy standards met for the quarter.
• Reviewed WCM utilization and service data.
  o Prospective rate for Behavioral Health Treatment Utilization – Low APM (Metabolic Monitoring for Children & Adolescents on Atypical Antipsychotics). Barrier was reported on receiving timely and accurate data. Remediation with staff education on APM best practice and follow-up visits with members are recommended.
  o For CalAIM, the highest utilization was in Enhanced Care Management, specifically housing navigation and medically tailored meals.

QIHEC Subcommittee Report Summary in Quarter 2, 2024
• Reviewed Pediatric Quality Measures – Opportunities for improvement are in the WCM 1-15 months of life; Combo-10 - Flu vaccine; Developmental screening; Topical Fluoride application; WCC 18-21. Strategy to close quality gap by leveraging opportunities during specialist visits and at special care centers; dental home for all WCM children; optimize TRC process for patients aging out.

For more detailed information on the workplan activities, please refer to the Second Quarter of the 2024 QIHETP Work Plan.

Attachment

Approved at QIHEC throughout Q2 2024: Second Quarter 2024 QIHETP Work Plan 2Q

2024 QI Work Plan – Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	2024 QIHETP Description and Annual Work Plan was first adopted by BOD on 4/4/24. Revisions were made to the QIHETP and Work Plan and was approved by QAC on 6/12/24. 1. Updated QIHETP staffing and resources to reflect current organizational structure and renamed Equity and Community Health Department formaly known as the Population Health Management Department. 2. Updated section in the QIHETP to reflect current operational and workflows. 3. Added Cultural and Linguistic Appropriate Services Program to QIHETP as Appendix D. 4. Added cultural linguistic and health equity goals and planned activities to the QIHETP Annual Work Plan.	The revised 2024 QIHETP Description and Work Plan was submitted for BoD approval at the 8/1/24 meeting.	
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	2023 Quality Improvement Program Evaluation was approved by BoD on 4/5/24.	Goal was completed	
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of Utilization Management	Utilization Management	The 2024 UM and CM Program was presented at the March 2024 BOD and approved	Goal Completed. Next steps not needed.	
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of Utilization Management	Utilization Management	The 2023 UM and CM Program Evaluation was presented at the March 2024 BOD and approved. Based on the approval of the 2023 UM/CM Program Evaluation, the 2024 UM/CM Program was written.	The 2024 UM/Program will be evaluated in Q1 2025.	
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: (1) Population Needs Assessment (PNA) (2) Risk stratification (3) Screening and Assessment (4) Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Equity and Community Health	Manager of Population Health Management /Director of Care Management	Equity and Community Health	1) PNA: Completed 2024 Population Needs Assessment Report Draft. Engaged with OCHCA to begin implementation of collaborative Community Health Assessment for 2027 and beyond.	1) PNA: Report 2024 PNA Key Findings to MAC, PAC, and PHMC; Publish 2024 PNA to CalOptima Health Website	

2024 QI Work Plan – Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Managemet (PHM) Strategy	The Population Heath Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/0520/24 QAC: 12/11/2024 Annual BOD Adoption by January 2025	Director of Equity and Community Health	Manager of Population Health Management /Director of Care Management	Equity and Community Health	DHCS paused reporting on PHM Program Key Performance Indicators (KPIs) until they update technical specifications. Developing shared SMART Goals with OCHCA related to improving outcomes for Maternal Depression and Childhood Blood Lead poisoning.	Evaluation of goals and KPIs to be included in PHM Strategy Evaluation in Q4 2024.	
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Presented and approved in the June 2024 QAC meeting and set to go for Board approval in July 2024. The workplan was embedded in the QI workplan and also approved in the June 2024 QAC meeting.	Obtain BoD approval in July 2024.	
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: 11/05/2024 QAC: 12/11/2024 Annual BOD Adoption by January 2025	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	No activities in April-June.	Evaluation assessment to begin Q3 or Q4 2024.	
Program Oversight	**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	(1) PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), (2) PHM Strategy activities, and PHM Workplan progress and outcomes. (3) Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health/ Director Case Management	Equity and Community Health	▪ Held second quarter PHM Committee Meeting in May 2024 which included both internal CalOptima Health updates on PHM Program and Community Spotlight on CHA/CHIP facilitated by OC HCA. ▪ Provided PHM Committee update for QIHEC in June 2024. ▪ Finalized the approval and reporting calendar, charter, and Policy GG. 1667. ▪ Developed and published PHM Committee SharePoint site to house committee materials	▪ Continue to assists this committee by reviewing relevant guidance, agenda setting, and presentation development, and deliverables shared with QIHEC. ▪ Next PHM Committee meeting is scheduled for August 2024 ▪ Report committee update to QIHEC in September 2024	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	**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	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	There remain five physicians undergoing the Fair Hearing process. Six PQI cases leveled 1, 2 or 3 were presented to CPRC. Two PQIs were brought back to CPRC and the physicians were recommended for an administrative termination. In Q2, 2024, PQI launched a new system to track PQI cases called Jiva. PQI reporting is still being developed, so trends will be reported when the reports are available. We can report that we have 629 open PQI cases. At the end of Q1, we completed the annual audit of contracted hospitals to ensure they have a policy and procedure for ensuring a 72 supply of medications at discharge. 10 hospitals were audited and all were in compliance. There were no new PPCs or OPPCs identifiefed in Q2. Two policies were presented: GG.1650 and GG.1651 with minor changes.	Two of the Fair Hearings are scheduled to commence in Q3, 2024. In Q3, 2024, we aim to have reporting available for PQI developed and be able to report trends for Q1 and Q2. We will continue to monitor claims data for PPCs and OPPCs.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	**Grievance and Appeals Resolution Services (GARS) Committee -** Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health netwoks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Grievance and Appeals	Manager of Grievance and Appeals	Grievance and Appeals Resolution Services	GARS Committee met on May 14 to review the trends and actions taken for the trends identified in Q1. During that discussion the following were presented: **Program - Grievances:** Medi-Cal received 3,713 grievances in Q1 and 15,420 appeals/payment disputes = 19,133 OneCare Connect received 2 Grievances in Q1 and 99 appeals/payment disputes = 101 OneCare received 475 grievances in Q1 and 1098 appeals/payment disputes = 20,807 There were no HN over the NCQA threshold Trending Health Networks for MediCal included - CCN at 2.48 per 1000 MM; Heritage at 1.32 per 1000 MM and Optum at 1.31 per 1000 MM Trending Health Networks for OneCare included - Prospect at 7.8 per 1000 MM, Optum at 7.6 MM and CCN at 7.6 MM Top reasons included transportation delays, provider service and CalOptima Services. Both Access to Care and Member Billing both saw a decrease in the volume over Q4. **Appeals:** No trends identified in appeals. Overturn rate in Q1 was 32% and the overturn reasons were consistent with prior quarters - additional records received, medical criteria not applied on the initial review used at the appeal level to support the request and missing information not available at the initial review received at the time of appeal.	The department will continue to perform quarterly reviews to identify trends. This information will be presented to GARS Committee as opportunies to improve operations across the organization. The department will host the next GARS Committee meeting on August 14 to discuss trends identified and any remediation activities found in Q2 2024.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health'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. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	Quality Analytics	In Q2, MemX Committee met 5/22/24 and reviewed/discussed the following: •Charter review and Committee approved the updates •Created quarterly reporting schedule •Reviewed Behavioral Health Member Experience Survey Results •Timely Access: Appointment Availability and Telephone Access: Reviewed the number of Provider and HN CAPS issued and received and DHCS audit findings. •Network Adequacy: SNC 2023 submitted 1/19/24 and revisions and corrective action plans submitted on 5/3/24. CalOptima's next quarterly update is due 7/1/24. ANC: phase 1 ANC 2023 submitted 2/1/24 and phase 2 ANC 2023 submitted 3/20/24. NAV audit: pre-virutal audit activities completed March-May 2024. CalOptima's virtual audit-7/25/24. •Improve Member Experience: Reviewed current response rates for HN and Plan level CAHPS. •KPI Updates: All KPI's for Customer Service, Health Ed, GARS, UM and CM were presented and are being monitored and addressed in respective committees.	Q3 meeting is scheduled for: 7/16/24	
Program Oversight	**Utilization Management Committee (UMC) Oversight** - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. **P&T and BMSC** reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Utilization Management	Manager of Utilization Management	Utilization Management	Internal and External oversight monitoring established by the Bed Reduction Strategy sub work group and presented for approval at the 5/23/2024 UMC Committee. The goals were approved by the committee. Utilization information will continue to be shared in UMC meetings to monitor these goals going forward. The UMC Committee information was presented to QIHEC at the 6/11/2024 meeting.The Committee information will be presented next in September.	On track - UMC scheduled for 8/22 where information will be reviewed, and next report out scheduled for September QIHEC meeting.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Whole Child Model Medical Director/Director of Case Management	Program Assistant QI	Medical Management	WCM CAC met 5/20/2024. They approved the 2/20/2024 meeting minutes and submitted a copy to QIHEC. WCM CAC unanimously voted to keep meeting virtually. The WCM CAC Charter updates were approved. Dr. Wyman Lai CHOC CCS representative resigned from serving on WCM CAC. Dr. James Chu, from CHOC is being considered to replace Dr. Lai. The Committee reviewed WCM data, pediatric quality improvement measures, pediatric CalAIM services.	CalOptima Health staff will continue active monitoring of WCM Health Network adequacy, collaborate with quality improvement staff on quality improvement strategies. Pediatric Risk Stratification Process (PRSP) monitoring will be reported at the next WCM CAC meeting scheduled for August 20, 2024.	
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Care Management	TBD	Medical Management	Enhanced Care Management (ECM): a)CalAIM ECM provider report documenting Lead Care Managers in CalOptima Connect showed an improvement from 3% to 44%. This ensures the Lead Care Manager is notified of any admissions. Expectation moving forward is to have ECM Providers continue to document accurately. Complex Case Management (CCM) a) NCQA Accreditation Audit-passed 100% b) Continue Monthly NCQA file audit for CCN and Health Networks. Basic PHM/CM: Case Management's quarterly audit for MOC for delegated Health Networks. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) a) CM: Implemented a multi-department work group to discuss EPSDT requirements meetings on 5/21/2024 and 7/1/2024. b) Health Network training 4/18/2024 on EPSDT. Transitional care services: a) Refer to Row 61 for TCS Updates. b) IT support for reporting to analyze outcomes on TCS response pending Phase II Jiva remediation c) Sharing of TCS qualifying discharge events with ECM providers to track successful outreach	Report on the following activities: Enhanced Care Management (ECM): a) Safety Net Connect to create self-reporting tool for Lead Care Manager to share contact information. Complex Case Management (CCM): a) Continue monthly NCQA file audits for CCN and HN members open to CCM level of care. Basic PHM/CM: Continue quarterly audits of delegated Health Networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: a) continued workgroup to discuss requirements for EPSDT Transitional care services: a) See Row 61 for TCS updates. b) Outcome analysis of Health Networks for JOMS presentation pending IT support post JIVA Phase II remediation. c) continued requests to ECM providers for information on TCS outreach day 1-7 post qualifying discharge event.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Audit and Oversight	Manager of Audit and Oversight (Delegation)/ Manager Delegation Oversight	Delegation Oversight	Delegate: Family Choice Health Services/Conifer Health Solutions (MSO) (83) Family Choice Medical Group/Conifer Health Solutions (MSO) (21) Area(s) Assessed: Case Management; Claims; Compliance; Credentialing; Customer Service; Provider Network Contracting; Provider Relations; Sub-Contractual; Utilization Management Corrective Action Plan(s) Issued: Claims (Medi-Cal) – Accepted & Closed Compliance, Staff Initial Training (All Lines of Business) - Accepted & Closed Customer Service (All Lines of Business) – Monitoring Utilization Management, Concurrent Review (Medi-Cal) – Monitoring Utilization Management, Expedited & Standard Denials (Medi-Cal) – Monitoring Utilization Management, Physician Administered Drugs (All Lines of Business) – Accepted & Closed Utilization Management, Notice of Medicare Non-Coverage (OneCare) – Accepted & Closed Utilization Management, ODAG Denials (OneCare) – Monitoring Utilization Management, Physician Administered Drugs (All Lines of Business) – Accepted & Closed	Continue to monitor CAPs in “Monitoring” status through acceptance & closure.	
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Population Health Management	Manager of Equity and Community Health	Equity and Community Health	1) A 2 way text messages targeting members with asthma was implemented on 6/19/2024. In responding to the text, there were 232 members that requested a call back from a health coach. 2) A column was added to the monthly diabetes stratification results identifying members with Chronic Kidney Disease Stage III and IV. 3) Currently piloting stratification/segmentation data from PointClickCare to identify members with Congestive Heart Failure and from Decision Point Opus to identify members with Asthma for outreach by the health coaches. 4) Monitoring the bi-monthly New Member Mailing for low-risk members with asthma and diabetes taking place since February 2024. 5) Collaboration with CalAIM to refer asthma members to the Asthma Housing Remediation Community Supports program. 6) Process has been established between the CalOptima Health Pharmacy department to conduct the medication therapy management for members receiving health coaching and interventions from Registered Dietitians. 7) CalOptima Health RDs are able to assess and submit their own Medically Tailored Meals referrals for qualifying members.	1. A new risk stratification has been proposed for the chronic condition programs pending approval from the leadership team. 2. Working toward expending the Diabetes Prevention Program services. Currently, working to identify vendors. 3. Plan to initiate Registered Dietitian Member Satisfaction Survey via text message. 4. Plan to create separate condition-specific assessment in Jiva to identify members enrolled by conditions.	

