Medi-Cal Managed Care Division

state of california

Medi-Cal Managed Care External Quality Review Organization

2007-2008 Annual Report of Performance for CalOptima

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DHCS
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Improving Health in the Communities We Serve

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Introduction

The Medi-Cal Managed Care Division (MMCD) of the California Department of Health Care Services (DHCS) contracts with managed care plans to provide care to 3.4 million Medi-Cal beneficiaries enrolled in managed care plans in 23 counties throughout California. Healthcare providers within each plan's contracted network provide comprehensive healthcare services—primary and preventive care, as well as the full range of specialty care mandated by federal and state law.

Federal law pertaining to Medicaid managed care programs (42 CFR § 438.240) requires the DHCS to contract with an External Quality Review Organization (EQRO) to independently evaluate the quality of care provided to Medi-Cal beneficiaries enrolled in any of California's managed care plans. The DHCS has retained the services of the Delmarva Foundation for Medical Care, Inc. (Delmarva) as its EQRO to provide this independent evaluation as to whether the care and service delivered meets the federal standards for quality, access, and timeliness. Among the services provided by the EQRO is an annual assessment of each contracted plan's "… quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract…" as stated in Title 42 of the U.S. Codes.

This annual review is for the reporting years 2007 and 2008, covering performance results and quality improvement activities during 2006 and 2007.

Definitions

The terms quality, access, and timeliness provide the framework for this plan-specific review of CalOptima ("CalOptima" or "the plan"). Consistency in meaning and use of these key terms are important for a thorough understanding of this report, so definitions are provided below:

- **Quality**, as it pertains to external quality review, is defined by the Centers for Medicare & Medicaid Service (CMS) as "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." (CMS, 2008.)

- **Access** (or accessibility) to health care, according to the Agency for Healthcare Research and Quality (AHRQ), means having "the timely use of personal health services to achieve the best health outcomes. Attaining good access to care requires three discrete steps: gaining entry into the health care system; getting access to sites of care where patients can receive needed services; and, finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust." (AHRQ, 2007.)

- **Timeliness,** according to AHRQ, is defined as "…the health care system's capacity to provide health care quickly after a need is recognized….Measures of timeliness include waiting time spent in doctors' offices and emergency departments (EDs) and the interval between identifying a need for specific tests and treatments and actually receiving those services." (AHRQ, 2007.)

It is important to note that some interdependence exists among the categories (also referred to as "domains") of quality, access, and timeliness. A measure or attribute identified in one of the categories of quality, access, or timeliness may also be noted under one or both of the other two categories throughout this review.

Data Sources

Delmarva used five sets of standards or information sources for the evaluation of performance. Each of the sources listed were used to systematically assess the contracted health plan's ability to provide its members with care that meets the requirements for quality, access, and timeliness:

- The Healthcare Effectiveness Data and Information Set (HEDIS®)[1] is a nationally recognized set of performance measures developed by the National Committee for Quality Assurance (NCQA). These measures are used by health care purchasers to assess the quality, access, and timeliness of care and service provided to members of managed care plans.

- In June 2007, each DHCS health plan submitted its results to Delmarva for the 12 required HEDIS measures, which reflect 16 measurement indicators, since several measures have multiple indicators.[2] The 2007 HEDIS results reflect data collected for the period January 1, 2006, through December 31, 2006.

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA, 2008).

[2] In 2007 and 2008, the DHCS required plans to report on 12 HEDIS measures. Some of these measures have multiple indicators (such as the *Comprehensive Diabetes Care* measure), so results are presented for the total number of indicators – 16 in 2007 and 23 in 2008. This report refers to the total number of indicators reported as "measures" since a result is reported for each indicator.

- In June 2008, each DHCS health plan submitted its results for the 12 required HEDIS measures, which reflect a total of 23 indicators. The 2008 HEDIS results reflect data collected for the period January 1, 2007, through December 31, 2007.[3] For a more detailed explanation of HEDIS, see the "Quality Assessment" discussion later under "HEDIS Performance Measures" and Appendix A: HEDIS.

- AHRQ developed the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[4] surveys to support the assessment of consumers' experiences with health care. This report utilizes results from the 2007 4.0H Adult Medicaid and the 3.0H Child Medicaid. Delmarva conducted these surveys between February and May 2007. For a more detailed explanation of CAHPS, see "Appendix B: CAHPS".

- Summaries of plan-conducted Quality Improvement Projects conducted during the period January 1, 2006, and December 31, 2007.

- The DHCS's Audits and Investigations Division and the California Department of Managed Health Care conduct routine medical surveys (audits) to assess compliance with contract requirements and state regulations. Findings from any audits conducted during the period January 1, 2006, and December 31, 2007, will be discussed in this report.

- Grievance and appeal data by contracted plans submitted to the DHCS and reports prepared by MMCD's Office of the Ombudsman during 2006 and 2007.

Report Organization

This report provides the plan's background and discusses each data source within the framework of quality, access, and timeliness. Due to some variations between the measures reported in the 2007 and 2008 HEDIS reports, the results and analysis of this source are presented separately by year. Where appropriate, sustainability of the plan's performance is discussed. The plan's performance is compared to other plan models of similar type and other state and national benchmarks. The document concludes with the plan's overall strengths and recommendations for improving the plan's quality of care, access to care, and timeliness of care for its members.

[3] The annual *Report of the Performance Measures for Medi-Cal Managed Care Members* is produced for the DHCS by the EQRO from the measurement results and comparisons of all contracted plans.

[4] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ, 2008).

Background

Medi-Cal beneficiaries receive their health care through three models of health care delivery: County Organized Health Systems (COHS), Two-Plan (Commercial Plans and Local Initiatives), and Geographic Managed Care (GMC). CalOptima is a full-service health plan contracted in Orange County as a COHS. COHS plans are county-operated managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS.

CalOptima has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since June 28, 2000. As of December 2007, CalOptima's Medi-Cal enrollment was 295,877 members.

Quality of Care Assessment

According to the CMS (2008), "[q]uality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results." The section below describes the measures used to assess CalOptima's healthcare delivery with regard to quality.

HEDIS Performance Measures

Delmarva categorized the HEDIS performance measures used in this report into quality, access, and timeliness areas for assessment. For a more detailed explanation of HEDIS and the specific HEDIS measures used in this report, see Appendix A: HEDIS.

Changes in HEDIS Performance Measures from 2007 to 2008

Health plans reported on 12 measures for the HEDIS 2007 reporting year, which included multiple indicators for *Comprehensive Diabetes Care* and *Prenatal and Postpartum Care*. The 2007 reporting year represents the data collection period January through December 2006. MMCD made some performance measure changes between 2007 and 2008 reporting years as explained below.

MMCD retired the *Chlamydia Screening for Women* performance measure from the required measurement set. The required HEDIS measures included several other measures focused on women's health screening (*Breast Cancer Screening* and *Cervical Cancer Screening*), and overall plan results for *Chlamydia Screening* had trended upward for a number of years. As a result, MMCD decided to eliminate the *Chlamydia Screening* measure and, instead, require the *Ambulatory Care* measure in order to focus more on the entire Medi-Cal managed care population, including seniors and persons with disabilities.

The *Ambulatory Care* measure provides utilization information across the whole spectrum of the population – from birth to 85+ years of age. Plus, this measure provides insight regarding emergency room (ER) use, which is an area of particular interest to MMCD because many members use the ER for avoidable visits and, as a result, may not be getting appropriate preventive care and follow-up care with chronic conditions. The *Ambulatory Care* measure consists of four indicators:

- *Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months)*
- *Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months)*
- *Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months)*
- *Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months)*

Additionally, in order to increase the focus on chronic diseases, MMCD added three more *Comprehensive Diabetes Care* indicators:

- *Comprehensive Diabetes Care—HbA1c Good Control (<7.0%)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- *Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)*

Comparisons of HEDIS Performance Measures

This report contains several charts displaying HEDIS rates for CalOptima and state and national benchmarks used for assessing plan performance. The plan's multi-year performance is also evaluated.

In some years, MMCD makes changes to the list of required measures. Moreover, NCQA continually updates the technical specifications for HEDIS measures. Some of the specification changes or a combination of changes can cause a significant change in the results and make comparisons with previous years' rates inappropriate. MMCD does not hold the plan to the Minimum Performance Level (MPL) in the baseline year (the first year a score is reported) and does not compare results to previous years in years when a measure's specifications have changed substantively. For these reasons, rates for measures may be displayed in the charts, but not compared in the narratives.

2007 HEDIS Quality Performance Measures

Table 1 provides CalOptima's 2007 HEDIS results for those measures specifically related to clinical quality of care along with the state's 2007 Medi-Cal managed care weighted averages[5] and the 2006 national Medicaid averages for these measures.

Table 1. 2007 HEDIS Quality Measure Results Comparing CalOptima to State and National Programs.

2007 Quality Measure	2007 CalOptima Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*
Appropriate Treatment for Children With Upper Respiratory Infection	79.7%	78.9%	82.5%
Chlamydia Screening in Women	52.2%	52.8%	50.6%
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis†‡	75.4%	71.0%	69.4%
Use of Appropriate Medications for People With Asthma	88.5%	86.8%	85.7%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	68.3%	54.1%	48.6%
Comprehensive Diabetes Care—HbA1c Testing	83.8%	79.5%	76.2%
Comprehensive Diabetes Care—LDL-C Screening‡	81.6%	75.9%	80.5%
Comprehensive Diabetes Care—Medical Attention for Nephropathy‡	80.9%	81.0%	48.8%
Cervical Cancer Screening‡	72.7%	67.9%	65.0%

* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*.
† For this 2007 measure, a lower rate indicates better performance.
‡ Due to significant changes in technical specifications, MPLs and HPLs had not yet been established for 2007. The rate is displayed for informational purposes only and will not be compared to benchmarks.

CalOptima scored equivalent to or better than the 2007 Medi-Cal managed care weighted average in all five of the quality domain HEDIS measures that could be compared. The plan scored better than the 2006 HEDIS national Medicaid average in four of the same five comparable measures. CalOptima's rate was 2.8 percentage points lower than the national benchmark for the measure *Appropriate Treatment for Children With Upper Respiratory Infection*.

[5] For each measure, a Medi-Cal managed care weighted average has been calculated to provide a comparative statistic. A weighted average, unlike a simple average, accounts for variations in membership across plans.

2008 HEDIS Quality Performance Measures

Table 2 provides CalOptima's 2008 HEDIS results for those measures specifically related to clinical quality of care along with the state's 2008 Medi-Cal managed care weighted averages and the 2007 national Medicaid averages for these measures.

Table 2. 2008 HEDIS Quality Measure Results Comparing CalOptima to State and National Programs.

