Policy:	GG.1637
Title:	**Assessing Member Experience**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/ Michael Hunn 06/20/2024*
Effective Date:	01/01/2009
Revised Date:	06/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the mechanism by which CalOptima Health assesses and develops strategies to improve Member experience regarding their health care and services.

II. POLICY

A. CalOptima Health shall assess Members' experience by identifying and collecting data on Member health status and experience with services and plan operations through standardized and regular measurement.

B. CalOptima Health shall participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, administered by the following regulatory agencies:

1. The Department of Health Care Services (DHCS) according to the DHCS survey and External Quality Review Organization (EQRO) reporting requirements.

2. The Centers for Medicare & Medicaid Services (CMS) according to the CMS survey and reporting requirements.

C. CalOptima Health shall, at minimum, use data from Complaints, Appeals, and CAHPS results to analyze Member experience.

D. The Quality Analytics Department shall coordinate the monitoring of timely access and network adequacy as part of Member experience.

1. The Quality Analytics Department shall annually update CalOptima Health's Access and Availability standards and desktop procedures to assess adherence to access and availability standards, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

E. The Quality Analytics (QA) Department, in conjunction with other CalOptima Health departments, shall coordinate survey activities, including vendor management, data submission, reporting, and data dissemination to affiliated networks.

III. PROCEDURE

A. To assess Member experience with its services and plan operations, CalOptima Health shall, on an annual basis:

1. Review and evaluate Member Complaints and Appeals. Such data shall be categorized as follows:

a. Quality of care;

b. Access;

c. Attitude and service;

d. Billing and financial issues; and

e. Quality of practitioner office site.

2. Review and evaluate data related to access and availability.

3. Engage a contracted and certified CAHPS vendor to conduct the CAHPS survey to monitor Member experience.

a. CalOptima Health shall participate in the CAHPS survey process as determined by DHCS and coordinate the survey process with the EQRO and/or a certified CAHPS vendor.

b. CalOptima Health shall participate in the annual CAHPS survey process, as determined by CMS, including contracting with a certified CAHPS vendor.

B. The QA Department shall coordinate annual qualitative and quantitative data analysis of Member experience data, including Complaints, Appeals, and CAHPS results, access and availability and any other data relevant to Members' health status and experience with care, including utilization management (UM) and Behavioral Health Care services, if appropriate. Data analysis shall:

1. Include plan-level and Health Network-level results and trends over time;

2. Utilize root cause analysis or barrier analysis to identify the reasons for the results; and

3. Compare such results against a standard, goal, or Benchmark, when available.

4. Based on the data analysis, CalOptima Health's Member Experience Sub-committee shall identify and prioritize opportunities for improvement.

C. Opportunities for improvement shall be considered quality improvement initiatives where CalOptima Health shall:

1. Address areas of dissatisfaction and low performance, when appropriate;

2. Formulate interventions, as appropriate, based on the results of data and barrier analysis;

3. Formulate a project plan indicating interventions for implementation, identification of responsible persons or departments, and establishment of time frames;

4. Consider the significance of concerns to Members when establishing priorities; and

5. Communicate results of improvement and satisfaction activities to Providers and Health Networks, as appropriate.

6. The Chair of the Member Experience Sub-Committee, or Designee, shall report a summary of results and analysis to the Quality Improvement Health Equity Committee (QIHEC), and other committees, as appropriate.

D. CalOptima Health's QA Department shall provide the Health Networks with the following:

1. Member experience results (i.e. CAHPS); and

2. Clinical performance data.

E. Upon request, the QA Department shall provide data to any delegate requesting clinical and/or Member experience data such as, but not limited to, clinical HEDIS, CAHPS, claims, Complaint and Appeal data, or other clinical data related to delegated activities.

F. Delegates may allow CalOptima Health to use their performance data for quality improvement activities and public reporting to consumers. CalOptima Health shall allow delegates to collect Member experience or clinical data directly.

G. If the Member Experience Sub-committee identifies deficiencies or non-compliance, the Chair of the Member Experience Sub-Committee, or Designee, may take the following steps:

1. Request that a Health Network submit a Quality Improvement Plan (QIP) or Plan-Do-Study-Act (PDSA) cycle(s) for performance measures that are deemed deficient or non-compliant, if applicable.

2. Submit a Request for Compliance Action (RCA) to the Office of Compliance to request corrective action, if applicable. Such corrective action may include the issuance of a request for a Corrective Action Plan (CAP) and/or the imposition of Sanctions, in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions, respectively; and

3. Report the deficiencies or non-compliance to the Delegation Oversight Committee (DOC) and/or Compliance Committee, as appropriate.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with Department of Health Care Services for Medi-Cal
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
C. CalOptima Health Policy GG.1619: Delegation Oversight
D. CalOptima Health Policy GG.1634: Quality and Performance Improvement Projects
E. CalOptima Health Policy HH.2002: Sanctions
F. CalOptima Health Policy HH.2005: Corrective Action Plan

G. National Committee for Quality Assurance (NCQA) – Member Experience. ME7.
H. Title 42, Code of Federal Regulations (C.F.R), §422.152(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/15/2015	Department of Health Care Services (DHCS)	Approved as Submitted
07/18/2016	Department of Health Care Services (DHCS)	Approved as Submitted
02/13/2018	Department of Health Care Services (DHCS)	Approved as Submitted

VI. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2009	GG.1637	Member Survey Process	Medi-Cal
Revised	12/01/2014	GG.1637	Assessing Member Experience	Medi-Cal
Revised	04/01/2016	GG.1637	Assessing Member Experience	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1637	Assessing Member Experience	Medi-Cal OneCare OneCare Connect
Revised	11/01/2018	GG.1637	Assessing Member Experience	Medi-Cal OneCare OneCare Connect
Revised	08/01/2019	GG.1637	Assessing Member Experience	Medi-Cal OneCare OneCare Connect
Revised	08/01/2020	GG.1637	Assessing Member Experience	Medi-Cal OneCare OneCare Connect
Revised	07/01/2022	GG.1637	Assessing Member Experience	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1637	Assessing Member Experience	Medi-Cal OneCare
Revised	11/01/2023	GG.1637	Assessing Member Experience	Medi-Cal OneCare
Revised	06/01/2024	GG.1637	Assessing Member Experience	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facilities services.
Benchmark	Performance information used to identify the operational and clinical practices that lead to the best outcome.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Complaint	Medi-Cal: A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.

Term	Definition
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	A multiyear initiative of the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care by developing standardized patient questionnaires that can be used to compare results across sponsors and over time and generate tools and resources that sponsors can us to produce understandable and usable comparative information for both consumers and health care providers.
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.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and performs EQR and other EQR–related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.
FDR	First Tier, Downstream, or Related Entity.
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

Term	Definition
Healthcare Effectiveness Data and Information Set (HEDIS™)	Medi-Cal: The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA). OneCare: A set of standardized performance measures designed to provide purchasers and consumers with relevant information on health plan performance and facilitate the comparison of managed care organizations. HEDIS is sponsored, supported, 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 beneficiary enrolled in a CalOptima Health program.
Plan-Do-Study-Act (PDSA)	The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).
Quality and Performance Improvement Project	A component of a comprehensive quality improvement program that addresses the quality of clinical care as well as the quality of health services delivery. A Quality Improvement Project is an initiative by the organization to measure its own performance in major focus areas of clinical and non-clinical care. Also known as Quality Improvement Projects (QIPs) and Performance Improvement Projects (PIPs).
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.