2024 QI Work Plan – Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: (1) Evaluation of current utilization of health education services (2) Maintain business for current programs and support for community. (3) Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health/Manager of Health Education	Manager of Equity and Community Health	Equity and Community Health	1) Evaluation of current utilization of health education services: -Most incoming referral are for weight control but hypertension continues to be one of the top health conditions. Exploring ways to target members who have high blood pressure, and to include efforts for making the blood pressure monitors more easily accessible as a covered benefit. 2) Maintain business for current programs and support for the community: -Expanded community classes and added ongoing Tuesdays and Thursdays virtual Zoom classes in English and Spanish. 3) Improve the process of handling member and provider requests: -Working on implementing a member self-referral form so that members can direly refer to health and wellness services.	1) Exploring available services, blood pressure cuff utilization among members, contracted pharmacy's locations and major gaps in services for members with hypertension. 2) Promoting community classes via a new standalone class flier, and exploring school interests for further collaboration with new community locations and potential new topics. 3) Seeking member feedback on the draft referral form.	
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	(1) SDOH Member assessment went live in the Member Portal and we continued to build out the assessment for integration into JIVA (2) Fully executed contract with FindHelp as the selected closed-loop referral vendor and working with JIVA for integration (3) HL4E certificate program continues through the end of the year to allow staff to complete their certifications. Currently, 73 out of 164 staff have completed their certification program. Four CalOptima Health staff participated in the Teach-back method Train the Trainer training.	(1) Update SDOH assessment in the Member portal to reflect updates done as part of the SDOH assessment integration into JIVA (2) Continue to work on integration of the closed-loop referral system into JIVA (3) Continue to encourage staff to complete their mini-credentials to earn their certification. Develop a Teach - Back method module to train new member facing staff as part of their onboarding process	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	Long-Term Support Services (LTSS)	95% compliance with TAT	CalAIM Turnaround Time (TAT): Determination completed within 5 business days CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days CBAS Turnaround Time (TAT): Determination completed within 5 business days LTC Turnaround Time (TAT): Determination completed within 5 business days	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of LTSS	Manager of LTSS	Long Term Care	CalAIM TAT: Met - 99.68% CBAS Inquiry to Determination TAT: Met - 100% CBAS TAT: Met 99.66% LTC TAT: Met 99.93%	Continue to monitor TAT.	
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Program Manger of Quality Improvement	Director of Quality Improvement	Quality Improvement	1) HP Accreditation: Successfully submitted all required documents by the submission deadline of 4/30/2024. Completed Virtual File Review with NCQA Surveyors on UM Appeals, UM Denials (BH, Pharmacy, Credentialing/Recred), and Complex Case Management (CCN and Delegates). We scored 100% on all File review elements. 2) HE Accreditation: initial GAP analysis report received on preliminary discovery meetings. Health Equity Workstreams Kick-Off meetings with project managers. Health Equity Guidelines and Elements Training. Currently building systems and processes (workstreams) in preparation for new GAP analysis meetings. 3) NCQA Consultants: Contracted with new NCQA Consultants Health Management Associates (HMA) to assist with the initial accreditation of 2025 Health Equity (HE) and 2027 Health Plan (HP) re-accreditation. Preliminary results indicate CalOptima Health met the required points to maintain NCQA HP Accreditation status.	1) HP Accreditation: Pending final report and decision letter from NCQA. Quality Improvement (QI) will develop a remediation plan for elements/factors missed. Share CalOptima Health's final HP accreditation results to the Oct QIHEC. 2) HE Accreditation: Schedule a meeting with PMs and new consultants for a new GAP Analysis. Submit Application for NCQA HE Survey by 9/2024. 3) NCQA Consultants: Kick-off meeting with new NCQA consultants scheduled July 24th.	

2024 QI Work Plan – Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 Q1: 01/14/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Improvement	Created monthly workgroups for Operations, Equity and Community Health, Case Management / Utilization Management / Behavioral Health, and Pharmacy. Created process metrics and deliverables for all workgroups. Created glidepaths for all measures with monthly targets to track performance to goal (4 or 5 Stars). Created call scripts and workflow for the Case Management team to begin member outreach for the OMW measure. Ongoing telephonic outreach to members across multiple measures via vendor Carenet. All measures are performing better in 2024 as compared to same time last year except for OMW.	Continue with plan as listed.	
Program Oversight	Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Manager of Quality Analytics	Manager Quality Analytics	Quality Analytics	There have been delays in sending monthly HN performance for P4V measures. Quality improvement grant process is on track.	Confer with the HEDIS team re: P4V reporting. Release the Medi-Cal NOFO as planned in Q3, and the OneCare NOFO as planned in Q4.	
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Director of Quality Analytics	Manager Quality Analytics	Quality Analytics	HEDIS MY2023 preliminary rates reported to May QIHEC.FUA and FUM measures are below the MPL.	Final rates will be presented to QIHEC in August.	

2024 QI Work Plan – Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Director of Behavioral Health Integration	Project Manager Behavioral Health Integration	Behavioral Health Integration	1) SBHIP Partners completed and sent their Q2 progress reports - first of 10 OCDE/CHOC WellSpaces installed; grand opening held on May 3rd at Marco Forster Middle School. 2) SBHIP Partners Meetings include Kaiser; SBHIP Collaboration Meeting with OCDE, and their mental health leaders have been scheduled for 2024-25. 3) Prepared 4 DHCS Biquarterly Reports for June submission. 4) June the 2nd SBHIP payment/check request was completed and issued to CHOC, HAZEL, OCDE, and WYS. 5) Reviewed and approved 14 OCDE school district budget plans. 6) Hazel Health began sending monthly dashboards showing the number of referrals and student visits	1) Individual meetings with CHOC, HAZEL, WYS, and OCDE to review their SBHIP-funded project level of implementation for the remainder of the program. 2) CalOptima Health will be represented at the OCDE Mental Health Summit on August 22. 3) Discuss and confirm the installment dates for the remaining WellSpaces with CHOC. 4) Review the school-based mental health training curriculum with WYS 5) Priority topics selected with OCDE for the SBHIP Collab Meeting (plan for end-of-year accomplishments	
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1) Reviewed, scored and selected 15 grant proposals for Board approval recommendation. Timeline for Board approval moved from June to August 2024. 2) Insight from the stakeholder sessions informed campaign strategy and approach, and staff is currently engaged with marketing firm in the development of creative concepts.	1) Subject to Board approval and contracting process, implementation of grant activities is expected to commence in September 2024. 2) Campaign soft launch is anticipated for Fall 2024.	
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	1. Member Health Reward:CCS:MC 290; BCS:MC 136; BCS:OC 20; COL: OC 7 2. CCS Mailing: 127,684 members; COL mailing 535 members; Text Campaign: CCS 85014 members; BCS MC 25538 members OC 1455; MC/OC live call campaign 3. Continuation of CCN OC COL GI outreach pilot program 4. Planning Phase for CCN Cologuard Project with Exact Sciences 5. May 2024 Prospective Rate Data: CCS: MC 38.27% BCS: MC 43.75%; BCS: OC 56%; COL: OC 52%	1. Continue to track CCS, BCS MC OC, COL OC member health reward 2. Continue member outreach campaigns: Mailing, IVR, text and MC/OC live call campaigns 3. Continue to monitor CCN OC COL GI outreach pilot program. 4. Kick off CCN Cologuard Project with Exact Sciences	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collaboratively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quatre. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	Behavioral Health Integration Program Specialist	Behavioral Health Integration	PR HEDIS RATES Q2 (May): Initiation Phase-46.50% Continuation and Maintenance Phase- 52.08% 1) Approved for printing vendor for printed flyers to send out for Member Health rewards. 2) Member Health reward approved by DHCS and added to CalOptima Health Website for members to access. 3) Text Messaging outreach to members sent May and June	1) Q3 data will be pulled to initiate fax blast for Non-Compliant Providers Provider best practices letter and tip-sheet to non-compliant providers. 2) Mail out Member Health Rewards flyer to eligible members. 3) Continue monthly data pull for text messaging campaign.	

2024 QI Work Plan – Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Health Equity/Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs for Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health	1) ACEs presentation to inform the group of our progress as a Health plan and educate on the importance of this screening given by BHI Executive Director at the BHQI Workgroup Meeting in April.	1) Continue collaborative meetings between teams to identify best practices to implement. 2) Continue Provider and member education. 3) Continue to participate in the ACEs stakeholder meetings.	

2024 QI Work Plan – Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	Behavioral Health Integration Program Specialist	Behavioral Health Integration	PR HEDIS RATES Q2 (May) : Blood Glucose all ages: 29.61%, Cholesterol all ages: 16.75%, Glucose & Cholesterol Combined all ages: 16.10% 1) Barriers included: Receiving timely data and accurate information. a)Sub measure names for this measure changed in 2024, causing delay in receiving data. 2) Identified members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report. 3) The following materials have been disseminated to Providers: a) Provider Best Practices Letter. b) APM Provider Tip Sheet. 4) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 6) Text Messaging Campaign	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue data pull for text messaging campaign. 3) Continue mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 4) Continue with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	Program Specialist Behavioral Health Integration	Behavioral Health Integration	PR HEDIS RATES Q2 (May): Effective acute Phase Treatment: 63.60%, Effective Continuation Phase Treatment: 39.66% 1) Worked with Quality Analytics/Financial Analysis team to develop a data report 2) Drafted following materials: a) Text Messaging script 1. Approved by DHCS b) Drafted AMM Provider Tip Sheet	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Send out Text Messaging campaign. 3) Submit Provider Best Practices Letter for internal review process.	
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	Program Specialist Behavioral Health Integration	Behavioral Health Integration	PR HEDIS Rates Q2 (May): M/C:45.33% OC: N/A 1) We are currently monitoring this measure. 2) Member Fall Newsletter for members.	1) Continue to monitor prospective rates on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	Behavioral Health Integration Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q2 (May): 30 day- 22.66%, 7 day- 12.72% 1) The main barrier has been not havng the bandwidth for outreach to members that we have been receiving on a daily basis. 2) Working with vendor to create a cohort report of FUM data only. 3) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis. 4) BI-weekly Member text messaging. 5) Artcle emphasizing importance of Follow up appointment after ED visit created and will be included in Spring Member Newsletter.	1) Pull data for Data Analyst to send out bi-weekly text messages based on real time ED data. 2) BHI is in the process of developing and implementig a Pilot project for CCN members identified who meet FUM criteria. BH Telehealth provider to conduct the outreach and assist with member linakge. 3) Collaborate with NAMI to share real-time ED data for member outreach. 4) Collaborate with Telemed2U vendor and internal ITS team to develop implementation plan for Member Outreach.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare-Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collabortively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	Behavioral Health Integration Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q2 (May): M/C:46.75% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report. 2) Conducted a text message campaign to reach out to members re: getting their glucose lab screening. 3) Barriers included: Receiving timely data, obtaining the correct contact information for members such as phone numbers. 4) Member Health reward approved by DHCS and added to CalOptima Health Website for members to access. 5) Mailed out Member Health reward flyer to eligible members. 6) Met with Quality Analytics Team to discuss data sourcing automation for Tableau on a monthly basis 7) Member Fall Newsletter for members.	1) Continue tracking members in need of glucose screening test. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue data pull for text messaging campaign 4) Mail out member health rewards flyer to eligible members. 5) Mail out to top 60 providers with the following: - Medical Director Letter - List of members/patients in need of screening - Provider Tool Tip Sheet	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Helath community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	B Behavioral Health Integration Program Specialist	Behavioral Health Integration/ Quality Analytics	Conduct quarterly/Annual oversight of MC Non Clinical PIPs (Jan 2023 - Dec 2025) Improve the percentage of members enrolled: Baseline Measurement Period: 01/01/23-12/31/23 Remeasurement 1 Period : 01/01/24 -12/31/24 Remeasurement 2 Period : 01/01/25-12/31/25	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis for CCN and COD members. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. Telehealth provider will conduct the outreach to members who meet FUM criteria and assist with linkage. Internal BHI PCC's to conduct outreach to members meeting FUA criteria and assist with linkage. Vendor and PCC's will also provide information about case managment including ECM and referrals. 3) Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CCN members identified who meet FUM/FUA criteria for the duration of each measuremnt period. 4) Work in collabration with internal Privacy dept to ensure compliance of data sharing with vendor.	
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	Behavioral Health Integration Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q2 (May): 30-Day- 19.29%, 7-Day-9.94% 1) Sharing real-time ED data with our Health Networks on a sFTP Site. 2) Bi-weekly member text messaging 3) Member Newsletter Spring edition	1) Data anaylst scrub data for bi-weekly text messaging. 2) BHI is in the process of developing and implementig a Pilot project for CCN members identified who meet FUA criteria.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: EED:MC 73; EED:OC 13 2. Text Message Campaign: MC 22254; OC 1190 3. EED VPS mailing for Jan to Jun: MC 3013; OC 988 4. VSP data sharing with HN kickoff 5. February 2024 Prospective Rate Data: EED: MC 35.36%; EED: OC 51%	1. Continue to track EED MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3. 2 way text message campaigns for diabetes by line of business 4. Finalize VSP data sharing with HN for production	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: HBD:MC 90; HBD:OC 25 2. Text Message Campaign: MC 22254; OC 1190 3. February 2024 Prospective Rate Data: HBD PC: MC 77.34%; HBD PC:76% OC	1. Continue to track HBD MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3. 2 way text message campaigns for diabetes by line of business	

Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Equity and Community Health/ Quality Analytics	Member Initiatives: - Bright Steps Program - Member Health Reward for postpartum care Community Initiatives - Prenatal social media ads May 2024 Prospective Rate: Timeliness of Prenatal Care: 67.74%, performing slightly lower than this same time last year. Postpartum Care: 63.19% performing slightly higher than this same time last year.	Planned: Maternal health workgroup meeting in Q3. Continue with public awareness and educaiton campaigns (e.g., radio digital, social media).	
Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS: DSF-E Depression	1) Identification and distribution of best practices to health network and provider partners.	Report progress to QIHEC quarterly: Q2 2024	Director of Operations Management / Director of Behavioral	Manager of Quality Analytics / Manager of Behavioral	Operations Management / Behavioral Health Integration	**Maternal** Timely identification: QA has a maternal health workgroup planned for Q3 to discuss member journey and data management which is inclusive of early identification of members for postpartum visit.	Planned: Maternal health workgroup meeting in Q3. Fall 2024 Medi-Cal member newsletter article "Let's Talk About Mental Health and Pregnancy"	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
		Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% PDS-E Postpartum Depression Screening and Follow-up: 27.77%	2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Health Integration	Health Integration		Prenatal Depression Screening and Follow Up and Postpartum Depression Screening and Follow Up are new measure that will be held to the MPL beginning MY2025. Prenatal Depression Screening: 6.74% Prenatal Screening Follow Up: 90% Postpartum Depression Screening: 10.35% Postpartum Screening Follow Up: 66%		

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	**Member Facing Initiatives:** - May: Launched an SMS text campaign via mPulse to encourage lead testing. - June: Launched telephonic outreach via CareNet vendor for members that are due for lead testing based on HEDIS and state testing requirements. - June: Launched 2-way SMS via Ushur for multiple pediatric age groups as part of pediatric wellness campaign. - Member health reward for members that test for lead at 12 months and 24 months of age. **Widespread Education Efforts:** May: PBS TV ad and radio ad for blood lead screening **Provider Facing Initiatives:** May: Presented at community health clinic forum on optimizing EMR processes to support state lead requirements. June: Developed provider facing education "Stay Compliant with State-Issued Lead Requirements." June: Email blast to providers who provide care to members ages 0-6. Email blast contained *Stay Compliant with State-Issued Lead Requirements* guide, informed providers of available health rewards including sample form, and attached OC HCA form to order free lead based educational materials for members. HEDIS measure is performing slightly higher than this same time around last year. March 2024 rate: 60.54%, MPL is 62.79%. Measure has not met MPL, therefore highlighted in yellow.	Continue with plan as listed. Planned: - Fax blast to providers to share lead based education - Continue with CareNet member outreach - CE/CME for in support of lead testing	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Launched 2-way SMS via Ushur for multiple pediatric age groups (launched on 6/20/24 and outreached to 4,292 members). Presented well-child visit best practices during the June monthly Community Clinic forum. Launched telephonic outreach via vendor Carenet. CIS performance is behind as compared to same time last year; as such, metric listed as yellow - concern. W30 performance is ahead of same time last year.	Continue with plan as listed and explore provider-facing education around parent declination for vaccines and parent-facing education around the importance of preventive care / well-child visits.	
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Launched 2-way SMS via Ushur for multiple pediatric age groups (launched on 6/20/24 and outreached to 4,292 members). Presented well-child visit best practices during the June monthly Community Clinic forum. Launched telephonic outreach via vendor Carenet.	Continue with plan as listed and explore parent-facing education around the importance of preventive care / well-child visits.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submitted by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024	Director of Finance	Manager of Finance	Finance	No activities in April-June	N/A	
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025 Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	FSR/MRR/PARS, NF and CBAS Oversight A. FSR: Initial FSRs=18; Initial MRRs=13; Periodic FSRs=61; Periodic MRRs=66; On-Site Interims=19; Failed FSRs=3; Failed MRRs=13 CAPs: CE=39; FSR=54; MRR=64; 60 Periodic FSRs completed before 36 month due date. B. PARS: Competed PARS=114 (Basic Access=49/43% Limited Access=65/57%) C. CBAS: Critical Incidents=23; 22 Critical Incidents reported were COVID cases. Non-Critical Incidents=14; Falls=3; Completed Audits=10: CAPs=; Unannounced Visits=0 D. NF: Critical Incidents=1; On-Site Visits=8; Unannounced Visits=2	Continue with plan as listed.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	There remain five physicians undergoing the Fair Hearing process. Six PQI cases leveled 1, 2 or 3 were presented to CPRC. Two PQIs were brought back to CPRC and the physicians were recommended for an administrative termination. In Q2, 2024, PQI launched a new system to track PQI cases called Jiva. PQI reporting is still being developed, so trends will be reported when the reports are available. We can report that we have 629 open PQI cases.	Two of the Fair Hearings are scheduled to commence in Q3, 2024. In Q3, 2024, we hope to have reporting available for PQI developed and be able to report trends for Q1 and Q2. An open position for a RN for PQI has been recruited and the individual is expected to begin in early Q3.	
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	Initial BH Credentialing Q2 = 71; Initial CCN Credentialing Q2 = 59. For Q2 we did not have any initial credentialing files out of compliance.	Initial credentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialling.	
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Quality Improvement	Manager Quality Improvement	Quality Improvement	BH Recredentialing - Q2 =23; CCN Recredentialing Q2 =99. For Q2 we did not have any recredentialing files out of compliance.	Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the recredentialing of providers. This will ensure that we continue with compliance and timeliness of the recredentialling files.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Health Coaches began calls from emerging risk call list.	1. Continue calls and refresh data. 2. Review completed assessment.	

2024 QI Work Plan – Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director Medical Management /Case Management	Quality Improvement Nurse Specialist	Case Management	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) Core Report CC0258 continues in phase II Jiva Remediation for ICT/ICP/HRA data. b) Q1 DHCS reporting for HRA1 and ICP1 submitted to DHCS reflecting for HRA1 members who were reached and willing to complete HRA at 100%; for ICP1 members who were reached and willing to complete ICP at 64%. c) as 6/30/2024 41% of HRAs completed to date achieving two star rating d) ICT rates pending Jiva Phase II remediation 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Communications to CCN and Health Networks in April and May on ICP development status for newly effective members Q1 and Q2. b) Addition of annual ICP development status on April and May file. c) Communication of ECM-Like eligibility and members missing face-to-face interaction 3) Creation and implementation of the Oversight audit tool. a) Ongoing quarterly audits of delegated health networks.	Assess and report the following activities: 1) Continue to use monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) Core Report CC0258 remediation should be completed by 8/30/2024 b) Q2 DHCS reporting for HRA1 and ICP1 will be submitted by 8/30/2024. CM will share adjusted score for both HRA1 and HRA2 of members who were reached and willing to complete HRA and ICP. c) Share % of HRAs completed to date per HRA Star Dashboard. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Continue communications to CCN and Health Networks for ICP1 development status for newly effective members Q2 and Q3. b) Continue to provide feedback on annual ICP development and missing face-to-face interactions. 3) Creation and implementation of the Oversight audit tool. a) Ongoing quarterly audits of delegated health networks.	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHECQ2: 06/11/2024Q3: 09/10/2024Q4: 12/10/2024Q1 03/11/2025	1) Director of Provider Network2) Director of Contracting	Analyst of Quality Analytics	Contracting	1. Hired PM 2. Established process for gap closure with Health Networks not meeting time and distance requirements 3. Closed CAPS for 2 health networks with Time and Distance gaps Transition - QI finalizizing transition plan	>Finalize transition plan, develop priorities of transition> Implement processes for network adequacy programs> Set up network adequacy workgroups to review gaps and trends	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely acces. 3) Continue to educate providers on timely acces standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	2023 CAP Responses: •In Q2, Timely Access workgroup/subgroup reviewed 8 (out of 11) HN CAP responses received. •Of the 117 Timely Access CAPs issued to individual providers, a total of 71 responses received by Q2, two termed and one provider passed away. June 2024, mailed approx 1400 non-compliance letters to individual providers based on the 2023 Access Survey (9/26-12/1/2023). •Education letters: 1034 •Warning letters: 281 **•Escalation/CAP letters: 110** RFP in the works for potential new vendor in 2025 and process will include additional surveying of those initially found non-compliant with annual survey. In June 2024, CareNet conducted an interim audit on providers who were identified as non-compliant with the 2022 survey results for telephone measure "instruct caller to dial 911 or go to nearest ER" to identify current status. Directors and Timely Access workgroup in the process of developing workflows and additional tools to facilitate standardization and better monitoring of the non-compliance and corrective action process.	For the three HN CAP responses not received, in the process of scheduling a meeting in July to discuss further with Optum. Issue HN Level CAPs in Q3 or Q4. Prep for fielding 2024 Timely Access Survey with a September target date Prep for fielding an In-Office wait Time Survey	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst	Network Operations/Quality Analytics	SNC Report Q2 2024: May 274 File. Submitted quarterly CAP status and reviewed 7 of 7 updates from HNs. Optum integration decreased HN updates requested by 2. One HN closed their CAP (Regal). Six remain with open CAPS. 1.Time/Distance: In compliance with the regulatory guidelines specified in APL 23-006, Assigned membership methodology to pull the report form May 274 file. For plan level 2 zip codes did not meet for PCP Adult and Pediatric Core Specialty, and for Specialists Gastroenterology and Orthopedic surgery. Meetings with HNs to review gaps and discuss options for gap closures. For HN level: PCP (Internal Meds) è AltaMed and CHOC_OB/Gyn: AltaMed_Ophthalmology: AltaMed and Optum_Hematology & Oncology: AMVI, Noble, Optum_Neurology: AMVI_Pulmonology: AMVI, UCMG_Gastro: Optum_Orthopedic Surgery: Regal & Optum AMVI then Noble have the greatest number of non-compliance zip codes. The specialties with the most non-compliance zip codes are: Physical Med and Rehab then Endocrinology 2.Out-of-Network (OON): using MCPD - OON Data Q1 2024 submissions to DHCS. 99 total requested for OON referral requests, 3.Network Capacity and Ratios were met. 4. PCP Overcapacity: For Q2 2024, we reopened the panel for 7 provider and closed one panel for Dr. Mobarak and send a notification letter as certified mail. 5.Timely Access: The 2023 Timely Access Survey was fielded September 26 through December 1, 2023, and letters of non-compliance and Corrective Action Plans will be mailed to individual providers in late June or early July 2024. 6.California Children's Services (CCS) Program/Whole Child Model (WCM: 0 deficiencies. Plan Statewide Level - all specialties met. All networks confirmed as met, with exception of UCMG, although AMVI showed non-compliant for 6 specialties, CalOptima H ealth is in receipt of a HN Agreement between AMVI and CHOC.		