2008 Quality Measure	2008 CalOptima Rate*	2008 Medi-Cal Managed Care Weighted Average*	2007 HEDIS National Medicaid Average*
Appropriate Treatment for Children With Upper Respiratory Infection	83.2%	83.1%	83.3%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis†‡	20.9%	28.4%	†
Use of Appropriate Medications for People With Asthma	90.8%	88.8%	87.1%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.4%	58.1%	51.4%
Comprehensive Diabetes Care—HbA1c Testing	84.5%	82.1%	78.0%
Comprehensive Diabetes Care—HbA1c Good Control (<7.0%)‡	35.5%	32.6%	¶
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)‡§	38.1%	42.6%	48.7%
Comprehensive Diabetes Care—LDL-C Screening	82.8%	77.8%	71.1%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)‡	36.2%	34.2%	30.6%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.7%	78.3%	74.6%
Cervical Cancer Screening	70.1%	68.7%	65.7%

* Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members*.
† The 2007 measure was called *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis,* and a lower score was better. The 2008 measure is called *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* and a higher score is better.
‡ 2008 is the first year MMCD required reporting of this measure. Because MPLs and HPLs had not yet been established, the rate is displayed for informational purposes only and will not be compared to benchmarks.
§ A lower rate for this measure is better as it represents better diabetes control.
¶ NCQA first-year measure; national benchmark not available.

Seven of the eleven measures in Table 2 may be compared to benchmarks. CalOptima's rates for the seven measures were higher than the 2008 Medi-Cal managed care weighted averages and than the 2007 HEDIS national Medicaid averages.

CAHPS Survey Results Pertaining to Quality

During this reporting period, the 2007 CAHPS 4.0H Adult Medicaid and 3.0H Child Medicaid Surveys were conducted among members of Medi-Cal managed care's contracted health plans. The table reflects survey results for three populations: Adult, Child, and Children with Special Health Care Needs (CSHCN). (See Appendix B: CAHPS for further detail.)

Delmarva chose two CAHPS composite areas to most appropriately represent the quality domain in this report: *Getting Needed Care* and *How Well Doctors Communicate*. Table 3 shows the plan's CAHPS scores for these composite categories.[6]

Table 3. 2007 CAHPS Quality Survey Results Comparing CalOptima and the Medi-Cal Managed Care Weighted Average.

CAHPS Composite	Population	2007 CalOptima Results	2007 Medi-Cal Managed Care Weighted Average*
Getting Needed Care	Adult	32%	40%
	Child	81%	80%
	CSHCN†	75%	‡
How Well Doctors Communicate	Adult	55%	59%
	Child	53%	52%
	CSHCN†	57%	‡

* Medi-Cal average was calculated from scores of all contracted health plans and weighted to be proportionate to plan enrollment.
† CSHCN - Child with Special Health Care Needs.
‡ MCMC overall averages were not calculated for CSHCN members because they are subsets of the same sampling and data cannot be used due to possibility of double counting. Refer to Appendix B: CAHPS for further detail.

CalOptima's composite score for *Getting Needed Care* indicates some possible areas for improvement with just 32 percent of adult members responding that they always got the care they needed. CalOptima's score was 8 percent lower than the 2007 Medi-Cal managed care weighted average in this composite category. Parents/guardians of child members appeared more pleased in this area with 81 percent of respondents indicating their children always received the care they needed. This response rate was higher than the Medi-Cal managed care weighted average in this area by one percent.

Fifty-five percent of CalOptima's adult members indicated their doctor always communicated well, ranking CalOptima seven percent lower than the Medi-Cal managed care weighted average for the composite *How*

[6] See Appendix B: CAHPS for further detail about categories and the DHCS's "Results of the 2007 CAHPS for Medi-Cal Managed Care Health Plans" for more detail about calculation methods.

Well Doctors Communicate. Parents/guardians of child members appeared more pleased in this area than CalOptima's adult members. Fifty-three percent of parents/guardians indicated their children's doctor or health care provider always communicated well, a score two percent higher than the Medi-Cal managed care weighted average.

Quality Improvement Projects

One of CalOptima's Quality Improvement Projects (QIPs)—*Appropriate Treatment for Children With Upper Respiratory Infection*—is categorized in the quality domain for assessment purposes. The QIP and its results are discussed below:

Appropriate Treatment for Children with an Upper Respiratory Infection

The plan developed this QIP in partnership with other plans in a small group collaborative.

- **Relevance:**
  CalOptima's 2006 HEDIS rate for *Appropriate Treatment for Children With Upper Respiratory Infection* was below 81.5 percent, the 2005 national Medicaid 50th percentile.

- **Goal:**
  Achieve 81.5 percent on the HEDIS *Appropriate Treatment for Children With Upper Respiratory Infection* indicator by Remeasurement 1.

- **Best Interventions:**
  Interventions were not available to Delmarva for validation in time to be included in this report.

- **Outcomes:**
  - HEDIS *Appropriate Treatment for Children With Upper Respiratory Infection*:
    - 2006 (Baseline): 79.7%
    - 2007 (Remeasurement 1): 83.2%

- **Attributes/Barriers to Outcomes:**
  Attributes and barriers to outcomes were not available to Delmarva for validation in time to be included in this report.

CalOptima submitted a proposal for its *Appropriate Treatment for Children With an Upper Respiratory Infection* QIP. The proposal included a baseline of 79.7 percent, while the goal for the measure was 81.5 percent, or an increase of 2.3 percent. With the baseline data submission, CalOptima was already near its goal. The plan

has been encouraged to select a more challenging goal in the future. Goals should reflect the desired level of achievement the plan sets for itself. Plans are not penalized if they do not reach a stated goal.

Medi-Cal Audit Findings

The DHCS and the Department of Managed Health Care conducted a combined audit and routine medical survey of CalOptima from January 23 through January 26, 2006, covering the audit period of January 1 through December 31, 2005. Results of issues categorized in the quality of care domain are noted below.

- Member's Rights
  - The plan did not have a comprehensive written program for the privacy and safety of protected health information.
  - The plan's program lacked a procedure to inform staff and providers that the DHCS Privacy Officer must be notified in the event of an actual or suspected breach of protected health information.

- Quality Management
  - Although the plan's contract and policies stated that the plan would assess, monitor, evaluate, and take effective action to improve the quality of care and services, the auditors found inconsistencies in the implementation of these activities.
  - Plan oversight failed to ensure a complete and effective credentialing process.
  - The plan possessed separate policies for Medi-Cal and Healthy Families programs causing inconsistencies in the way the Quality Improvement Program functioned and making it unclear whether the plan was consistently monitoring quality activities.

In the Member's Rights area, the auditors found the plan lacked a comprehensive written program to ensure privacy and safety of protected health information. The plan also lacked a procedure to inform staff and providers that the DHCS Privacy Officer must be notified in the event of an actual or suspected breach of protected health information. Auditor recommendations indicated CalOptima should correct the system deficiency to ensure the DHCS would be notified of actual or suspected breaches of personal health information. CalOptima was also encouraged to advise plan staff and providers of their responsibility to notify DHCS of such breaches. CalOptima did not correct this deficiency during the corrective action plan period (45 days after the April 3, 2006, Exit Conference) to the satisfaction of the auditors by submitting a print screen of their website section for providers and a revised HIPAA Privacy Program. The auditors recommended that CalOptima revise their privacy program to include timelines for notifying the DHCS Privacy Officer and for submitting a written report of investigation to same. The plan corrected deficiencies during the 120-day corrective action plan follow-up period.

The Quality Management survey showed the plan's contract and policies require that the plan assess, monitor, evaluate, and take effective action to improve the quality of care and services. However, the auditors found inconsistencies in these activities such as the Quality Improvement Committee not consistently monitoring care and services rendered by the delegated health network. Further, none of the delegated activities reviewed were summarized and reported to the Board of Directors. This was a repeat non-compliance from the June 2003 final report.

Auditors recommended that the plan reconcile policy and procedure documents to establish consistency and revise the Quality Improvement Program to address repeated noncompliance issues, resolve identified deficiencies, and demonstrate a proactive approach to improving health care outcomes. The plan did develop goals for improving quality indicators, but needed more time to develop and implement the recommended policies. The plan was not able to totally correct the deficiencies by the end of the 45-day corrective action plan period, but did fully correct the deficiencies during the 120-day corrective action plan follow-up period.

Another Quality Management issue identified was the plan's failure to provide requisite oversight of the credentialing process. Five network providers were not re-credentialed or scheduled to be re-credentialed within three years of their last credentialing date. Auditors recommended that the plan document: regular monitoring oversight of health network credentialing activities; consistent policies for all product lines; timely re-credentialing of providers consistent with written policy; and Peer Review recommendations for credentialing decisions. Although the plan was working on implementing the recommendations, CalOptima needed more time to complete the requested documentation. The plan was not able to totally correct the deficiencies by the end of the 45-day corrective action plan period, but did fully correct the deficiencies during the 120-day corrective action plan follow-up period.

Finally, auditors in the Quality Management area found inconsistencies in the plan's monitoring activities. Auditors recommended documenting consistent and regular oversight of each delegated health network for each delegated quality activity, for as long as such delegation is to remain in effect. Auditors also recommended that the plan document the Board of Directors' accountability for delegation oversight. Again, the issue was not completely resolved by end of the corrective action plan period, as the plan required more time to complete the recommended documentation. The plan fully corrected the deficiencies during the 120 corrective action plan follow-up period.