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1) Increase health network and provider communications, trainings, and resources Goal being met, see below. a. HN and Provider Communications/Presentations: -Provider Monthly Newsletter: Send messaging out at least once per quarter; messaging sent in April and June. -Health Network Communication/ Presentations: Began meeting with each HN via Health Network Quality Update Meetings starting in May; Further follow-up Meetings began with HNs individually to discuss CAP process which includes the Delegation Oversight Dashboard Response Form; Meeting Presentations and individual follow up meetings replaced email communication in HN Weekly Update. b. Training/Presentations with IHA Updates: -Planning for a provider CME in August 2024. -Provider toolkit that includes the IHA is in progress. 2). Expand oversight of provider IHA completion: Goal being met, see below. a. Continue to audit CHCN clinics. b. Continuing to inform all HNs of the expectation to meet the minimum IHA completion rate of 50%; Still in discussion with management regarding the approach for establishing Corrective Action Plan. c. Provider office visits (CHCN): Established and implemented a process to visit providers and bring IHA data (or give staff presentations) and related resources. 3) Increase member outreach efforts: Goal being met, see below. a. Developing text campaign for new members +IHA: Message currently in review with internal team and vendor for DHCS submission preparation. b. Continuing IVR campaign twice monthly to new members. c. Message to new members on the IHA continues to be sent out in the new member handbook and in the Medi-Cal newsletter.	1) Continue collaboration with HNs and providers via Presentations and Newsletter updates. 2) Continue chart review efforts and provider office visits. 3) Continue identifying new members monthly and sending targeted messages via text, IVR and mailings.	
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst for Quality Analytics/ Manager of Provider Data Management Services	Provider Data Management Services	All ANC Phase 2 Time and Distance submissions were completed in March 2024, including Mandatory Provider Types Roster, P&Ps, MPT and Facility Validation supporting documentation, , Alternative Access Standard Analysis,	Ongoing monitoring in transition to PDMS.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Quality Analytics Project Manager	Quality Analytics	1. 217,988 members were outreached to through live calls, text messaging and mailings for both lines of business. 2. CalOptima's Just In Time campaign used live calls and text messaging to reach members that were likely to respond negatively. 13,239 live calls and 57,169 text messages were sent to members in both lines of business. 3. CAHPS continues to be part of the P4V for the HN. Final CAHPS reports have not been received. Distribution to health networks is pending final reports due in July.	1. Closed 2. Closed 3. Share HNQR with the HN when available	
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Grievance and Appeals Resolution Services	Manager of Grievance and Appeals Resolution Services	Grievance and Appeals Resolution Services	GARS identified and reported a non-compliance issue to the Committee regarding untimely Discrimination cases submitted to DHCS. Regulation APL21-004 requires that the named discrimination grievance coordinator properly investigates and responds to all complaints within 30 days of receipt. Additionally, within ***10 calendar days*** of mailing the discrimination grievance resoluion letter to a member, CalOptima Health must submit a copy to DHCS. CalOptima Health did not consistently submit within 10 days. Root cause: lack of reporting. Remediation: documented a process to be followed in Jiva that provides the ability to track not only the date of closure but also the date of submission to DHCS.	GARS will continue to identify and report any Compliance Issues to QIHEC related to either the GARS process, internal departments, providers and/or Health Networks at least quarterly. This report will include any remdiation activities if applicable.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Service	Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Associate Director of Customer Services	Manager of Customer Service	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (2 min and 1 sec). Internal business goal of abandonment rate not exceeding 5% met (exactly 5% for Q2). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Continue working with HR to onboard additional staff (permanent vacant positions or temporary staff), maintain the telephonic call back offering, and partner with other departments (QA, Equity and Community Health, etc.) to stagger their member engagement campaigns (i.e., text messaging).	
Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS' 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls. 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: ~~Q2 2024 Update (08/13/2024)~~ ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (07/09/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Associate Director of Customer Services	Manager of Customer Service	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (2 min and 1 sec). Internal business goal of abandonment rate not exceeding 5% met (exactly 5% for Q2). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Continue working with HR to onboard additional staff (permanent vacant positions or temporary staff), maintain the telephonic call back offering, and partner with other departments (QA, Equity and Community Health, etc.) to stagger their member engagement campaigns (i.e., text messaging).	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Safety of Clinical Care	Coordination of Care: Member movement across practitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Case Management	TBD	Medical Management	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement a) Work-Plan goal revised on May 9 for multi-department approach between CM, PHM, QA, and other departments as indicated. b) Inter-department training not previously reported by PHM for CM department on 3/27/2024: Health Education Materials and Chronic Conditions Coaching TipsElisa Mora, MPH, RD, Manager, Chronic Conditions, PHM Noushin Dehbozorgi, MSN, PHN,RN,CCM, Health Coach, PHMPHM 2) Provider and member education a) existing information on CalOptima Website for both Provider and Member under Health and Wellness with links to Diabetes Management resources in video, download, or print format with language preference b) existing Health Education materials for members on Sharepoint that Case Managers can print and mail.	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement a. Meeting on 7/8 between Claims, UM, and QA to discuss authorization requirement for diabetic eye exam and feasibility for this potential barrier to be eliminated. 2) Provider and member education a. Continue with existing Health Educational resources on Sharepoint and CalOptima Website. b. Member and Provider education in the event changes to authorization process are implemented.	
Safety of Clinical Care	Emergency Department Member Support	Emergency Department Diversion Pilot has been implemented. In 2024 plan to expand a virtual program to additional hospital partners starting with UCI.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of LTSS	Manager of LTSS	LTSS	Establishing the virtual program has not been accomplished due to the inability to execute a data usage agreement.	Two staff members (MSW & RN) were approved in the 2024/2025 budget to be embedded in the UCI emergency department. Currently in the process of developing job descriptions to begin recruitment. The plan is to have UCI ED embedded staff in place by the end of September 2024.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Safety of Clinical Care	Coordination of Care: Member movement across settings - Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% from Q4 2023 by end of December 31,2024.	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of UM, CM and LTSS	Manager of Medical Management	Utilization Management Case Management Long Term Care	•IPP 4.3 report (percentage of members who had ambulatory visits within 7 days post hospital discharge) – Enterprise Analytics updated report with the correct technical specifications. It helps monitor the effectiveness of TCS (mirror the state's monitoring approach). •CalAIM ECM provider report documenting Lead Care Managers in CalOptima Connect showed an improvement from 3% to 44%. This ensures the Lead Care Manager is notified of any admissions. Expectation moving forward is to have ECM Providers continue to document accurately.	•Develop a texting campaign leveraging the Usher platform •Develop report for FFS Medicare members •Develop process and desktop procedure outreaching to pregnant members (TCS high-risk) not enrolled in the Bright Steps program. •Continue motivational interviewing trainings (started in June).	
Cultural and Linguistic Appropriate Services	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from 41.90% to 55.78% by 12/31/2024.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	1. 85 African American members were identified for outreach. 34 parents/guardians were successfully outreached to. Members that were unsuccessfully reached via telephone were sent an unable to contact letter advising of attempt to reach and encouraged a call back to CalOptima Health. 2. Out of the 51 unsuccessful members, 10 were identified as having a email and CalOptima Health provided outreach to encourage reaching out to provider to make well-child visit. Out of the 10 emails, we encountered an error with one email and did not receive a response from the 9 other members outreached to. **Barriers:** Within the organization there was a data transition that contributed to delays in the identification of members in the population of focus. Data for member outreach was not available until April 2024 which resulted in delayed outreach. Barriers to member outreach: Various members has incorrect contact information. **Findings:** Final summary pending. Findings suggest that in scenarios where members were successfully outreached, many children had a well-child visit scheduled or one that was recently completed. When offered assistance to schedule future well-child visits, parents declined. Data suggests that parents are unaware of how often well-child visits should take place during the first few years of life.	Submission of results in September 2024. Quality Analytics team will utilize survey findings to inform interventions for 2025.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Enhance interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Intitiate Request for Proposal (RFP) to add and/or replace the translation and interpreter services vendors to improve the member experience.	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	The Request for Proposal (RFP) Scope of Work draft has been completed and currently under review by Vendor Management.	>Finalize Scope of Work and submit RFP bid. *The RFP's Scope of Work (SOW) is currently being reviewed by Vendor Management.*	

Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24. 2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.	Assess and report the following activities: 1) Determine the primary drivers to noncompliance via member outreach and literature review 2) Targeted member engagement and outreach campaigns in coordination with health network partners 3) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 6) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Manager Equity and Community Health/ Director of Operations Management	Program Manager of Quality Analytics/ Manager of Quality Analytics	Equity and Community Health	Data as of May 2024: PPC - Postparum Care: - 63.19% compliance rate for the entire population - 46.27% compliance rate for the Black population - 45.45% compliance rate for the Native American population PPC - Timeliness of Prenatal Care: - 67.74% compliance rate for the entire population - 55.22% compliance rate for the Black population - 63.64% compliance rate for the Native American population	Planned: Continue with public awareness and educaiton campaigns (e.g., radio digital, social media). Contiue to develop identification of eligible members to enroll with CalAIM providers. Continue to build doula provider network to ensure person-centered, culturally competent care that supports the racial, ethnic, linguistic and cultural diversity of members	
Cultural and Linguistic	Data Collection on Member	Implement a process to collect member SOGI data	1) Develop and implement a survey to collect the	Report progress to QIHEC	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	• The SOGI survey was submitted to Compliance and to The Department of Managed Health Services (DHCS) for review. • The survey has been approved by DHCS and translated in CalOptima	• ITS to complete upload survey to the Member Portal. • Work with Communications to create a new member mailing packet for mailing to new CalOptima members	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Appropriate Services	Demographic Information	by December 1st, 2024.	Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 4) Develop and implement a survey via the Member Portal, mail to new members adn other methods. 5) Share member demographic information with practitioners.	quarterly: ~~Q2 2024 Update (08/13/2024)~~ Q2 2024 Update (07/09/2024) ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (10/08/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update 01/14/2025)				Health's threshold languages. • The survey has been submitted to ITS to start the process of implementing into the Member Portal. • Facets Core system where data will be stored has been updated with the capabilities to store SOGI data that is collected from members.	(over the age of 18 years of age) • ITS to upgrade XXI in Facets for the survey to upload properly to prepare for the integration of the survey.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Provider Data Management Services	Manger Provider Data Management System	Provider Data Management Services	1. Meetings scheduled to plan 2. Develop plan for key activities 3. Identified stakeholders 4. Completed analysis of requirements	1. Set up indicators in Facets 2. Identify methods for collecting data 3. Survey and collect data 4. Enter data in FACETS 5. Set up on going process for collecting information	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC quarterly: ~~Q2 2024 Update (08/13/2024)~~ Q2 2024 Update (07/09/2024) ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (10/08/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update 01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	• Draft language experience Surveys for both members and staff has been completed and has been distributed to Health Equity workgroup for review and feedback. • C&L met with contracted vendors and internal workgroups on best approach to implement the member and staff survey • C&L met with contracted vendors and confirmed vendors, currently, cannot support CalOptima with conducting a member survey.	• Complete the review of draft surveys with internal workgroups. • Send draft surveys to consultants for review and feedback • Explore other options for conducting the survey including texting campaigns and live outreach.	

Board of Directors'
Quality Assurance Committee Meeting
October 9, 2024

Program of All-Inclusive Care for the Elderly
Quality Improvement Committee
Second Quarter 2024 Meeting Summaries

May 7, 2024: Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Committee (PQIC) and PACE Infection Control Subcommittee Summary of the Health Plan Monitoring Data and PACE Quality Initiatives

- Infection Control Subcommittee: PACE's Response to COVID-19:
  - PACE will continue to report on any updates in recommendations regarding COVID and any outbreaks or reporting trends for quality purposes.
  - There were 12 reported participant cases of COVID-19 in Q1 2024.
  - PACE Staff have been reminded to report exposure/illness to their supervisor and HR, and not to come in if feeling sick.
  - COVID-19 vaccination is being monitored as part of Quality Assurance Performance Improvement (QAPI) measures.
- Presentation of the Q1 2024 Health Plan Management System (HPMS) Elements:
  - Membership data figures presented. In terms of total membership, Q1 ended with 471 total enrolled. The goal of 490 was not met.
  - Immunizations
    - Pneumococcal Immunization rate in Q1 2024 was 82% (no exclusions) 395 received, 60 had prior immunization, 25 refused and 2 missed opportunities.
    - The influenza Immunization rate in Q1 2024 was 80% (no exclusions). 370 received, 25 had prior immunization, 29 refused and 32 missed opportunities.
  - Falls without Injury. Q1 ended with 78 falls without injury. Most happened in the bedroom and bathroom, from not using Durable Medical Equipment (DME). Loss of balance and Dizziness are the main contributing factors.
  - Grievances. 5 grievances received in Q1 2024. 2 were invalid transportation grievances. 3 were communication related grievances. All resolved.
  - Emergency Room (ER) Visits. 91 ER visits, an increase of 16 from Q4 2023. 44 were sent home without hospital admission. 47 were admitted from ER to hospital. Trends in admission diagnoses: Kidney/Urinary Issues, chest pain, physical injuries (Fracture, Contusion, Laceration) and Infections (Pneumonia, Viral Infections, Sepsis).
  - Medication Errors Without Injury. No medication errors reported in Q1 2024.

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  - Quality Incidents with Root Cause Analysis Reported in HPMS. 6 Falls with Injury, 6 Burn Injuries (Being addressed through participant kitchen safety training) and 1 Pressure Ulcer case.
- Presentation of the 2024 PACE Quality Initiative Data
  - Advanced Health Care Directive (AHCD)
    - Goal: ≥ 70% of participants will have completed AHCD in 2024. Q1 ended at 36%. Goal not met yet.
  - Dental Satisfaction Quality Initiative.
    - Goal: ≤ 1 dental related grievance per quarter in 2024.
    - 0 dental grievance reported in Q1 2024. Goal was met for the quarter.
  - Transportation Satisfaction Quality Initiative
    - Goal is ≤ 3 **valid** transportation related grievances per quarter in 2024
    - QI received 2 invalid grievances and 1 valid communication/transportation grievance. Goal was met for the quarter.

May 7, 2024: PACE Quality Improvement Committee (PQIC) Summary Quality Assurance and Performance Improvement Work Plan

- Presentation of the 2024 Quality Work Plan Elements
  - *Elements 3 – 5: Immunizations*
    - Pneumococcal Immunization rate in Q1 2024 was 91%. Goal of 94% was not met. Clinic team will work on discussion with participants who previously refused to be vaccinated.
    - Influenza Immunization rate in Q1 2024 was 93%. Goal of 94% was not met.
    - Covid-19. Goal for 2024 is >50% will receive the latest Centers for Disease Control (CDC) recommended COVID vaccine. Rate for Q1 2024 was 54%, goal met for the year. In 2024, Participants will receive the 2023-2024 Updated COVID booster and PACE will continue to follow update vaccine recommendations and changes as we are notified.
  - *Element 6: Colorectal Cancer Screening.* Goal > 65% will have colorectal cancer screening as defined in quality workplan. Q1 ended with 54% completed and 46% missing.
  - *Elements 7: Breast Cancer Screening.* Goal is >82.56% will have breast cancer screening as defined in quality workplan. Q1 ended with 78% completed and 22% missing.
  - *Element 8: Physicians Orders for Life Sustaining Treatment (POLST)* Goal is ≥95% %. In Q1, 98% of participants had a POLST in their chart. Goal was met.
  - *Elements 9: Blood Pressure Control.* Goal is >82.98% of qualifying participant will have a blood pressure reading <140/90mm. Q1 2024 rate is 88%. Goal not met.

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- *Elements 10: Diabetic Eye Exams.* The goal is that 87.29% of qualifying diabetic enrollees will receive annual eyes exams. Q1 2024 rate is 87.57%. Goal was met.
- *Elements 11: Diabetic Care – Blood Sugar Control.* Goal is <11.78% of qualifying diabetics will have blood sugar levels control. Q1 ended at 17% Goal not met.
- *Element 12: Osteoporosis Treatment.* Goal of 75% of qualifying participants receiving osteoporosis monitoring. The current rate is 79%, goal is met.
- *Element 13: Reduce Percentage of Falls reported by PACE Enrollees.* Q1 2024 ended with 85 falls, higher than the Goal of <72 falls per quarter in 2024. Goal not met. Excluded were falls in a hospital or SNF (1).
- *Elements 14: Potentially Harmful Drug/Disease Interactions in the Elderly*
  - Dementia and Drug Interactions- Goal is that <25% of qualifying enrollees will be prescribed potentially harmful medications. Q1 2024 rate is 15%. Goal met. Excluded are participants with Palliative Care Approach diagnosis and those with schizophrenia or bipolar disorder.
- *Element 15: Decrease the Use of Opioids at High Dosage.* Goal: 100% of members receiving opioids for 15 or more days at an average milligram morphine dose of (MME) 90mg will be reevaluated monthly by their treating provider.
- *Element 16: Medication Reconciliation Post Discharge (MRP)*. Goal is ≥93% of participants will have meds reconciled within 7 calendar days 15 days. Q1 2024 rate is 100%, goal met.
- *Element 17: Access to Specialty Care.* Goal is >90% of appointments to be scheduled within 14 calendar days. 91% in Q1 2024. Goal met.
- *Element 18: Alternative Care Sites (ACS) Utilization.* At the end of Q1 2024, the rate is 2%. Goal is ≥15% of all eligible PACE Enrollees will utilize day center services at one of the PACE ACS by end of 2024.
- *Element 19: Acute Hospital Days.* Goal of <3,300 was met with the current number of 2,358 hospital days for Q1 2024.
- *Element 20: ER Visits.* In 2024, the goal changed to 825 ER visits per 1000 per year. Q1 2024 rate is 806, goal is met.
- *Element 21: All Cause Readmissions.* Goal is <14% of hospital stays will be recent readmissions. The rate significantly went up from 7% to 16%. Goal not met. Participants who are readmitted for scheduled treatment, such as cancer treatment, will now be excluded in 2024.
- *Element 22*: *Long Term Care (LTC) Placement.* Goal is <4%. The rate is 0% in Q4. Goal met. There were no participants in LTC in Q1.
- *Element 23: Enrollment Conversion.* In 2024, the goal is 70% conversion from inquiries to active enrolled participants. Rate is 84%. Goal met.

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- *Element 24: 90-Day Disenrollment.* The goal is <6% of disenrollments are from new enrollees in 2024. Rate in Q1 2024 was 5.56%. Goal was met. There was 1 controllable disenrollment in Q1. Due to participant did not like how the plan worked.
- *Element 25: Total Attrition Rate.* The goal is a <8% overall attrition rate in 2024. Q1 2024 rate is 3.88%. Goal met.
- *Element 26: Transportation <60 minutes.* There was a total of 126 in January, 151 in February and 158 in March one-hour violations. A Corrective Action Plan (CAP) was issued to Secure Transportation in Q1 2024.
  * Per Secure- Time stamps are recorded on Quality Improvement (QI) platform. Drivers are to inform dispatch if they are going to pass the 60-minute time frame.
- *Element 27: Transportation on Time Performance.* On time performance data gathered directly from Secure transportation report to reflect on time trips with a +/- 15-minute window. The goal is ≥92% of all transportation rides will be on-time. Q1 2024 rate is 80%. Goal not met.

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Grievance and Appeals Resolution Services (GARS) Member Trend Report Second Quarter 2024

Quality Assurance Committee Meeting

October 9, 2024

Tyronda Moses, Director, Grievances, Appeals and Resolutions

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Agenda

- Definitions
- Executive Summary
- Grievance Volume and Trends
- Grievance Actions Taken
- Appeals Volume and Trends
- Appeals Actions Taken

Definitions

- Grievance: An expression of dissatisfaction with any aspect of a CalOptima Health program, provider or representative.

- Appeal: A request by the member or on the member's behalf for the review of any decision to deny, modify or discontinue a covered service.

Executive Summary

- CalOptima Health received a total of 4,593 grievances and 423 appeals for the Medi-Cal and OneCare lines of business. The turnaround times for both grievances and appeals are compliant with regulatory standards, averaging a closure rate of 25 days (regulatory requirement is 30 days).
- Grievances
  - Medi-Cal experienced an increase in grievances from 3,127 in first quarter to 4,170 in second quarter (33% increase). A portion of the increase was related to the transition of transportation service vendors. Other increases were related to delays in referrals and authorizations and the dissatisfaction with plan staff or providers.
  - OneCare experienced a decrease in grievances from 469 in first quarter to 423 in second quarter (11% decrease), with the decrease related to access to care and billing services.

Executive Summary (Continued)

- Appeals

  - Medi-Cal received an increase in appeals from 320 in first quarter to 356 in second quarter (11% increase), with an overturn rate increase (30% to 35%). The higher overturn rate is related to Applied Behavior Analysis (ABA) appeals (41% increase), tertiary level specialty care appeals and appeals for services related to continuity of care.

  - OneCare experienced a slight decrease from 71 in first quarter to 67 in second quarter (6% decrease), with an overturn rate decrease (48% to 40%).

  - The contributing factors for the overturn rate for both Medi-Cal and OneCare were continuity of care and tertiary level specialty care services.

CalOptima Health

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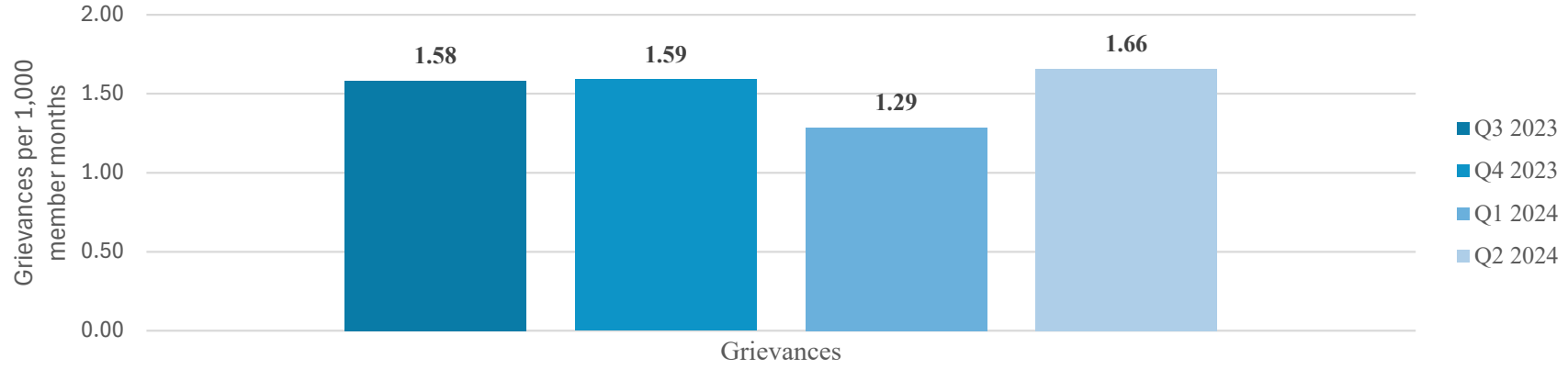
Grievances

Grievance Volume and Compliance

Timeframe	Total Grievances
Q3 2023	4,671
Q4 2023	4,585
Q1 2024	3,596
Q2 2024	4,593

Grievance: Any expression indicating dissatisfaction with any aspect of a CalOptima Health program, provider or representative.



Note: Turnaround Time (TAT) Remains Compliant

Complaint Type	Required TAT	CalOptima Average TAT	Compliance Percentage
Grievances	30 Days	25 Days	99%

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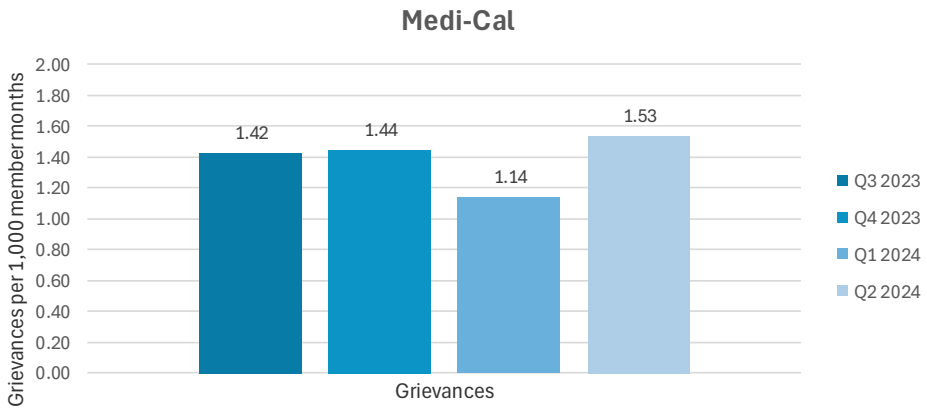
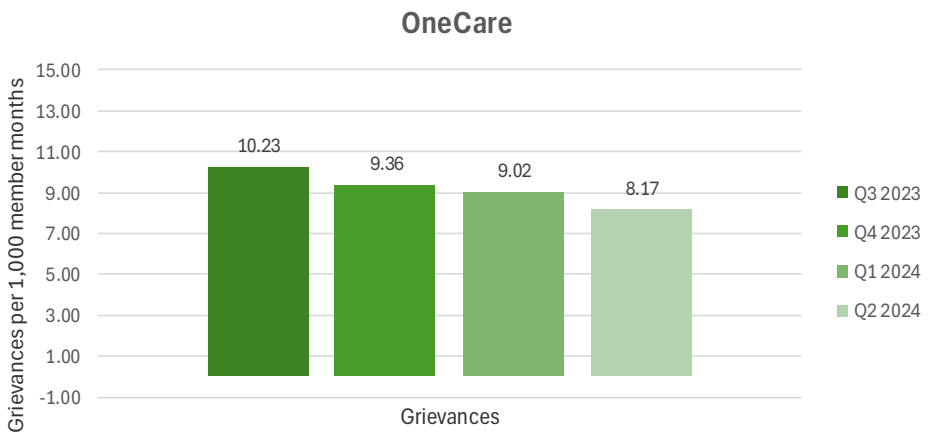
Grievance Volume by Line of Business





Q2 2024	4,170
Q1 2024	3,127
Q4 2023	4,090
Q3 2023	4,126

Q2 2024	423
Q1 2024	469
Q4 2023	495
Q3 2023	545

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CalOptima Health

CalOptima Health Comparison

- National Committee for Quality Assurance (NCQA) benchmark is 5, meaning we should receive less than 5 grievances per 1,000 member months

- DHCS rolling average across all similar plans is 3.1 grievances per 1,000 member months. Please note that DHCS delays publication by two quarters

- CalOptima Health remains below both the industry average and the NCQA benchmark at 1.97 grievances per 1,000 member months