Sustainability of Quality Indicators

Sustainability of quality improvement correlates with a health plan's ability to bring about positive change in health care processes. For the purpose of this report, a plan's ability to achieve sustainability is generally categorized as follows:

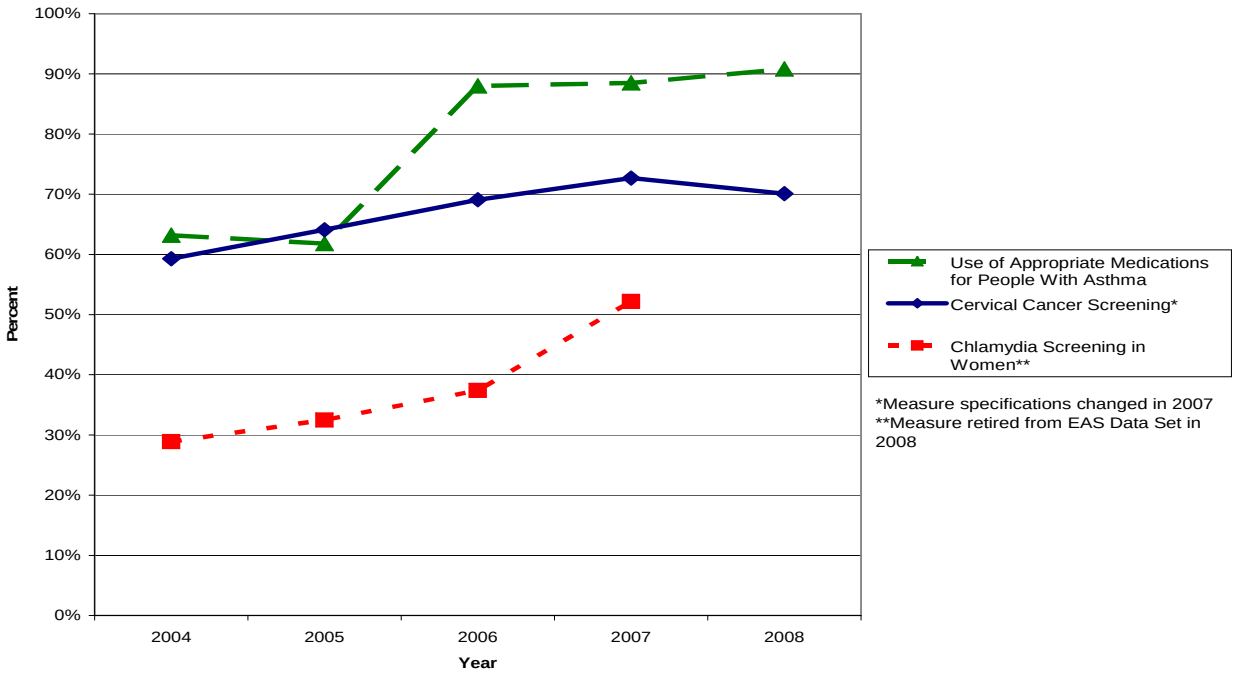
- Sustained improvement – performance level improves at some point and then levels off or continues to improve.
- Maintaining performance level – rates over multiple years reflect no meaningful change (generally a flat line).
- Declining – performance goes down.

Figure 1 shows the plan's sustainability of performance in a trending graph. Note that performance measurement results are trended when three or more years of data are available.

CalOptima rates showed sustained improvement for *Chlamydia Screening in Women* during the three-year measurement period. MMCD retired the *Chlamydia Screening in Women* measure in 2008.

There were HEDIS technical specification changes in 2006 for the *Use of Appropriate Medications for People With Asthma* measure, which resulted in more accurate identification of true asthmatics in the denominator. Likewise, in 2007, the *Cervical Cancer Screening* measure had specification changes. Both measures remained trendable over the four-year measurement period. CalOptima's rates showed sustained improvement for the *Use of Appropriate Medications for People With Asthma* measure. The plan showed consistent rate increases for the *Cervical Cancer Screening* measure until 2008, when the rate showed a slight decline. Overall, the plan has demonstrated sustained improvement for the *Cervical Cancer Screening* measure.

Figure 1. CalOptima's Sustainability of Quality of Care Indicators.



Grievance and Ombudsman Reports

The Medi-Cal Managed Care Division (MMCD) requires that contracted health plans maintain grievance systems as required by state law (California Code of Regulation Title 28, Section 1300.68). All grievances received by a plan—in writing or verbally—must be tracked in a grievance log. Plans submit quarterly reports to MMCD, as well as to the Department of Managed Health Care, with detailed information about pending grievances and those that were not resolved within 30 days (MMCD All Plan Letter No. 03-008).

MMCD's Office of the Ombudsman also provides assistance to members who have questions or problems related to provider and plan services, as well as other areas, such as Medi-Cal eligibility. The Office of the Ombudsman functions, in part, to help solve problems from a neutral standpoint to ensure that members receive all medically necessary covered services for which plans are contractually responsible. Complaints or issues that are not resolved immediately by the Office of the Ombudsman are entered into the Ombudsman Case Management System (OCMS) for tracking and follow-up. The Office of the Ombudsman also assists members who wish to request a formal hearing with the State Fair Hearings Board.

It should be noted that the DHCS monitors plans' quarterly grievance reports and MMCD Office of the Ombudsman monthly statistics in order to understand what aspects of provider and plan performance generate many or few grievances, calls, or requests for State Fair Hearings over time. Unusual patterns in grievances, calls, or hearing requests are discussed with plans when appropriate. The DHCS does not generally perceive any particular number of grievances, calls, or hearing requests as indicators of poor plan performance. Rather, these statistics are an ongoing indication of the degree to which plan members are using the various avenues available to them to ask questions or raise concerns about healthcare quality and plan service.

CalOptima's Grievance Reports

In 2006 and 2007, CalOptima reported a combined total of 1,538 grievances.

Office of the Ombudsman's Reports[7]

- 2006: 290 OCMS cases (9.4% of all cases; 1.235 cases per 1,000 members)
- 2006: 74 State Fair Hearings (7.7% of all cases; 0.315 cases per 1,000 members)
- 2007: 329 OCMS cases (7.2% of all cases; 1.408 cases per 1,000 members)
- 2007: 46 State Fair Hearings (9.4% of all cases; 0.197 cases per 1,000 members)

[7] OCMS cases and State Fair Hearings are presented as a percentage of all managed care plan cases and rates per 1,000 members.

Summary of Quality

Delmarva assessed CalOptima's quality of care in five ways: HEDIS performance measures, CAHPS survey results, QIPs, Medi-Cal audits, and sustainability of quality indicator results.

CalOptima scored equivalent to or better than the 2007 Medi-Cal managed care weighted average in all five of the quality domain HEDIS measures that could be compared. The plan scored better than the 2006 HEDIS national Medicaid average in four of the same five measures. CalOptima's 2007 rate was lower than the 2006 national benchmark for the measure *Appropriate Treatment for Children With Upper Respiratory Infection.*

In 2008, CalOptima's rates were equivalent to or higher than the 2008 Medi-Cal managed care weighted average and the 2007 HEDIS national Medicaid average.

CalOptima's 2007 composite scores for *Getting Needed Care* and *How Well Doctors Communicate* indicate adult members are less satisfied than the Medi-Cal managed care weighted average. Parent/guardian respondents appeared more pleased in both these composite areas than adult members.

CalOptima submitted a proposed QIP categorized in the quality domain—*Appropriate Treatment for Children with an Upper Respiratory Infection*. The proposal's goal was to increase the baseline rate for the measure by only 2.3 percentage points. Delmarva has encouraged CalOptima to select a more challenging goal in the future.

Medi-Cal audit findings revealed deficiencies in Member's Rights and Quality Management. Auditors provided recommendations for each deficiency. CalOptima partially corrected deficiencies during the 45-day corrective action plan period and fully corrected deficiencies during the 120-day corrective action plan follow-up period.

CalOptima demonstrated sustained improvement for the measures, *Use of Appropriate Medications for People With Asthma* and *Chlamydia Screening in Women*. The *Cervical Cancer Screening* measure showed a slight decline in its rate in 2008, but the plan has demonstrated overall sustained improvement for the *Cervical Cancer Screening* measure over the four-year measurement period.

Access to Care Assessment

One of MMCD's goals is to protect enrollee access to care. Access is an essential component of a quality-driven system of care. The findings with regard to access for CalOptima are presented in the following section.

2007 HEDIS Performance Measures Pertaining to Access

Delmarva used two HEDIS measures *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care* as indicators for access to care in this report. Table 4 shows CalOptima's 2007 results for these access-related HEDIS measures.

Table 4. 2007 HEDIS Access Measure Results Comparing CalOptima to State and National Programs.

2007 Access Measure	2007 CalOptima Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*
Adolescent Well-Care Visits	57.6%	36.9%	40.6%
Prenatal and Postpartum Care—Postpartum Care	59.8%	58.7%	57.0%
* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*.			

CalOptima reported rates higher than both the 2007 Medi-Cal managed care weighted average and the 2006 national Medicaid average for both the *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care* measures.

2008 HEDIS Performance Measures Pertaining to Access

Table 5 shows CalOptima's 2008 results for these access-related HEDIS measures.

Table 5. 2008 HEDIS Access Measure Results Comparing CalOptima to State and National Programs.

2008 Access Measure	2008 CalOptima Rate*	2008 Medi-Cal Managed Care Weighted Average*	2007 HEDIS National Medicaid Average*
Adolescent Well-Care Visits	56.3%	39.6%	43.7%
Prenatal and Postpartum Care—Postpartum Care	64.9%	59.1%	59.1%
* Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members*.			

CalOptima reported rates higher than both the 2008 Medi-Cal managed care weighted average and the 2007 national Medicaid average for both the *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care* measures.

CAHPS Survey Results Pertaining to Access

Delmarva chose the CAHPS composite, *Getting Care Quickly*, to represent the access domain of this report. The results of this composite are shown in Table 6 and discussed below.

Table 6. 2007 CAHPS Access Survey Results Comparing CalOptima to the Medi-Cal Managed Care Weighted Average .

CAHPS Composite	Population	2007 CalOptima Result	2007 Medi-Cal Managed Care Weighted Average*
Getting Care Quickly	Adult	44%	45%
	Child	37%	37%
	CSHCN†	39%	‡

* Medi-Cal average was calculated from scores of all contracted health plans and weighted to be proportionate to plan enrollment.
† CSHCN - Child with Special Health Care Needs.
‡ MCMC overall averages were not calculated for CSHCN members because they are subsets of the same sampling and data cannot be used due to possibility of double counting. Refer to Appendix B: CAHPS for further detail.

CalOptima's composite score for *Getting Care Quickly* showed 44 percent of adult members indicated they always received care quickly—slightly below the Medi-Cal managed care weighted average. Thirty-seven percent of parents/guardians of CalOptima's child members indicated their children always received care quickly. The child member composite score is equal to the Medi-Cal managed care weighted average.

Quality Improvement Projects

CalOptima engaged in two access-related Quality Improvement Projects (QIPs):

- *Improving Access to Adolescent Well-Care Visits*
- *Avoidable Emergency Room Visits*

Improving Access to Adolescent Well-Care Services

The plan developed this QIP as part of the statewide collaborative QIP on adolescent health.

- **Relevance:**

  In 2005, CalOptima's Medi-Cal HEDIS rate was 40 percent for the *Adolescent Well-Care Visits* measure. This rate was only slightly above the 2004 national Medicaid average of 37.4 percent, indicating improvement would be warranted in routine adolescent well-care services.

- **Goal:**

  Achieve a rate of 55 percent on the HEDIS *Adolescent Well-Care Visits* indicator by 2007.

- **Best Interventions:**
  - Members were given incentives for completed well-care exams, including a $20 gift card to Target for each parent and a $40 gift card raffle to a sports store for each adolescent.
  - Provided member education through collaboration with schools.

- **Outcomes:**
  - HEDIS *Adolescent Well-Care Visits*:
    - 2003 (Baseline): 43.06%
    - 2004 (Remeasurement 1): 40.05%
    - 2005 (Remeasurement 2): 55.09%
    - 2006 (Remeasurement 3): 57.64%

- **Attributes/Barriers to Outcomes:**
  - Barrier: Parent and teen reluctance and/or indifference to accessing healthcare for well visits.
  - Barrier: Lack of provider awareness.