CalOptima Health

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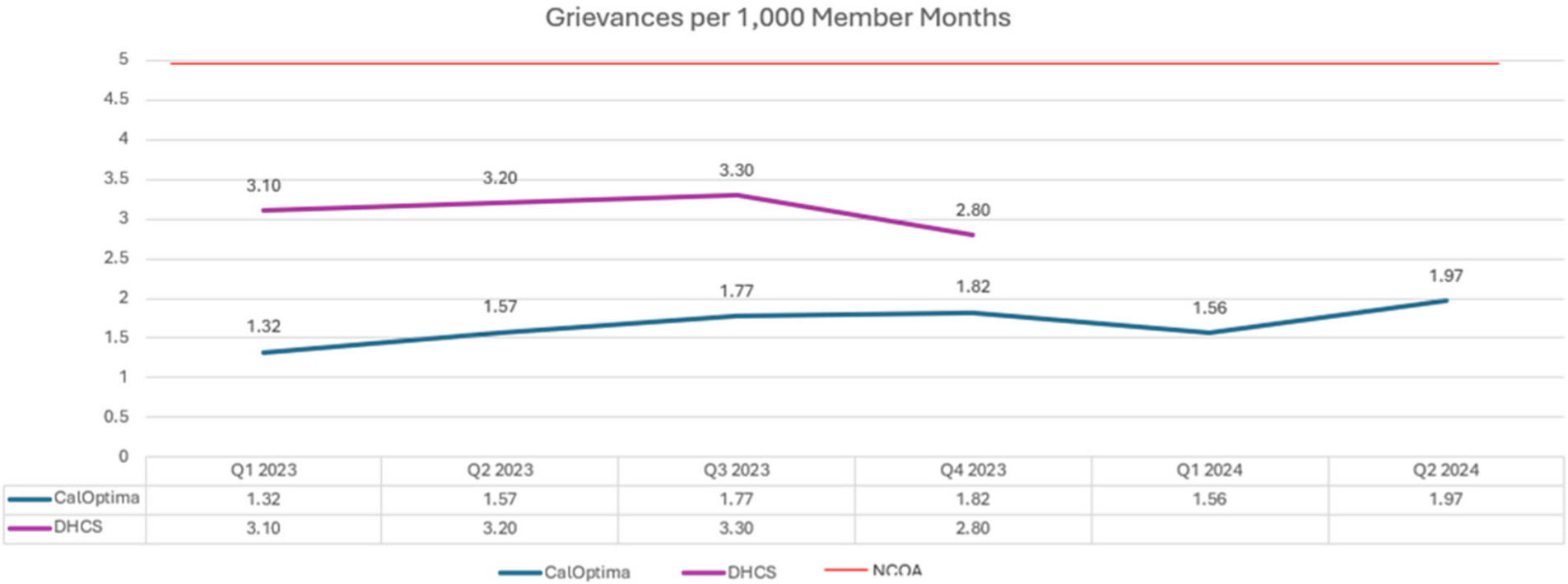
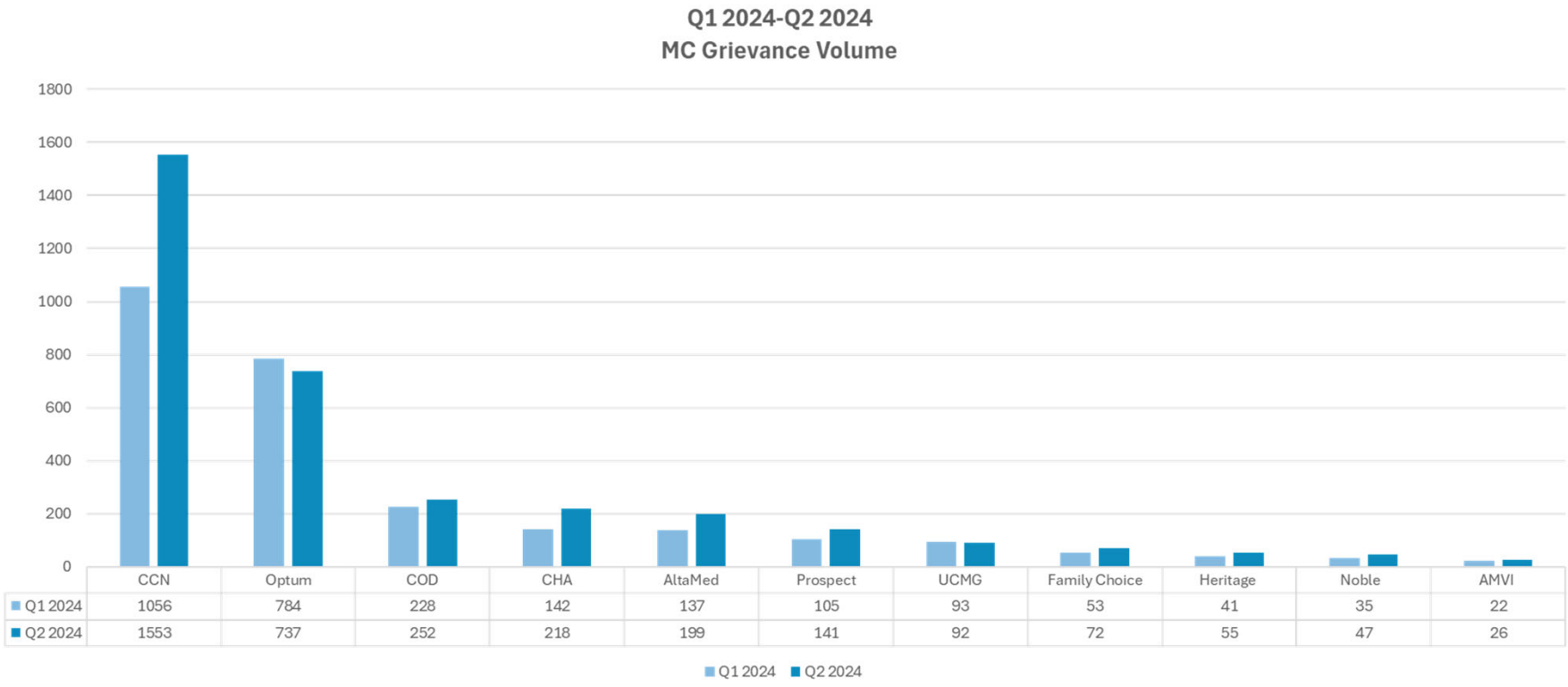
CalOptima Health Comparison (Continued)



	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024
CalOptima	1.32	1.57	1.77	1.82	1.56	1.97
DHCS	3.10	3.20	3.30	2.80		

Grievance Volume by Health Network (HN)



	CCN	Optum	COD	CHA	AltaMed	Prospect	UCMG	Family Choice	Heritage	Noble	AMVI
Q1 2024	1056	784	228	142	137	105	93	53	41	35	22
Q2 2024	1553	737	252	218	199	141	92	72	55	47	26

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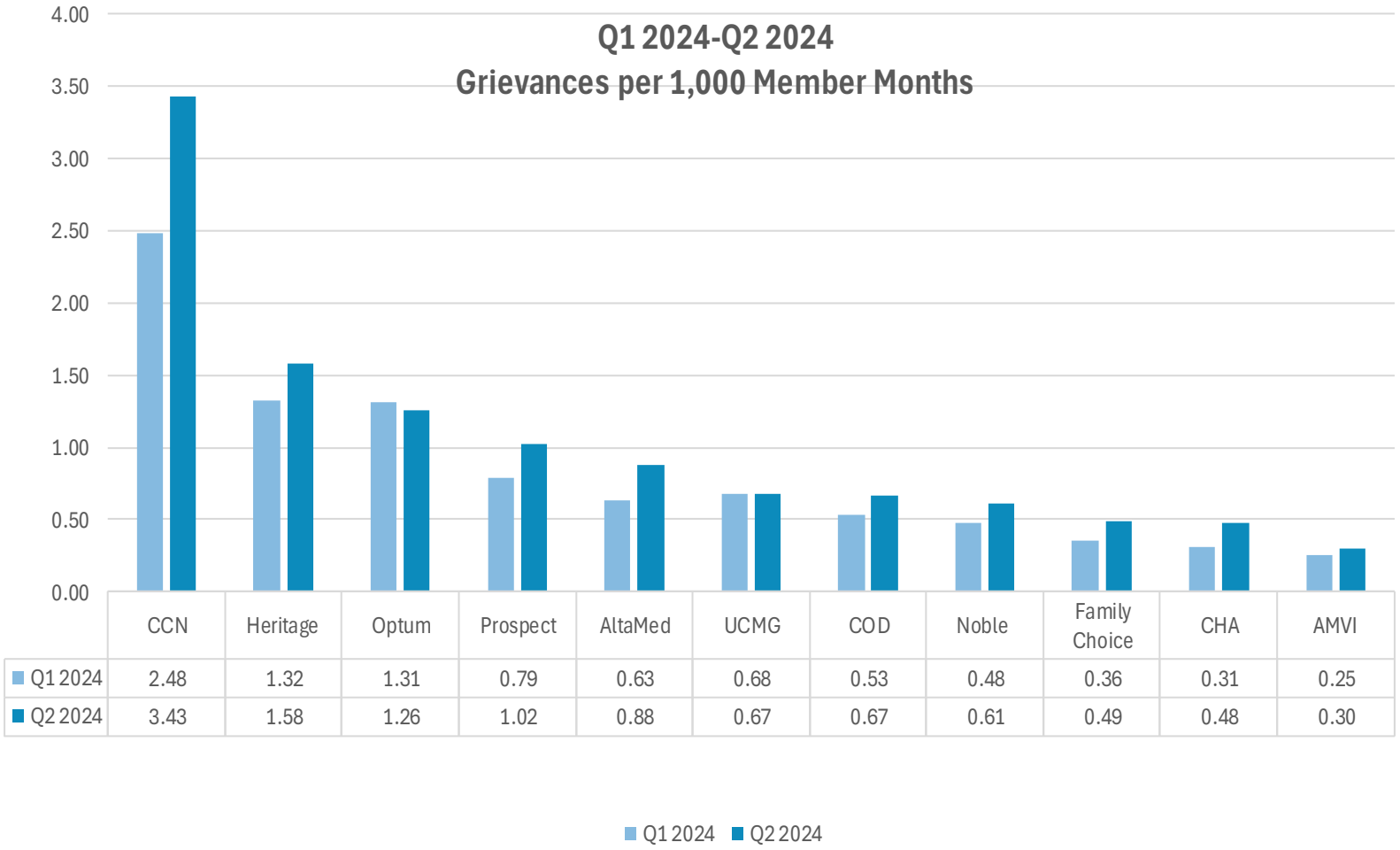
HN Grievances per 1,000 Member Months



	CCN	Heritage	Optum	Prospect	AltaMed	UCMG	COD	Noble	Family Choice	CHA	AMVI
Q1 2024	2.48	1.32	1.31	0.79	0.63	0.68	0.53	0.48	0.36	0.31	0.25
Q2 2024	3.43	1.58	1.26	1.02	0.88	0.67	0.67	0.61	0.49	0.48	0.30

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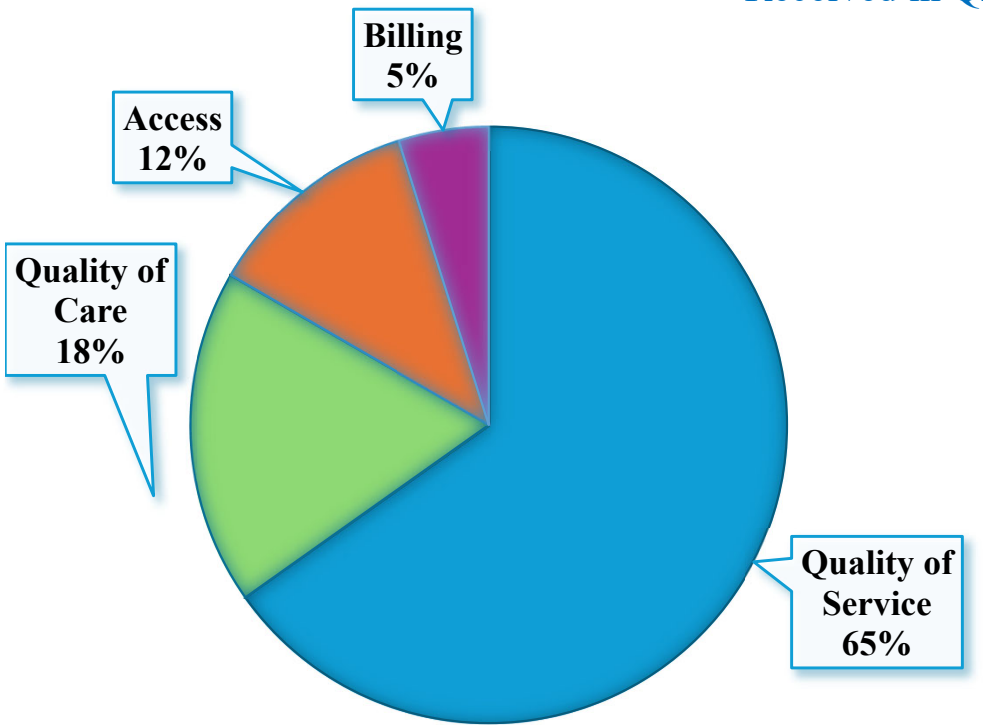
Overall Grievance Types (Medi-Cal and OneCare)

Received in Q2 2024



Type	Volume
Quality of Service	2,994
Quality of Care	539
Access	836
Billing	224

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.
Access: Concerns regarding accessing care. This includes physically accessing a provider, provider availability, timely access, language access and geographical location.
Billing: Concerns regarding direct member billing and provider balance billing for covered services.