CalOptima saw a 14.6 percent increase over baseline in the HEDIS *Adolescent Well-Care Visits* measure during the four-year study period.

Avoidable Emergency Room Visits

- ***Relevance:***

  CalOptima is participating in the statewide collaborative QIP on reducing avoidable emergency room (ER) visits. In 2006, 18.02 percent of the plan's ER visits were identified as avoidable.

- ***Goals:***
  - Decrease the rate of members seen in the ER to 31 visits per 1,000 member months by Remeasurement 1.
  - Decrease avoidable ER visits by five percent by Remeasurement 1.

- ***Best Interventions:***

  Collaborative interventions were being developed during this reporting period.

- ***Outcomes:***
  - HEDIS rate of members seen in the ER:
    - 2006 (Baseline): 33.89 visits per 1,000 member months
  - Rate of members seen in the ER with designated avoidable visits:
    - 2006 (Baseline): 18.02%

- ***Attributes/Barriers to Outcomes:***

  Attributes and barriers to outcomes were not available to Delmarva for validation in time to be included in this report.

The *Adolescent Well-Care* project was closed during 2007, and CalOptima began participating in a new statewide collaborative project, *Avoidable Emergency Room Visits,* during this reporting period.

Medi-Cal Audit Findings

The DHCS and the Department of Managed Health Care conducted a combined audit and routine medical survey on January 23 through January 26, 2006, that covered the audit period January 1 through December 31, 2005. Results for access-related issues are as follows:

- Continuity of Care
  - Tracking and follow up for Initial Health Assessments (IHAs) and Individual Health Education Behavioral Assessments (IHEBAs) was inadequate to ensure members receive these assessments within 120 days of enrollment.
- Availability and Accessibility
  - CalOptima delegates assessment of access and availability to the provider networks. Although the plan requires quarterly access and availability monitoring reports, there was no evidence that plan committees reviewed monitoring reports from delegated entities. Omissions in waiting-time standards and incomplete monitoring reports further indicated a lack of plan oversight.
  - Review of another delegated activity, payment of claims for out-of-plan emergency services, found that one provider network incorrectly denied 5 of 30 claims for "late filing dates" despite having been submitted within a year of the date of service.

In the Continuity of Care area, auditors found that tracking of IHAs and IHEBAs was inadequate to ensure that members received these assessments within 120 days of enrollment. Auditors recommended that CalOptima trend and analyze this assessment data and develop processes to ensure contractual requirements are met. Additionally, the plan needed to describe intervention steps for low assessment completion rates and to train staff in assessment requirements. The issue was not completely resolved during the 45-day corrective action plan period (45 days after the April 3, 2006, Exit Conference), but CalOptima fully corrected deficiencies during the 120-day corrective action plan follow-up period.

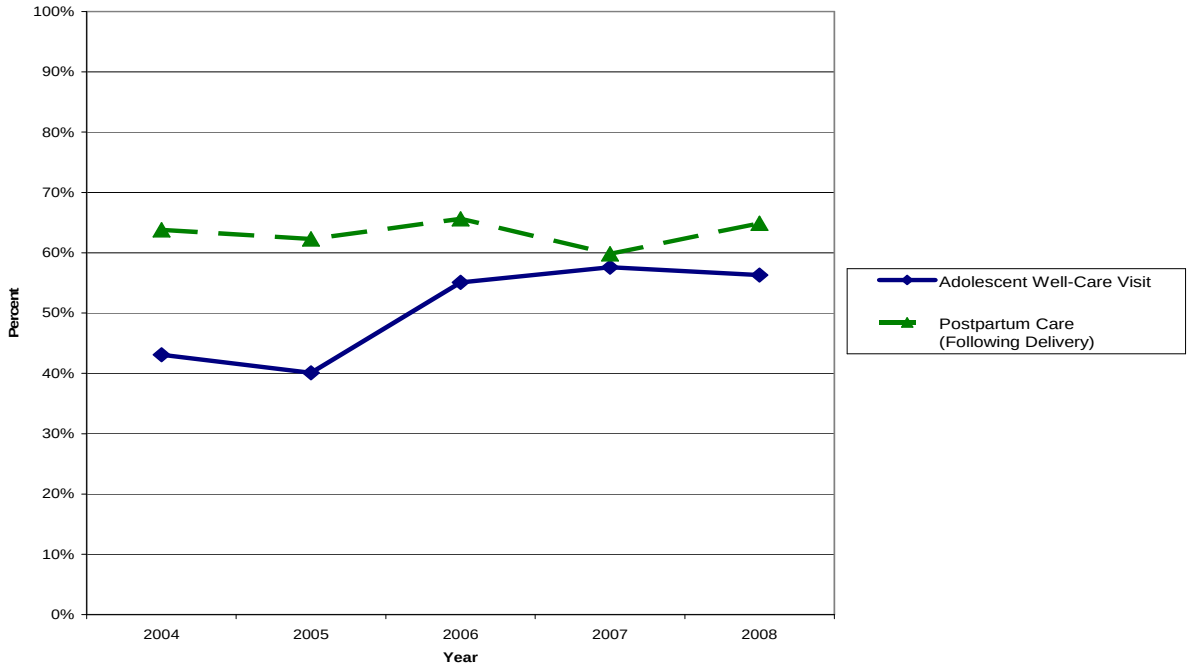
In the Availability and Accessibility area, auditors noted two issues—one related to monitoring wait times and the other involving payment of claims. Auditors recommended the plan revise policies and procedures to require more effective monitoring of wait times. Auditors noted that the plan needed more time to revise and implement the recommended policies and procedures. With regard to the late payment of claims issue, auditors recommended the plan improve oversight of payment issues. The issue was not resolved during the 45-day corrective action plan period as the plan needed to evaluate the effectiveness of their existing claim payment compliance monitoring activities. CalOptima fully corrected deficiencies during the 120-day corrective action plan follow-up period.

Sustainability of Access Measures

Sustainability of access measures indicates a plan's ability to improve and maintain improvement of enrollee access to health care services. Delmarva chose two measures to represent the access domain: *Prenatal and Postpartum Care—Postpartum Care* and *Adolescent Well-Care Visits*. Figure 2 charts the rates for those measures over a four-year period.

CalOptima's performance demonstrated an overall rate increase for the *Adolescent Well-Care Visits* measure. The 2008 rate for the measure was over 10 percent higher than the measure's 2004 rate. For the measure *Prenatal and Postpartum Care—Postpartum Care,* the plan's rates fluctuated over the measurement period. The plan has been unable to demonstrate sustained improvement for this access to care indicator.

Figure 2. CalOptima's Sustainability of Access to Care Indicators.



Summary of Access

Delmarva assessed CalOptima in five areas of the access domain: HEDIS performance measures, CAHPS survey results, QIPs, Medi-Cal audit findings, and sustainability of access indicator results.

CalOptima reported rates higher than both the state and national benchmarks for both the *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care* measures for both 2007 and 2008.

CalOptima's composite score for *Getting Care Quickly* showed that slightly fewer adult respondents indicated they always received care quickly than the Medi-Cal managed care weighted average. The CAHPS rate for parent/guardian respondents who indicated their children always received care quickly was equal to the managed care weighted Medi-Cal average.

The plan participated in two QIPs categorized in the access domain: *Improving Access to Adolescent Well-Care Services* and *Reducing Avoidable Emergency Room Visits*. Regarding the *Improving Access to Adolescent Well-Care Services* project, CalOptima reported a 14.6 percent increase over baseline in HEDIS *Adolescent Well-Care Visits* during a four-year study period. The plan's QIP, *Reducing Avoidable Emergency Room Visits*, is part of the statewide collaborative and was still in the baseline phase during the period covered by this report.

The Medi-Cal audit revealed plan deficiencies in the areas of Continuity of Care and Availability and Accessability. Auditors provided recommendations to CalOptima. The plan did not totally correct deficiencies during the 45-day corrective action plan period, but fully corrected deficiencies during the 120-day corrective action plan follow-up period.

In the sustainability area, CalOptima showed overall improved performance for the measure *Adolescent Well-Care Visits*. The plan has been unable to demonstrate sustained improvement for *Prenatal and Postpartum Care—Postpartum Care*.

Timeliness of Care Assessment

Access to necessary health care and related services alone is insufficient to advance the health status of Medi-Cal managed care enrollees. Timely delivery of those services is equally important. The findings related to timeliness are described in the following section.

2007 HEDIS Performance Measures Pertaining to Timeliness of Care

Delmarva included the five measures shown in Table 7 in the timeliness domain because each measure is associated with the receipt of services within a certain timeframe.

Table 7. 2007 HEDIS Timeliness Measure Results Comparing CalOptima to State and National Programs.

2007 Timeliness Measure	2007 CalOptima Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*
Breast Cancer Screening†	55.1%	48.6%	53.9%
Childhood Immunization Status—Combination 2	82.6%	77.9%	70.4%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.8%	79.4%	79.1%
Well-Child Visits in the First 15 Months of Life	68.1%	57.7%	48.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	81.2%	74.3%	63.3%

* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*.
† Due to significant changes in technical specifications, this measure is treated as a first-year measure in 2007. Because new MPLs and HPLs had not yet been established, the rate is displayed for informational purposes only and will not be compared to benchmarks.

CalOptima reported rates equivalent to or higher than both the 2007 Medi-Cal managed care weighted average and the 2006 HEDIS national Medicaid average for the four measures that can be compared.

2008 HEDIS Performance Measures Pertaining to Timeliness of Care

For the 2008 reporting year, Delmarva used the same measures to represent the timeliness domain and added a newly required measure, *Childhood Immunization Status—Combination 3*. Table 8 shows the results of the 2008 HEDIS timeliness measures.

Table 8. 2008 HEDIS Timeliness Measure Results Comparing CalOptima to State and National Programs.

2008 Timeliness Measure	2008 CalOptima Rate*	2008 Medi-Cal Managed Care Weighted Average*	2007 HEDIS National Medicaid Average*
Breast Cancer Screening	55.2%	50.4%	49.1%
Childhood Immunization Status—Combination 2	83.1%	80.1%	73.3%
Childhood Immunization Status—Combination 3†	76.9%	72.0%	60.6%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.0%	82.6%	81.2%
Well-Child Visits in the First 15 Months of Life	74.3%	60.2%	55.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	83.9%	75.8%	66.8%

* Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members*.
† 2008 is the first year MMCD required reporting of this measure. Because MPLs and HPLs had not yet been established, the rate is displayed for informational purposes only and will not be compared to benchmarks.

In the timeliness domain, CalOptima reported higher 2008 rates for all five measures than either benchmark.