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Grievance Type by Line of Business 2024

	Medi-Cal Q1 2024	Medi-Cal Q2 2024	OneCare Q1 2024	OneCare Q2 2024
Quality of Service	2,034	2,668	366	326
Quality of Care	320	505	27	34
Access	594	789	54	47
Billing	190	208	22	16
TOTAL	3,127	4,170	469	423

Quarter 2 Total	4,593
Quarter 1 Total	3,607

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Medi-Cal Grievance Trends for Q2 2024

Quality of Service

Trend	Percentage of Total Volume
Provider/Staff Attitude	11%
Plan's Customer Service	9%
Scheduling	6%

Quality of Care

Trend	Percentage of Total Volume
Quality of Care	7%
Inappropriate Care	1%
Driver Punctuality	1%

Access

Trend	Percentage of Total Volume
Provider Availability	3%
Scheduling	2%
Timely Access	2%

Billing

Trend	Percentage of Total Volume
Provider Direct Member Billing	3%
Reimbursement Request	1%
Provider Balance Billing	0.2%

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OneCare Grievance Trends for Q2 2024

Quality of Service

Trend	Percentage of Total Volume
Driver Punctuality	23%
Provider/Staff Attitude	16%
Scheduling	7%

Quality of Care

Trend	Percentage of Total Volume
Quality of Care	3%
Inappropriate Care	2%
Driver Punctuality	1%

Access

Trend	Percentage of Total Volume
Technology/Telephone	2%
Timely Access	2%
Referral Related	1%

Billing

Trend	Percentage of Total Volume
Provider Balance Billing	1%
Provider Direct Member Billing	1%
Reimbursement Request	1%

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Actions Taken in Response to the Trends

- **Transportation**: Punctuality, Scheduling, Customer Service, Quality of Care
  - Transportation vendor has terminated contracts with providers with consistent punctuality issues
  - Addressing scheduling challenges (some confusion in April with services/trips available)
  - Updated the interactive voice phone system
  - Collaboration calls between vendor and CalOptima Health (weekly and as needed)

- **Medically Tailored Meals**: Timely Access, Plan Customer Service
  - Trending food providers were terminated
  - Vendor hired additional staff to address the issues

- **Provider Access**: Timely Access, Provider Availability, Scheduling, Technology/Telephone
  - Network Management completed provider outreach to educate three provider clinics on access standards, securing commitments from the providers for improvement
  - GARS continues to monitor for additional trending providers

CalOptima Health

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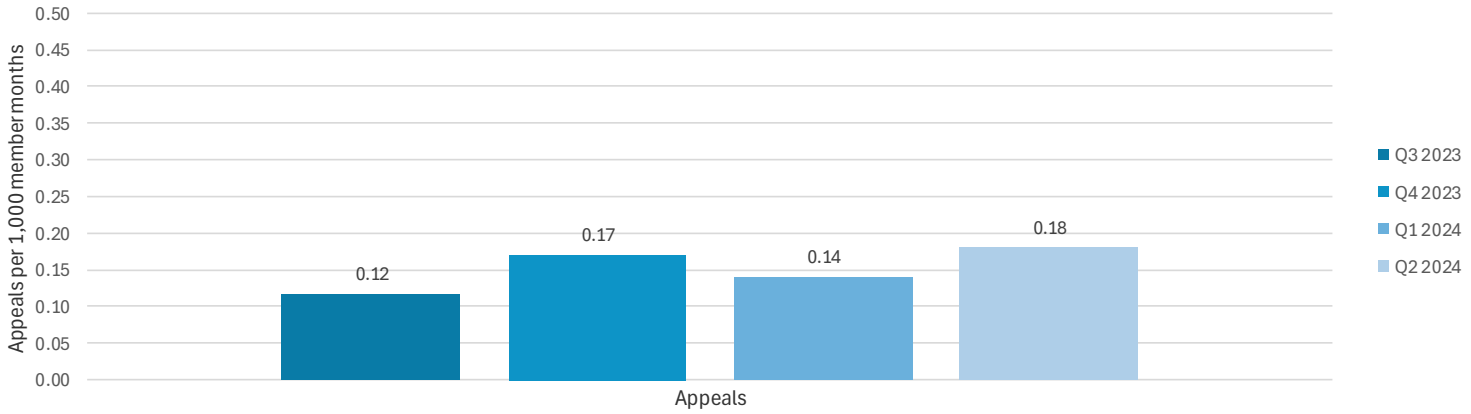
Appeals

Appeals Volume and Compliance

Timeframe	Total Appeals
Q3 2023	343
Q4 2023	490
Q1 2024	391
Q2 2024	423

Appeal: A request by the member or on the member's behalf for the review of any decision to deny, modify or discontinue a covered service.

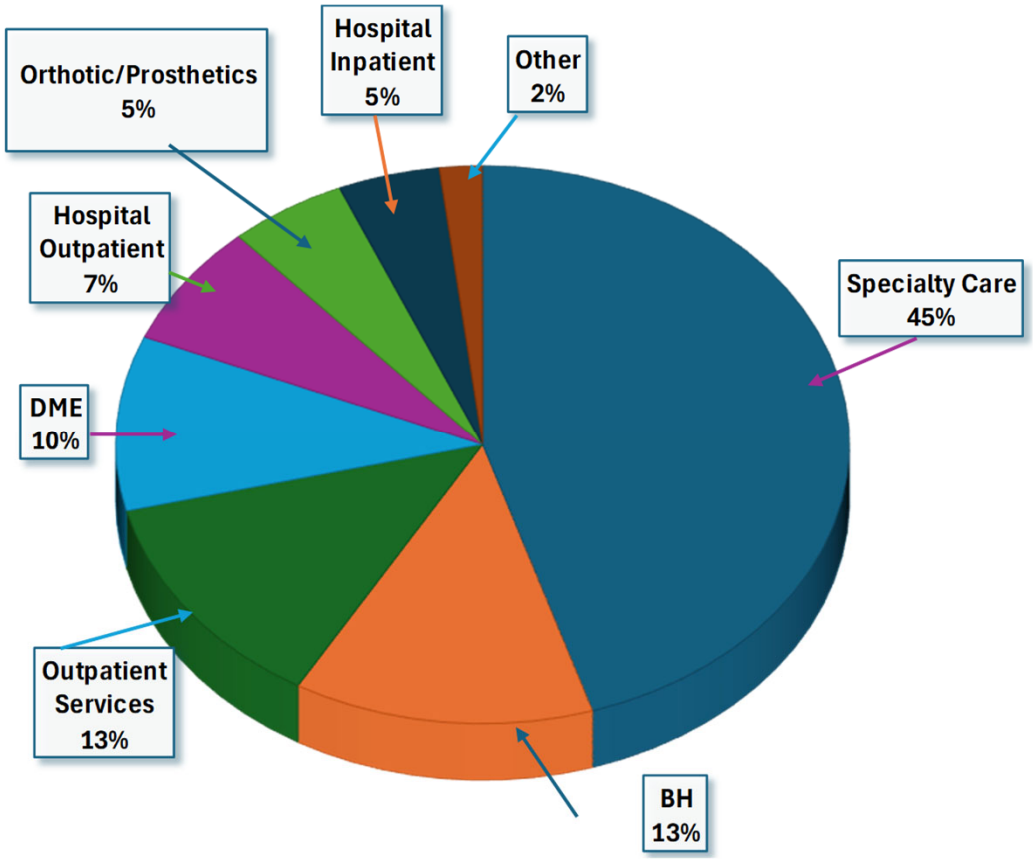


Note: Turnaround Time (TAT) Remains Compliant

Complaint Type	Required TAT	CalOptima TAT	Compliance Percentage
Appeals	30 Days	25 Days	98

Overall Appeal Types (Medi-Cal and OneCare)

Received in Q2 2024



Type	Volume
Specialty Care	191
Behavioral Health (BH)	56
Outpatient Services	54
DME	43
Hospital Outpatient	30
Orthotics/Prosthetics	22
Hospital Inpatient	19
Other	8

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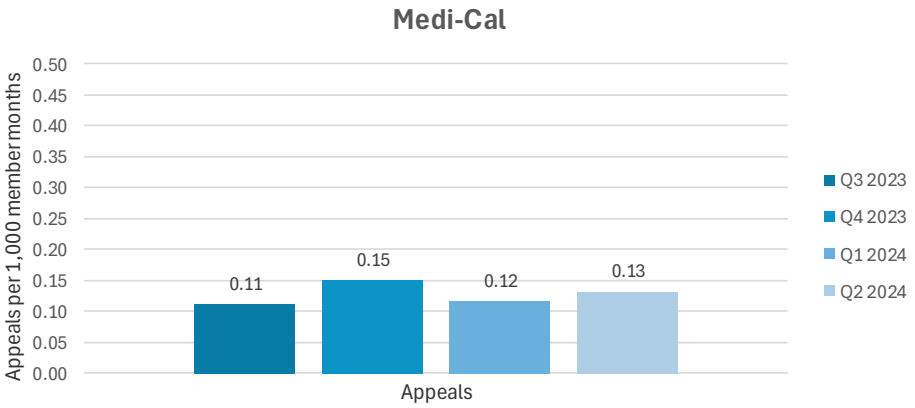
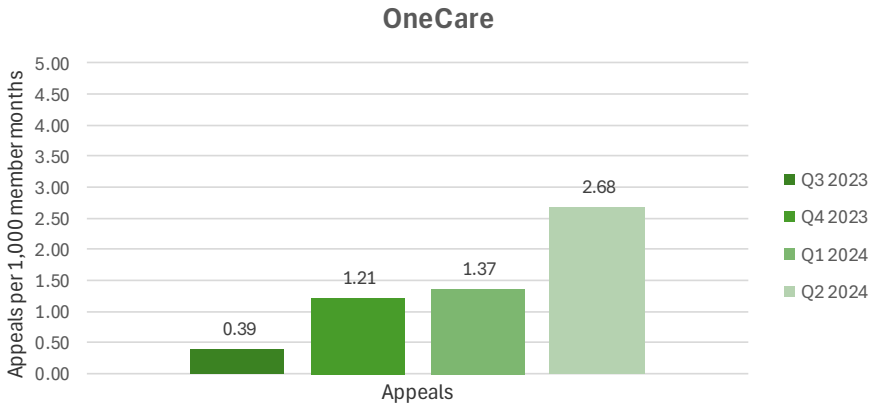
Appeals Volume by Line Of Business (LOB)





Total Appeals	
Q2 2024	356
Q1 2024	320
Q4 2023	426
Q3 2023	322

Total Appeals	
Q2 2024	67
Q1 2024	71
Q4 2023	64
Q3 2023	21

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Appeal Types by Line of Business Q2 2024

Service Types	Medi-Cal Q2 2024 (Percentage of Total Volume)	OneCare Q2 2024 (Percentage of Total Volume)
Specialty Care	45% (162)	45% (29)
Behavioral Health (BH)	16% (56)	0% (0)
Outpatient Services	12% (43)	17% (11)
DME	9% (32)	17% (11)
Hospital Outpatient	8% (27)	5% (3)
Orthotics/Prosthetics	5% (17)	8% (5)
Hospital Inpatient	5% (18)	2% (1)
Other	1% (4)	6% (4)
TOTAL	359	64

Quarter 2 Total	**423**

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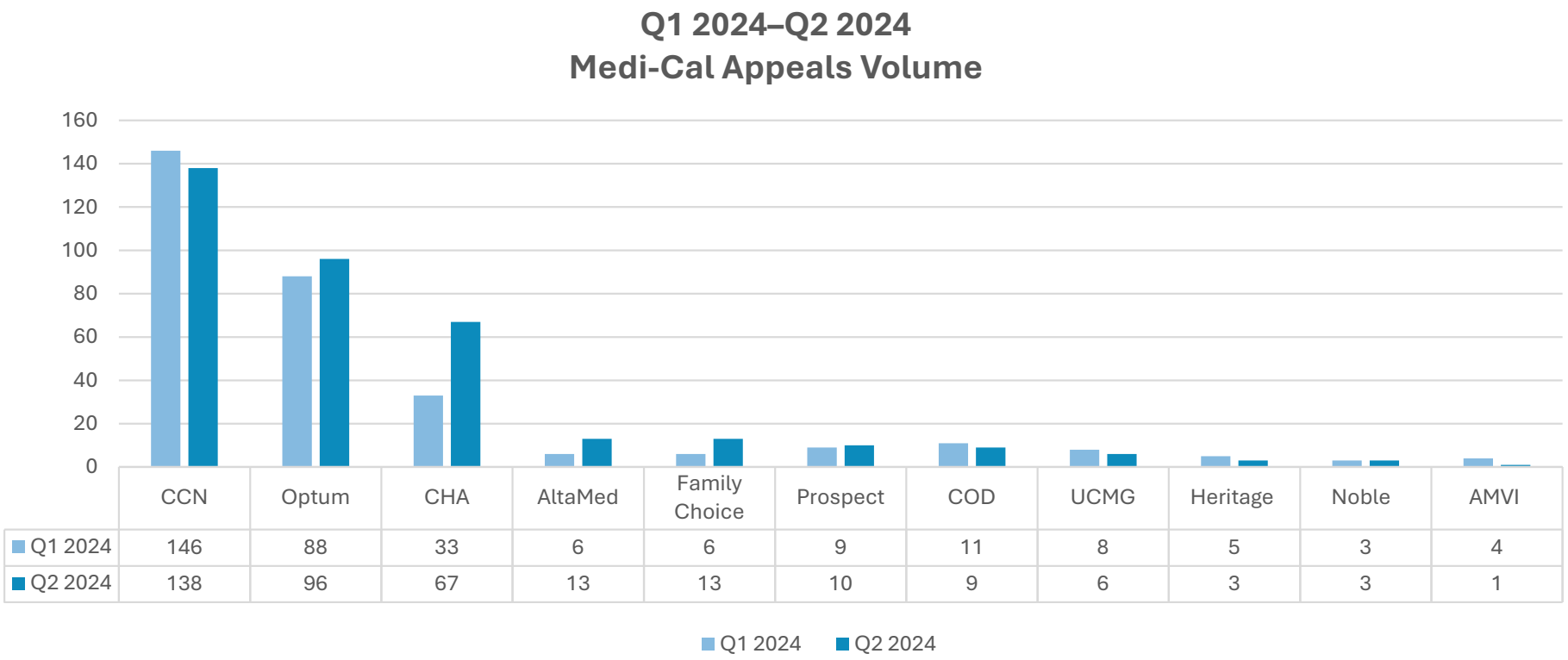
Appeals Volume by Health Network (HN)