CAHPS Survey Results Pertaining to Timeliness

Delmarva chose two CAHPS composites, *Courteous and Helpful Office Staff* and *Health Plan's Customer Service*, to represent the timeliness of care domain. The results of the composite scores are shown in Table 9, which is followed by a discussion of the results.

Table 9. 2007 CAHPS Timeliness Survey Results Comparing CalOptima to the Medi-Cal Managed Care Weighted Average.

CAHPS Composite	Population	2007 CalOptima Result	2007 Medi-Cal Managed Care Weighted Average*
Courteous and Helpful Office Staff	Adult	†	†
	Child	53%	52%
	CSHCN‡	58%	§
Health Plan's Customer Service	Adult	37%	45%
	Child	76%¶	79%
	CSHCN‡	59%¶	§

* Each Medi-Cal average is calculated from scores of all contracted health plans and weighted to be proportionate to plan enrollment.
† The composite *Courteous and Helpful Office Staff* was eliminated from the 2007 CAHPS Adult survey.
‡ CSHCN - Child with Special Health Care Needs.
§ MCMC overall averages were not calculated for CSHCN members because they are subsets of the same sampling and data cannot be used due to the possibility of double counting. Refer to Appendix B: CAHPS for further detail.
¶ The plan received <100 responses to some of the questions in this area, so this result is not statistically valid.

Fifty-three percent of CalOptima's parents/guardians of child members indicated that the office staff was always courteous and helpful, whereas the Medi-Cal managed care weighted average for this composite was 52 percent.

CalOptima adult members were less satisfied with their health plan's customer service than the Medi-Cal average, indicating some possible issues and areas for improvement. Delmarva will not discuss the Child Category results in the composite area, *Health Plan's Customer Service*, because the number of survey responses the plan received was too low to be statistically valid.

Quality Improvement Projects

CalOptima did not engage in any quality improvement projects categorized in the timeliness domain during this reporting period.

Medi-Cal Audit Findings

The DHCS and the Department of Managed Health Care conducted a combined audit and routine medical survey on January 23 through January 26, 2006, that covered the audit period January 1 through December 31, 2005. Audit findings identified as timeliness issues are outlined below.

- Utilization Management
  - Deficiencies in delegated prior authorization request processing included a lack of timely adjudication of requests, notification to members and providers of deferrals and denials, and physician review of all denials. Additionally, denial letters contained incorrect language and address information for State Fair Hearings.
  - The plan did not provide sufficient oversight to ensure that an adequate supply of drugs would be available to members in the event of an emergency and in sufficient qualities to last until members could obtain a prescription refill.
- Administrative and Organizational Capacity
  - The plan had no documentation to show that their 10 new providers had received Medi-Cal Managed Care training before they were placed on active status.

The first deficiency noted in Utilization Management (UM) was that of oversight of delegated UM activities. Although CalOptima had procedures for monitoring delegated UM, the above-identified deficiencies indicated inadequate implementation of such procedures. Auditors made a recommendation that would require all provider networks to adopt CalOptima's guidelines requiring physicians' review of all denials for medical necessity and non-covered benefits. The plan submitted proposed activities designed to correct the deficiency, but the auditors indicated that the CalOptima needed more time to implement these. As a result, the deficiency was not corrected during the 45-day corrective action plan period (45 days after the April 3, 2006, Exit Conference), but CalOptima fully corrected deficiencies during the 120-day corrective action plan follow-up period.

Additionally, in the Utilization Management area, auditors noted that the plan did not provide sufficient oversight to ensure that an adequate supply of drugs would be available to members in the event of an emergency and in sufficient qualities to last until members could obtain a prescription refill. Auditors recommended that the plan increase monitoring of this activity and ensure adequate supplies of medication. This was a repeat non-compliance issue from the previous audit, and the plan did not correct the deficiency the 45-day corrective action plan period. CalOptima fully corrected deficiencies during the 120-day corrective action plan follow-up period.

In regards to the Administrative and Organization Capacity issue identified, auditors indicated that some new providers had not had proper training and the plan's policy did not explain who was qualified to do the

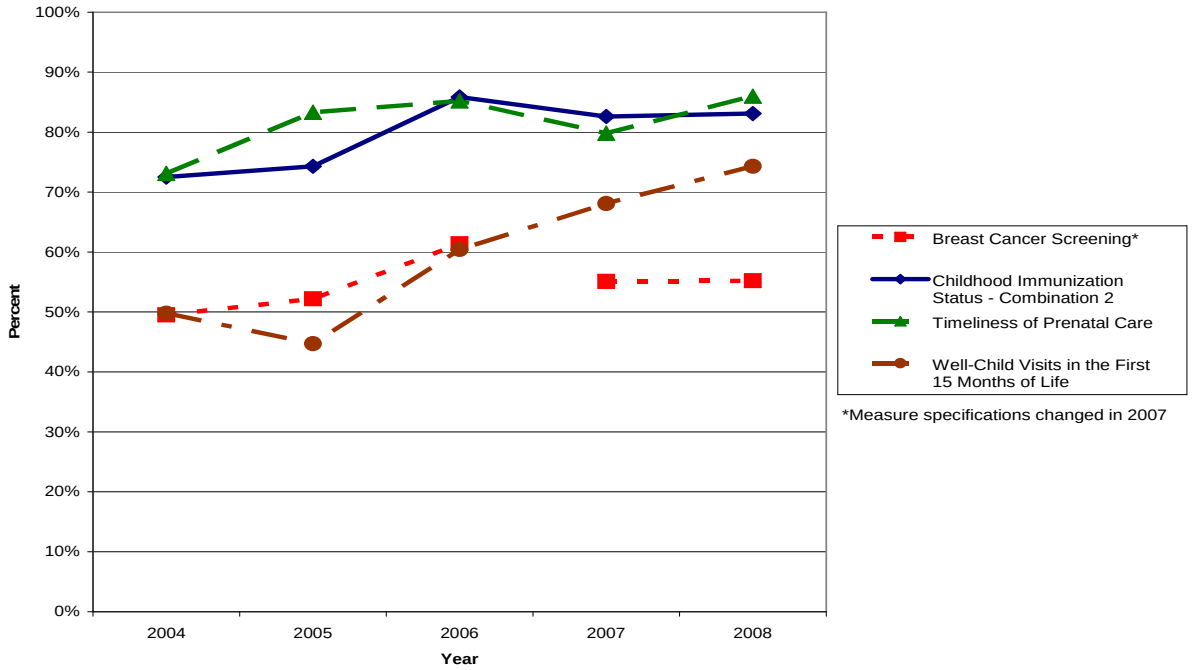
training, what topics were to be covered, or how compliance was to be monitored. Furthermore, the plan did not have a manual listing of policies, procedures, and services specific to Medi-Cal Managed Care. Auditors recommended that the plan should develop a provider manual that would include descriptions of these identified deficiencies. Although the plan did develop such a manual, it did not correct the deficiencies during the 45-day corrective action plan period and auditors indicated CalOptima needed more time to implement the identified training activities. CalOptima fully corrected deficiencies during the 120-day corrective action plan follow-up period.

Sustainability of Timeliness of Care Measures

Sustainability of timeliness relates to the plan's delivery of screening tests, preventive health visits, and/or preventive health procedures early enough to prevent the consequences of delayed care. Delmarva chose four measures to represent timeliness for this assessment. Figure 3 charts those measures.

Despite some fluctuation in the rates during the four-year reporting period, CalOptima demonstrated overall improvement in the indicators *Childhood Immunization Status—Combination 2, Prenatal and Postpartum Care—Timeliness of Prenatal Care,* and *Well-Child Visits in the First 15 Months of Life.* The plan's *Well-Child Visits in the First 15 Months of Life* rates showed an increase of over 25 percentage points from 2005 to 2008. The trend line for the *Breast Cancer Screening* measure is broken between 2006 and 2007 to reflect the substantive changes in the measure's 2007 technical specifications; therefore, Delmarva cannot determine sustainability of the *Breast Cancer Screening* rates over the measurement period.

Figure 3. CalOptima's Sustainability of Timeliness of Care Indicators.



Summary of Timeliness of Care

Delmarva assessed CalOptima's timeliness of care in four ways: HEDIS performance measures, CAHPS survey results, the Medi-Cal audit, and sustainability of timeliness indicator results.

CalOptima reported rates equal to or higher than both the state and national benchmarks for all four comparable measures in 2007 and for all five comparable measures in 2008.

For the CAHPS timeliness-related composites, CalOptima's parents/guardians of child members indicated that the office staff was always courteous and helpful at a rate one percent point higher than the Medi-Cal managed care weighted average. The plan's adult members were less satisfied with their health plan's customer service than the Medi-Cal average, indicating some possible issues and areas for improvement.

The Medi-Cal audit revealed plan deficiencies in Utilization Management and Administrative and Organizational Capacity, and auditors provided recommendations. Although the plan did not totally correct the deficiencies during the 45-day corrective action plan period, the plan fully corrected deficiencies during the 120-day corrective action plan follow-up period.

Finally, in the sustainability area, CalOptima demonstrated overall improvement in the indicators *Childhood Immunization Status—Combination 2, Prenatal and Postpartum Care—Timeliness of Prenatal Care,* and *Well-Child Visits in the First 15 Months of Life.* Delmarva could not determine sustainability for the *Breast Cancer Screening* measure due to substantive changes in the measure's 2007 technical specifications.

Comparison of CalOptima's 2007 and 2008 HEDIS Scores

CalOptima's 2007 and 2008 HEDIS rates are displayed in Table 10 and rate comparisons follow.

Table 10. Comparison of CalOptima's 2008 and 2007 HEDIS Performance Rates.

2008 Performance Measure	2008 CalOptima Rate*	2007 CalOptima Rate*
Childhood Immunization Status—Combination 2	83.1%	82.6%
Childhood Immunization Status—Combination 3†	76.9%	†
Well-Child Visits in the First 15 Months of Life	74.3%	68.1%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	83.9%	81.2%
Adolescent Well-Care Visits	56.3%	57.6%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.0%	79.8%
Prenatal and Postpartum Care—Postpartum Care	64.9%	59.8%
Breast Cancer Screening	55.2%	55.1%
Cervical Cancer Screening	70.1%	72.7%
Use of Appropriate Medications for People With Asthma	90.8%	88.5%
Appropriate Treatment for Children With Upper Respiratory Infection	83.2%	79.7%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis†‡	20.9%	†
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.4%	68.3%
Comprehensive Diabetes Care—HbA1c Testing	84.5%	83.8%
Comprehensive Diabetes Care—HbA1c Good Control (<7.0%)†	35.5%	†
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)†§	38.1%§	†
Comprehensive Diabetes Care—LDL-C Screening	82.8%	81.6%
Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)†	36.2%	†
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.7%	80.9%

2008 Performance Measure	2008 CalOptima Rate*	2007 CalOptima Rate*
Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months) †	322.73	†
Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months) †	36.16	†
Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months) †	3.65	†
Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months) †	0.87	†

* Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members.*
† 2008 is the first year MMCD required reporting of this measure. Because MPLs and HPLs had not yet been established, the rate is displayed for informational purposes only and will not be compared to benchmarks.
‡ 2007 and 2008 rates cannot be compared. The 2007 measure was called *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis,* and a lower score was better. The 2008 measure is called *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* and a higher score is better.
§ This measure represents poor diabetes control as measured by HbA1c levels. A lower number represents better diabetes control.

Due to 2007 specification changes, the plan's rates of *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* cannot be compared between reporting years 2007 and 2008. MMCD eliminated the *Chlamydia Screening* measure and instead required the *Ambulatory Care* measure in order to focus more on the entire Medi-Cal managed care population, including seniors and persons with disabilities. The *Ambulatory Care* measure provides utilization information across the whole spectrum of the population – from birth to 85+ years of age. Plus, this measure provides insight regarding emergency room (ER) use, which is an area of particular interest to MMCD because many members use the ER for avoidable visits and, as a result, may not be getting appropriate preventive care and follow-up care with chronic conditions. Rates for the four *Ambulatory Care* indicators are included for discussion purposes only. Conclusions should not be drawn regarding plan performance for these indicators as noted in the Table 10 footnotes.

CalOptima improved on 10 of the 14 HEDIS measures that could be compared between years:

- *Childhood Immunization Status—Combination 2*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Appropriate Medications for People With Asthma*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Screening*

CalOptima's rates remained relatively unchanged for two measures:

- *Breast Cancer Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

CalOptima's performance for two measures decreased:

- *Adolescent Well-Care Visits*
- *Cervical Cancer Screening*

Comparison of 2007 and 2008 HEDIS Measures by Model Type

Medi-Cal beneficiaries receive their health care through three models of health care delivery—County Organized Health Systems (COHS), Two-Plan, and Geographic Managed Care (GMC).

- COHS plans are county-operated managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS.
- The Two-Plan model consists of two plan types: Commercial Plans (CPs), which are commercially-operated managed care plans; and Local Initiatives (LIs), which are community developed managed care plans operated as quasi-governmental agencies. In a Two-Plan model, county members choose between an LI and a CP. Enrollment is mandatory for specified beneficiaries.
- In the GMC model, enrollees choose from several commercially operated plans within a certain geographic area. Enrollment is mandatory for specified Medi-Cal beneficiaries.

CalOptima is contracted in Orange County as a COHS plan. Tables 11 (2007) and 12 (2008) show the ranking (1 through 5) of the five different plan types when HEDIS results were compared across plan types. Note that averages are not ranked (1 through 5) for measures where MPLs and HPLs were not applied in the reporting year.

Table 11. Comparison of 2007 Medi-Cal Managed Care Weighted Averages by Plan Type.

2007 Performance Measure	Plan Type Rate (ranking among plan types)				
	COHS*	CP†	LI†	GMC – N‡	GMC – S‡
Childhood Immunization Status—Combination 2	82.9% (1)	79.5% (3)	75.6% (4)	73.6% (5)	80.2% (2)
Well-Child Visits in the First 15 Months of Life	68.0% (1)	44.8% (5)	53.0% (3)	57.2% (2)	51.4% (4)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	76.3% (1)	73.6% (3)	74.6% (2)	70.3% (5)	72.5% (4)
Adolescent Well-Care Visits	47.8% (1)	36.8% (3)	34.0% (5)	36.7% (4)	37.8% (2)
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.0% (2)	81.4% (3)	77.5% (5)	77.9% (4)	82.6% (1)
Prenatal and Postpartum Care—Postpartum Care	64.3% (1)	56.6% (4)	58.7% (2)	58.5% (3)	53.8% (5)
Chlamydia Screening in Women	54.4% (3)	52.8% (4)	50.5% (5)	58.1% (2)	59.8% (1)
Breast Cancer Screening ¶	55.6%	42.8%	48.4%	47.8%	50.6%
Cervical Cancer Screening ¶	70.1%	65.7%	69.3%	62.9%	66.5%
Use of Appropriate Medications for People With Asthma	88.7% (1)	85.8% (4)	86.9% (2)	86.4% (3)	84.9% (5)
Appropriate Treatment for Children With Upper Respiratory Infection	81.3% (3)	74.5% (5)	79.3% (4)	84.8% (2)	85.1% (1)
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis §¶	71.0%	73.7%	70.2%	71.8%	64.6%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	68.7% (1)	54.6% (3)	45.5% (5)	54.2% (4)	56.9% (2)
Comprehensive Diabetes Care—HbA1c Testing	85.4% (1)	79.5% (2)	76.7% (4)	76.1% (5)	78.0% (3)
Comprehensive Diabetes Care—LDL-C Screening ¶	80.7%	74.5%	74.2%	71.4%	77.5%
Comprehensive Diabetes Care—Medical Attention for Nephropathy ¶	81.2%	75.4%	83.8%	77.7%	78.3%

Plan Model Definitions:
* County Organized Health System (COHS) – County-operated and managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS.
† Two-Plan consists of two plan types:
Commercial Plans (CPs) are commercially-operated managed care plans.
Local Initiatives (LIs) are community-developed managed care plans operated as quasi-governmental agencies.
Members choose between an LI and a CP. Enrollment is mandatory for specified beneficiaries.
‡ Geographic Managed Care (GMC) - Enrollees choose from several commercially-operated plans within a certain geographic area. Enrollment is mandatory for specified Medi-Cal beneficiaries.
§ For this measure, a lower score indicates better performance.
¶ Averages not ranked for measures where MPLs and HPLs are not applied in the reporting year.

- COHS plans ranked first of the five plan types in the following HEDIS measures:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Adolescent Well-Care Visits*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Use of Appropriate Medications for People With Asthma*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Comprehensive Diabetes Care—HbA1c Testing*

- COHS plans ranked second of the five plan types in the following HEDIS measure:
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

- COHS plans ranked third of the five plan types in the following HEDIS measures:
  - *Chlamydia Screening in Women*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*

- The COHS plan type has no measures in the fourth or fifth ranking of the five plan types.

Table 12. Comparison of 2008 Medi-Cal Managed Care Weighted Averages by Plan Type.

2008 Performance Measure	Plan Type Rate (ranking among plan types)				
	COHS*	CP†	LI†	GMC – N‡	GMC – S‡
Childhood Immunization Status—Combination 2	83.3% (1)	77.4% (3)	82.3% (2)	70.8% (5)	71.4% (4)
Childhood Immunization Status—Combination 3¶	77.4%	68.8%	73.6%	65.8%	62.8%
Well-Child Visits in the First 15 Months of Life	72.3% (1)	46.6% (5)	56.7% (2)	55.9% (3)	49.5% (4)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	78.9% (1)	75.1% (3)	76.1% (2)	69.1% (5)	73.1% (4)
Adolescent Well-Care Visits	48.4% (1)	38.8% (2)	38.4% (4)	38.7% (3)	37.1% (5)
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.2% (1)	83.1% (2)	81.9% (3)	81.7% (4)	80.8% (5)
Prenatal and Postpartum Care—Postpartum Care	66.9% (1)	57.4% (3)	59.1% (2)	54.8% (4)	52.0% (5)
Breast Cancer Screening	56.4% (1)	45.3% (5)	50.5% (3)	47.4% (4)	51.3% (2)
Cervical Cancer Screening	69.1% (2)	69.9% (1)	68.2% (3)	68.2% (3)	67.0% (4)
Use of Appropriate Medications for People with Asthma	90.1% (1)	88.8% (3)	89.0% (2)	86.6% (4)	85.1% (5)
Appropriate Treatment for Children With Upper Respiratory Infection	85.2% (3)	81.3% (5)	82.5% (4)	89.5% (1)	88.4% (2)
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis¶	26.1%	30.3%	28.4%	28.7%	26.5%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	69.6% (1)	58.2% (2)	52.0% (5)	56.2% (3)	52.4% (4)
Comprehensive Diabetes Care—HbA1c Testing	85.3% (1)	81.0% (4)	81.4% (2)	78.1% (5)	81.1% (3)
Comprehensive Diabetes Care—HbA1c Good Control (<7.0%)¶	39.7%	27.4%	31.0%	32.8%	32.1%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)§¶	35.5%	49.4%	43.1%	42.9%	45.5%
Comprehensive Diabetes Care—LDL-C Screening	81.3% (1)	76.4% (4)	77.4% (2)	72.0% (5)	77.0% (3)
Comprehensive Diabetes Care—LDL-C Control(<100mg/dL) ¶	40.0%	28.9%	32.9%	32.3%	40.6%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.0% (1)	77.7% (3)	76.9% (4)	75.1% (5)	78.8% (2)

2008 Performance Measure	Plan Type Rate (ranking among plan types)				
	COHS*	CP†	LI†	GMC– N‡	GMC– S‡
Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months) ¶	322.38	254.75	268.14	263.24	250.02
Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months) ¶	43.49	33.42	38.17	33.98	33.79
Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months) ¶	4.95	2.04	2.09	2.48	2.92
Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months) ¶	2.87	0.29	0.52	0.26	0.40

Plan Model Definitions:
* County Organized Health System (COHS) – County-operated and managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS.
† Two-Plan consists of two plan types:
Commercial Plans (CPs) are commercially-operated managed care plans.
Local Initiatives (LIs) are community-developed managed care plans operated as quasi-governmental agencies.
Members choose between an LI and a CP. Enrollment is mandatory for specified beneficiaries.
‡ Geographic Managed Care (GMC) - Enrollees choose from several commercially-operated plans within a certain geographic area. Enrollment is mandatory for specified Medi-Cal beneficiaries.
§ This measure represents poor diabetes control as measured by HbA1c levels. A lower number represents better diabetes control.
¶ Averages not ranked for measures where MPLs and HPLs are not applied in the reporting year.

- COHS plans ranked first of the five plan types in the following HEDIS measures:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Adolescent Well-Care Visits*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Breast Cancer Screening*
  - *Use of Appropriate Medications for People with Asthma*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Comprehensive Diabetes Care—HbA1c Testing*
  - *Comprehensive Diabetes Care—LDL-C Screening*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

- COHS plans ranked second of the five plan types in the following HEDIS measure:
  - *Cervical Cancer Screening*

- COHS plans ranked third of the five plan types in the following HEDIS measure:
  - *Appropriate Treatment for Children With Upper Respiratory Infection*

- The COHS plan type has no measures in the fourth or fifth ranking of the five plan types.