	CCN	Optum	CHA	AltaMed	Family Choice	Prospect	COD	UCMG	Heritage	Noble	AMVI
Q1 2024	146	88	33	6	6	9	11	8	5	3	4
Q2 2024	138	96	67	13	13	10	9	6	3	3	1

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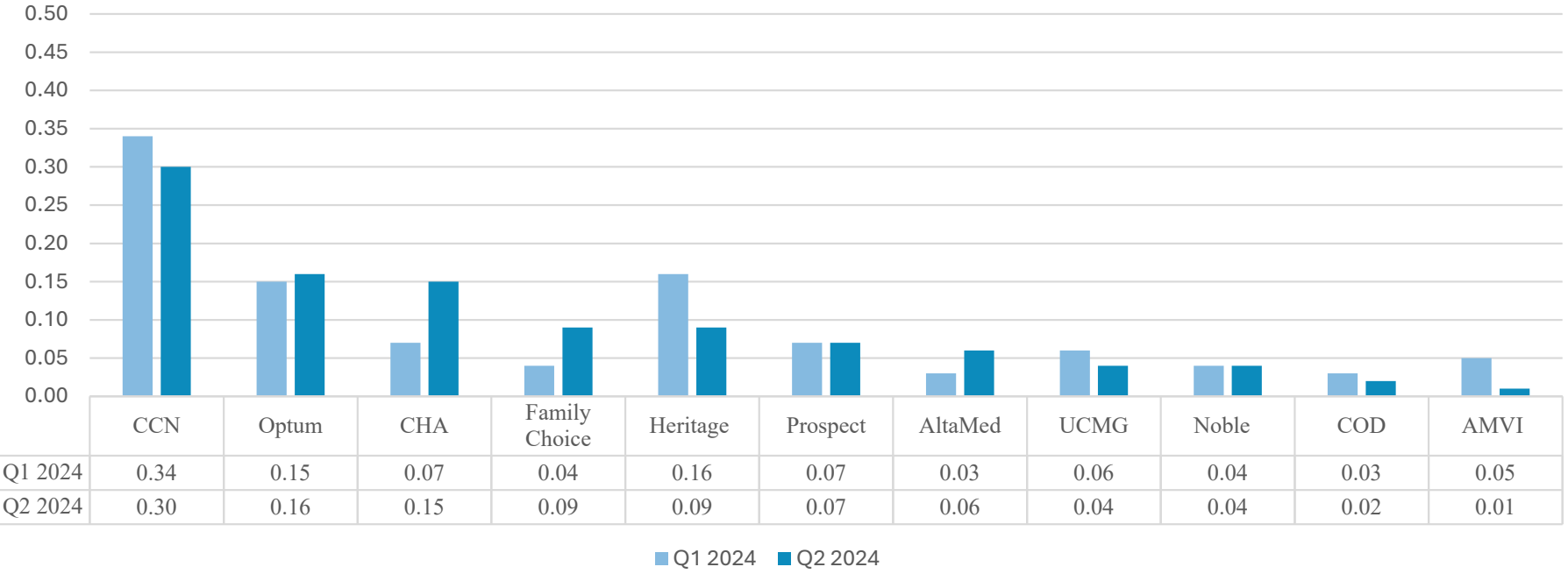
HN Appeals per 1,000 Member Months

Q1 2024–Q2 2024
Medi-Cal Appeals per 1,000 Member Months



	CCN	Optum	CHA	Family Choice	Heritage	Prospect	AltaMed	UCMG	Noble	COD	AMVI
Q1 2024	0.34	0.15	0.07	0.04	0.16	0.07	0.03	0.06	0.04	0.03	0.05
Q2 2024	0.30	0.16	0.15	0.09	0.09	0.07	0.06	0.04	0.04	0.02	0.01

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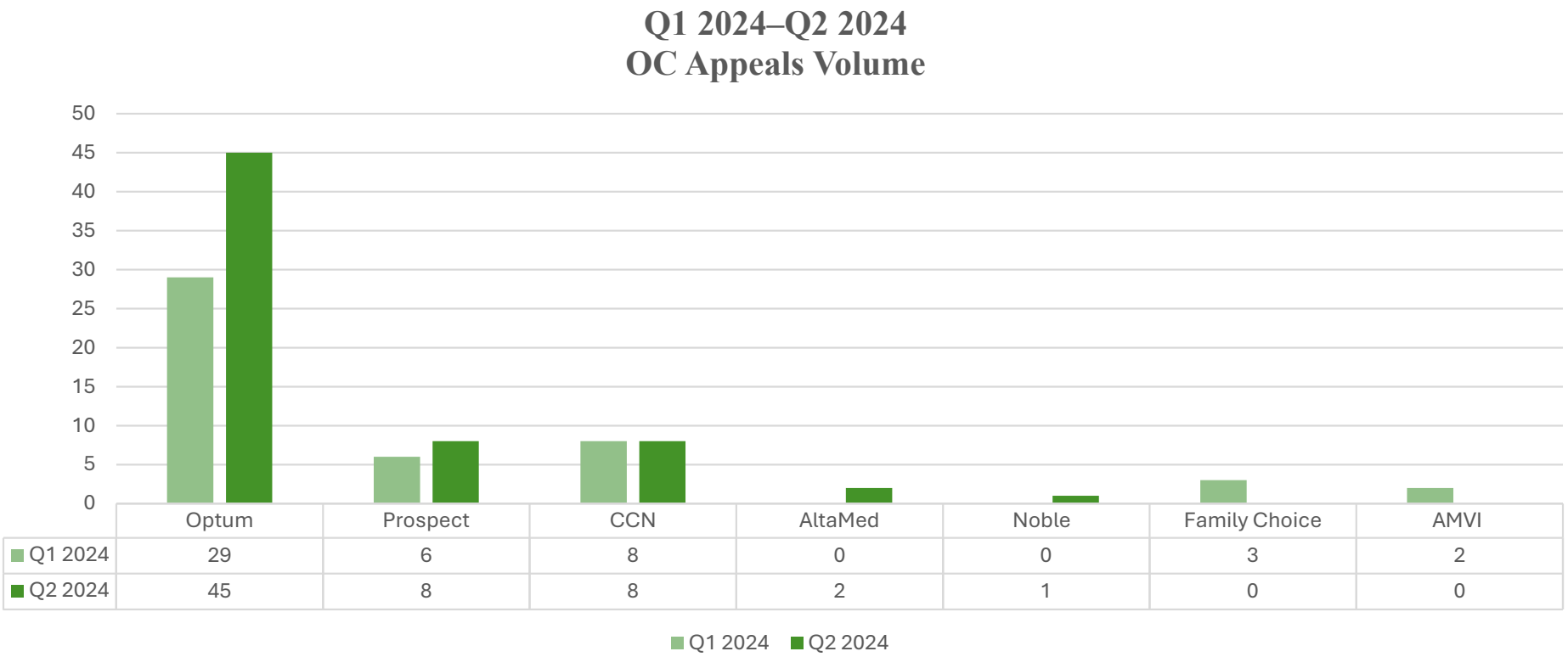
Appeals Volume by HN — OneCare



	Optum	Prospect	CCN	AltaMed	Noble	Family Choice	AMVI
Q1 2024	29	6	8	0	0	3	2
Q2 2024	45	8	8	2	1	0	0

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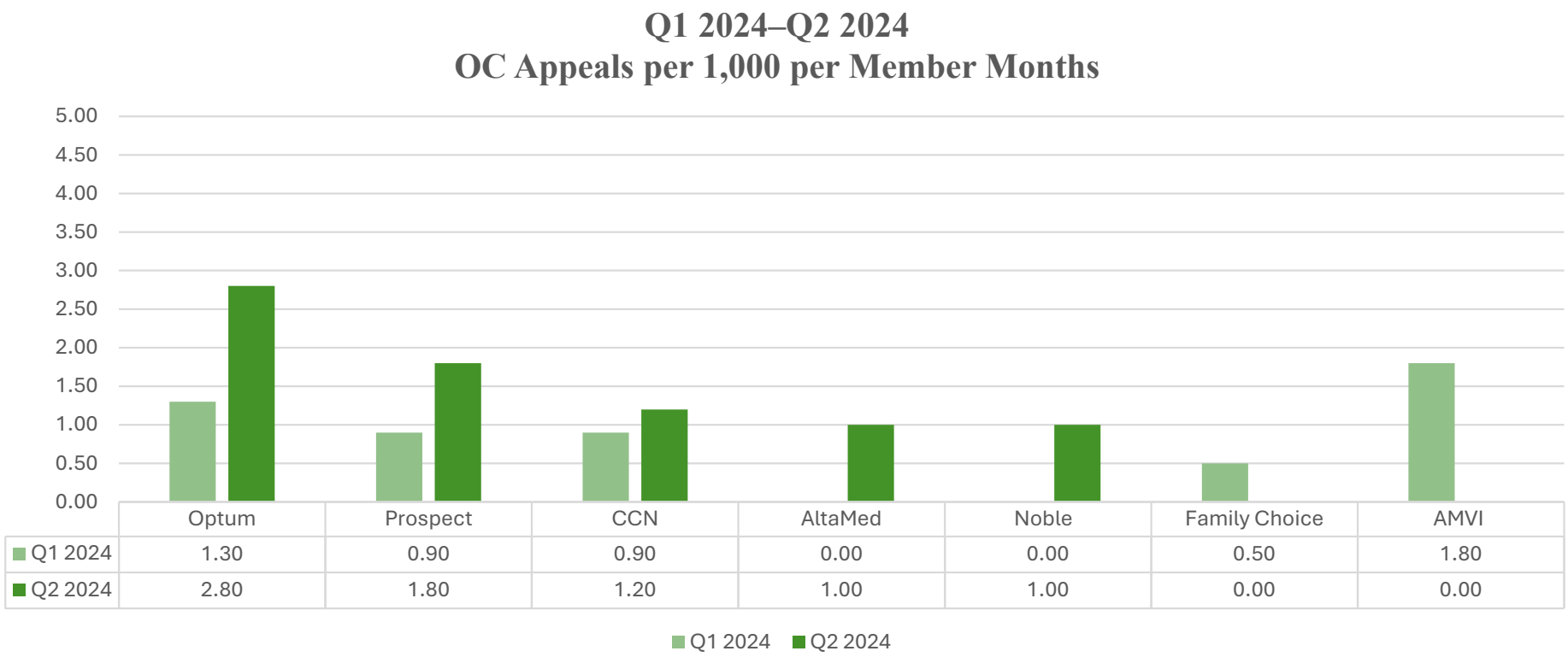
HN Appeals per 1,000 Member Months



	Optum	Prospect	CCN	AltaMed	Noble	Family Choice	AMVI
Q1 2024	1.30	0.90	0.90	0.00	0.00	0.50	1.80
Q2 2024	2.80	1.80	1.20	1.00	1.00	0.00	0.00

Medi-Cal Appeals Trends for Q2

Type	Upheld Count	Overturned Count	Total	Overturn %
Behavioral Health	12	44	56	78.6%
Hospital Outpatient	18	9	27	33.3%
DME	21	11	32	34.4%
Orthotics/Prosthetics	11	6	17	35.3%
Outpatient Services	31	12	43	27.9%
Specialty Care	123	39	162	24.1%
Hospital Inpatient	15	3	18	16.7%
Other	4	0	4	0%

OneCare Appeals Trends for Q2

Type	Upheld Count	Overturned Count	Total	Overturn %
Hospital Outpatient	0	3	3	100%
Orthotics/Prosthetics	2	3	5	60%
Other	2	2	4	50%
DME	6	4	(1-dismissed) 11	40%
Specialty Care	17	12	29	41.4%
Outpatient Services	8	3	11	27.3%
Hospital Inpatient	1	0	1	0%

Actions Taken

- Behavioral Health Services
  - Provider training completed to educate providers on the submission requirements for a complete review of Applied Behavior Analysis (ABA) services

- Specialty Care: Related to Tertiary Level of Care and Continuity of Care
  - Provider authorization requests are being redirected to available providers who can treat the condition and have appointment availability
  - Providers are being educated on the tertiary level of care requirements
  - Optum was reminded of the requirements regarding continuity of care among the providers previously contracted under Monarch, Talbert and Arta

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