Comparison to Other National and California State Programs

In each of the quality, access and timeliness assessments provided earlier in this report, CalOptima's performance was compared with the Medi-Cal managed care weighted average and the national Medicaid average. This section provides two comparisons that have not been made elsewhere in this report—national commercial averages and the California Healthy Families Program averages. The Healthy Families Program, administered by the Managed Risk Medical Insurance Board, is a low cost health, dental, and vision coverage plan for uninsured children (up to age 19) of working families. In addition to the new rate comparisons, the Medi-Cal managed care weighted averages and the national Medicaid averages are provided in Tables 13 and 14.

Table 13. 2007 Performance Measurement Rates Comparing CalOptima to National and State Programs.

2007 Performance Measure	2007 CalOptima Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*	2006 HEDIS National Commercial Average*	2007 CA Healthy Families Average†
Childhood Immunization Status—Combination 2	82.6%	77.9%	70.4%	77.8%	79.2%
Well-Child Visits in the First 15 Months of Life	68.1%	57.7%	48.6%	71.0%	56.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	81.2%	74.3%	63.3%	64.4%	72.9%
Adolescent Well-Care Visits	57.6%	36.9%	40.6%	38.7%	43.5%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.8%	79.4%	79.1%	91.9%	‡
Prenatal and Postpartum Care—Postpartum Care	59.8%	58.7%	57.0%	81.5%	‡
Chlamydia Screening in Women	52.2%	52.8%	50.6%	34.9%	41.1%
Breast Cancer Screening§	55.1%	48.6%	53.9%	72.0%	‡
Cervical Cancer Screening§	72.7%	67.9%	65.0%	81.8%	‡
Use of Appropriate Medications for People With Asthma	88.5%	86.8%	85.7%	89.9%	94.0%
Appropriate Treatment for Children With Upper Respiratory Infection	79.7%	78.9%	82.5%	82.9%	83.1%
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis¶§	75.4%	71.0%	69.4%	66.1%	‡
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	68.3%	54.1%	48.6%	54.8%	‡
Comprehensive Diabetes Care—HbA1c Testing	83.8%	79.5%	76.2%	87.6%	‡
Comprehensive Diabetes Care—LDL-C Screening §	81.6%	75.9%	80.5%	92.3%	‡
Comprehensive Diabetes Care—Medical Attention for Nephropathy§	80.9%	81.0%	48.8%	55.1%	‡

* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members.*
† 2007 rates obtained from the Healthy Families Program at http://www.mrmib.ca.gov/MRMIB/quality_reports.html.
‡ Healthy Families did not report data on these measures.
§ Due to significant changes in technical specifications, MPLs and HPLs had not yet been established for 2007. The rate is displayed for informational purposes only and will not be compared to benchmarks.
¶ For this 2007 measure, a lower rate indicates better the performance. For 2008, this measure will be called *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* and a higher score will be better.

- The plan reported higher 2007 rates than all benchmarks for 4 of the 11 measures that could be compared:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Adolescent Well-Care Visits*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

- The plan had mixed results on several measures. CalOptima scored higher than 2007 Medi-Cal managed care weighted average and the 2006 HEDIS national Medicaid average, but scored lower than the 2006 national commercial average on the following measures:
  - *Well-Child Visits in the First 15 Months of Life*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Use of Appropriate Medications for People With Asthma*
  - *Comprehensive Diabetes Care—HbA1c Testing*

- CalOptima scored higher than the 2007 Medi-Cal managed care weighted average, but scored lower than the 2006 HEDIS national Medicaid average and the 2006 national commercial average on one measure:
  - *Appropriate Treatment for Children With Upper Respiratory Infection*

- CalOptima scored lower than the 2007 Medi-Cal managed care weighted average, but scored higher than the 2006 HEDIS national Medicaid average and the 2006 national commercial average on one measure:
  - *Chlamydia Screening in Women*

Table 14. 2008 Performance Measurement Rates Comparing CalOptima to National and State Programs.

2008 Performance Measure	2008 CalOptima Rate[a]	2008 Medi-Cal Managed Care Weighted Average[a]	2007 HEDIS National Medicaid Average[a]	2007 HEDIS National Commercial Average[a]	2007 CA Healthy Families Average[b]
Childhood Immunization Status—Combination 2	83.1%	80.1%	73.3%	79.8%	79.2%
Childhood Immunization Status—Combination 3[c]	76.9%	72.0%	60.6%	65.8%	73.4%
Well-Child Visits in the First 15 Months of Life	74.3%	60.2%	55.6%	72.9%	56.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	83.9%	75.8%	66.8%	66.7%	72.9%
Adolescent Well-Care Visits	56.3%	39.6%	43.7%	40.3%	43.5%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.0%	82.6%	81.2%	90.6%	(d)
Prenatal and Postpartum Care—Postpartum Care	64.9%	59.1%	59.1%	79.9%	(d)
Breast Cancer Screening	55.2%	50.4%	49.1%	68.9%	(d)
Cervical Cancer Screening	70.1%	68.7%	65.7%	81.0%	(d)
Use of Appropriate Medications for People with Asthma	90.8%	88.8%	87.1%	91.6%	94.0%
Appropriate Treatment for Children With Upper Respiratory Infection	83.2%	83.1%	83.3%	82.8%	83.1%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[e]	20.9%	28.4%	(e)	(e)	(d)
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.4%	58.1%	51.4%	54.7%	(d)
Comprehensive Diabetes Care—HbA1c Testing	84.5%	82.1%	78.0%	87.5%	(d)
Comprehensive Diabetes Care—HbA1c Good Control (<7.0%)[c]	35.5%	32.6%	N/A	41.8%	(d)
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)[c][f]	38.1%	42.6%	48.7%	29.6%	(d)
Comprehensive Diabetes Care—LDL-C Screening	82.8%	77.8%	71.1%	83.4%	(d)
Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)[c]	36.2%	34.2%	30.6%	43.0%	(d)
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.7%	78.3%	74.6%	79.7%	(d)

2008 Performance Measure	2008 CalOptima Rate[a]	2008 Medi-Cal Managed Care Weighted Average[a]	2007 HEDIS National Medicaid Average[a]	2007 HEDIS National Commercial Average[a]	2007 CA Healthy Families Average[b]
Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months)[c] [g]	322.73	271.57	317.97	296.73	(d)
Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months)[c] [g]	36.16	37.26	57.02	16.71	(d)
Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months)[c] [g]	3.65	2.58	5.30	10.49	(d)
Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months)[c] [g]	0.87	0.79	1.78	0.83	(d)

(a) Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members*.
(b) 2007 rates obtained from the Healthy Families Program at http://www.mrmib.ca.gov/MRMIB/quality_reports.html.
(c) Due to first-year reporting requirements, MPLs and HPLs were not established for 2008. The rate is displayed for informational purposes only and will not be compared to benchmarks.
(d) Healthy Families did not report data on these measures.
(e) 2007 and 2008 rates cannot be compared. The 2007 measure was called *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis,* and a lower score was better. The 2008 measure is called *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* and a higher score is better.
(f) This measure represents poor diabetes control as measured by HbA1c levels. A lower number represents better diabetes control.
(g) MMCD has yet to determine whether to apply an MPL or HPL to the *Ambulatory Care* measure. Scores are reported, but no conclusions should be drawn regarding plan performance in this area.

Plan performance of on newly required measures is not assessed because the first-year results are considered "baseline" results, and MMCD does not apply the MPLs or HPLs to these measures. In addition, the newly required *Ambulatory Care* indicators are not scored as percentages, but rather as utilization counts per 1,000 member months. MMCD has yet to determine whether to apply MPLs or HPLs to these measures.

- CalOptima's 2008 rates were equivalent to (within 0.1 percentage points) or higher than all benchmarks for 7 of 14 measures that could be compared:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Adolescent Well-Care Visits*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

- CalOptima had mixed results when comparing rates to benchmarks for the remaining 7 measures that can be compared. The plan scored higher than 2008 Medi-Cal managed care weighted average and the 2007 HEDIS national Medicaid average, but scored lower than the 2007 national commercial average on the following measures:
  - *Prenatal and Postpartum Care—Timeliness of Prenatal*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Use of Appropriate Medications for People with Asthma*
  - *Comprehensive Diabetes Care—HbA1c Testing*
  - *Comprehensive Diabetes Care—LDL-C Screening*

2007 Overall Strengths

- CalOptima rated better than the all benchmarks in 4 of 11 HEDIS measures that could be compared.

- CalOptima's CAHPS Child survey results were equal to or higher than the Medi-Cal average in the following composite areas: *Getting Needed Care, How Well Doctors Communicate, Getting Care Quickly,* and *Courteous and Helpful Office Staff.*

- CalOptima reported a 14.6 percent increase in *Adolescent Well-Care Visits* during its participation in a statewide collaborative aimed at improving these rates.

- In the sustainability area, CalOptima sustained or maintained performance for the following HEDIS measures: *Use of Appropriate Medications for People With Asthma, Chlamydia Screening for Women*, *Cervical Cancer Screening, Adolescent Well-Care Visits, Well-Child Visits in the First 15 Months of Life, Childhood Immunization Status—Combination 2,* and *Timeliness of Prenatal Care.*

2007 Recommendations

Delmarva's overall assessment of CalOptima in the areas of quality, access, and timeliness has identified an opportunity for improvement. Delmarva recommends that the plan focus on:

- Which factors may be causing CalOptima's adult respondents to rank the plan lower than the Medi-Cal average in the composite areas *Getting Needed Care, How Well Doctors Communicate,* and *Getting Care Quickly.*

2007 Summary

Both strengths and continued opportunities for improvement exist for CalOptima in the areas of quality, access, and timeliness. CalOptima performed well in several areas, including the HEDIS measures *Childhood Immunization Status—Combination 2, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, Adolescent Well-Care Visits, Chlamydia Screening in Women,* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.* Additionally, CAHPS survey results for CalOptima's parents/guardians' responses were equal to or higher than Medi-Cal managed care weighted averages in the composite areas *Getting Needed Care, How Well Doctors Communicate,* and *Getting Care Quickly,* and *Courteous and Helpful Office Staff.*

Delmarva recommends that CalOptima focus on adult enrollee perceptions in the composite areas *Getting Needed Care, How Well Doctors Communicate,* and *Getting Care Quickly.*

2008 HEDIS Measure Strengths

CalOptima's rates were equivalent to (within 0.1 percentage point) or higher than all benchmarks for 7 of the 14 measures that could be compared:

- *Childhood Immunization Status—Combination 2*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

2008 Recommendations

Delmarva makes no recommendations for CalOptima concerning 2008 HEDIS measure performance.

2008 Summary

Delmarva concludes that CalOptima is performing well in the area of 2008 HEDIS measures as presented in this report.

Appendix A: HEDIS®

HEDIS Background

The Healthcare Effectiveness Data and Information Set (HEDIS®)[8] is a nationally recognized, standardized set of performance indicators developed by the National Committee for Quality Assurance (NCQA). NCQA's Committee on Performance Measurement annually evaluates and makes collective decisions about the content of the measures and the entire HEDIS process. State governments, employer and business groups, payers, and consumers use the results of these measures. More than 90 percent of all national health plans use HEDIS to measure their performance on established dimensions of health care and plan services.

HEDIS data collection and validation is standardized across all plans. HEDIS methodology makes it possible to compare the performance of health plans to each other and to national benchmarks. Results are used to identify performance variances to help plans focus their quality improvement activities.

HEDIS Domains of Care

- NCQA assigns each of the technically-defined HEDIS measures (71 measures in 2007 and 70 measures in 2008) to one of eight domains of care:
  - Effectiveness of Care
  - Access/Availability of Care
  - Satisfaction with the Experience of Care (Adult and Child CAHPS)
  - Use of Services
  - Cost of Care
  - Health Plan Descriptive Information
  - Health Plan Stability
  - Informed Health Care Choices

[8] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

DHCS-Required Measures

2007 DHCS-Required HEDIS Measures

For the 2007 Reporting Year, the DHCS required plans to report on 12 selected HEDIS measures—including multiple indicators for *Comprehensive Diabetes Care* and *Prenatal and Postpartum Care*—for a total of 16 measurement indicators.[9]

- *Adolescent Well-Care Visits*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Breast Cancer Screening**
- *Cervical Cancer Screening**
- *Childhood Immunization Status—Combination 2*
- *Chlamydia Screening in Women*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Screening**
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy**
- *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis**
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Appropriate Medications for People With Asthma*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*

[9] The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 06-010, entitled "Quality and Performance Improvement Program Requirements for 2007."

* MPL/HPL were not applied to these measures in 2007.

2008 DHCS-Required HEDIS Measures

For the 2008 Reporting Year, the DHCS required plans to report on 12 selected HEDIS measures—including multiple indicators for *Ambulatory Care*, *Childhood Immunization Status*, *Comprehensive Diabetes Care,* and *Prenatal and Postpartum Care*—for a total of 23 measurement indicators.[10]

- *Adolescent Well-Care Visits*
- *Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months)**
- *Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months)**
- *Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months)**
- *Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months)**
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 2*
- *Childhood Immunization Status—Combination 3**
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Good Control (<7.0%)**
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)**
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Use of Appropriate Medications for People With Asthma*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*

The DHCS strives to select measures that gauge the quality of care provided to and access to care experienced by the largest segments of the Medi-Cal managed care population. The EQRO compiles and validates the measurement results from all the plans and communicates the results to the DHCS in an annual *Performance Measures for Medi-Cal Managed Care Members* report.

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[10] The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 07-013, entitled "Quality and Performance Improvement Program Requirements for 2008."

* MPL/HPL were not applied to these measures in 2008.

The *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members* and the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members* ("*Annual Performance Measures reports*"), provide the Medi-Cal managed care weighted average for each measure. The Medi-Cal managed care weighted average accounts for variation in membership across plans. The plans' HEDIS data processes are audited according to the protocols described in the *Annual Performance Measures reports*. CalOptima's rates in this plan report were taken from the *Annual Performance Measures reports*, as were the state and national benchmark rates used for comparison.

Performance Level Criteria

This report utilizes the following established benchmarks in assessing plans' performance on measures:

- Medi-Cal Managed Care Weighted Average (Same Year)
- National Medicaid Average (Prior Year)
- National Commercial Average (Prior Year)

The DHCS compares plan rates to Minimum Performance Levels (MPLs) and High Performance Levels (HPLs) for each measure to assess further program-wide quality of care and to identify specific health plan improvement needs. MPLs and HPLs are equal to the 25th and the 90th percentiles, respectively, of the 2006 and 2007 national Medicaid results. The performance benchmarks (MPLs and HPLs) were taken from NCQA's *Quality Compass* for the previous year.

The HPL rates help identify plans that outperform the national Medicaid 90th percentile from the previous year. The DHCS does not apply the MPL and HPL to the first-year scores reported for any measure since that rate establishes a "baseline." Similarly, the MPL and HPL are not applied in years when there were substantive changes to a measure's technical specifications, since making a comparison to the previous rate would be inappropriate.

Appendix B: CAHPS®

CAHPS Background

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] program is funded and administered by the U.S. Agency of Healthcare Research and Quality (AHRQ). AHRQ works closely with a consortium of public and private organizations to develop and support a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their health care experiences.

The CAHPS surveys capture members' ratings of health care experiences and probe those aspects of care for which members are the best, and sometimes, the only source of information. CAHPS results allow the DHCS to determine how well health plans are meeting their members' expectations and provide individual feedback to plans. This data-driven communication encourages health plan accountability and supports health plan efforts to develop and implement action plans for improving members' satisfaction with their healthcare and plan services. CAHPS results are presented and discussed in this report in relation to quality, access, and timeliness.

The DHCS generally has CAHPS surveys administered every two years. The survey discussed in this report was administered in 2007. Across all MCMC plans, a total of 38,824 adult surveys and 85,028 child surveys were mailed to members. A total of 12,985 adult members and 25,224 child members responded to this survey—a 35 percent and 30 percent adjusted response rate,[12] respectively.

CAHPS Measurements

During this reporting period, the 2007 CAHPS 4.0H Adult Medicaid Survey and the 3.0H Child Medicaid Survey were administered to members of the Medi-Cal Managed Care contracted health plans.

The 2007 Adult (4.0H CAHPS) survey consisted of 51 questions. The 51 questions were categorized into five major areas:

- Your Health Care in the Last 6 Months
- Your Personal Doctor
- Getting Health Care From Specialists
- Your Health Plan

[11] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

[12] The adjusted response rate for the category is calculated by dividing the total number of surveys completed by the difference between the number of surveys mailed and the number of surveys found to be ineligible.

- About You

The 2007 Child (3.0H CAHPS) survey consisted of 110 questions. The 110 questions were categorized into seven major areas:

- Your Child's Personal Doctor or Nurse
- Getting Health Care From a Specialist
- Your Child's Health Care in the Last 6 Months
- Specialized Services
- Your Child's Health Plan
- Prescription Medicines
- About Your Child and You

Survey results were divided into composite areas. The composite areas are used to report plan scores and are derived by combining similar questions. Composite areas include: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Courteous and Helpful Office Staff,* and *Customer Service.* As with other data sources used throughout this report, Delmarva assessed CAHPS scores using the quality, access, and timeliness framework. CAHPS composite scores were divided as follows:

- Quality
  - *Getting Needed Care*
  - *How Well Doctors Communicate*
- Access
  - *Getting Care Quickly*
- Timeliness
  - *Courteous and Helpful Office Staff*
  - *Customer Service*

Adult members were classified as those 18 years or older and child members were classified as those members 17 years or younger for survey purposes.

Medi-Cal Adult and Child overall averages were calculated from the ratings of all 30 contracts within the Medi-Cal managed care plans operating in the State of California and were weighted to be proportionate to plan enrollment. Delmarva employed a calculation method whereby a plan's result is considered indicative of high performance in a CAHPS composite area when 80 percent or more of the total responses for the composite area fall within the most positive response category (*i.e.,* definitely yes, always, etc.). It should be noted that this calculation method differs from the standardized scoring method established by NCQA. For future CAHPS surveys, California is likely to adopt NCQA's calculation methods, including scoring.

Sample Selection and Survey Methodology

Sample selection and survey methodology are summarized below:

Sample Groups

Surveyors pulled a random sample of eligible members from each managed care plan for participation in the survey.

Adult Sample

For each managed care plan, the CAHPS 4.0H adult survey sample was drawn first, employing the required sample size. An overall score was calculated for the adult population by collecting the results from all plans and weighting the results by each plan's population size relative to the total Medi-Cal managed care population.

Child Sample

The CAHPS 3.0H child survey sample was drawn second, employing the required sample size.

Children with Chronic Conditions and CSHCN Population

The Children with Chronic Conditions (CCC) supplemental sample is drawn from the set of prescreened members who were not already selected for the CAHPS 3.0H child survey sample. The CCC survey-based screening tool contains five questions representing five different health consequences. A child member is identified as having a chronic condition if all parts of the question for at least one of the specific health consequences are answered "Yes."

The CSHCN population consists of all child members identified as having a chronic condition, as defined by the parent's/guardian's responses to the CCC survey-based screening tool. The term "CSHCN" refers to all child members surveyed who met the criteria for Children with Special Health Care Needs. After Sample A was drawn, an oversample (Sample B) was drawn as required by NCQA sampling methodology. Sample B contains the CCC Measurement Set. These children were identified by the prescreening process described above. Therefore, it is important to note that the CCC population data set is a subset of Sample A/General Population and the CCC population may also have been included in the results for Sample B.

Calculating an overall score by collecting the results from all plans and weighting the results by plan population size could not be accomplished for the CSHCN population due to the selection methodology and possibility of "double counting." Overall, 31 percent of child members across all plans qualified as having special health care needs based on parent's/guardian's responses to the CCC screening tool.

References

42 Code of Federal Regulations, Section 438.240, Ch. IV (10–1–02 Edition). *Quality Assessment and Performance Improvement Program.*

42 US Code, Section 1396u-2(c)(2), *State Option to Use Managed Care—Use of Medicaid Managed Care Organizations and Primary Care Case Managers.* Retrieved August 1, 2008, from website: http://www.socialsecurity.gov/OP_Home/ssact/title19/1932.htm.

Agency for Healthcare Research and Quality (2007). *National Healthcare Disparities Report.* Retrieved August 4, 2008, from website: http://www.ahrq.gov/qual/nhdr07/Chap3.htm.

Agency for Healthcare Research and Quality (2007). *National Healthcare Quality Report.* Retrieved June 24, 2008, from website: http://www.ahrq.gov/qual/nhqr07/Chap4.htm.

California Code of Regulations, Title 28, Section 1300.68, *Grievance System.*

California Department of Health Care Services. *2006-2007 QIPs Quarterly Status Reports.* Retrieved October 17, 2008, from website: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx, subheading: Quality Improvement Project (QIP) Reports.

California Department of Health Care Services. *Quality and Performance Improvement Program Requirements for 2007* (issued November 30, 2006). Retrieved October 17, 2008, from website: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx, see All Plan Letter No. 06-010.

California Department of Health Care Services. *Quality and Performance Improvement Program Requirements for 2008* (issued September 25, 2007). Retrieved October 17, 2008, from website: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx, see All Plan Letter No. 07-013.

California Department of Health Care Services. *Quarterly Submission of Grievance Logs* (issued July 7, 2003). Retrieved October 17, 2008, from website: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx, see All Plan Letter No. 03-008.

California Department of Health Care Services. *Report of the 2006 Performance Measures for Medi-Cal Managed Care Members, Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*, and *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members*. Retrieved August 12, 2008, from website: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx, see subheading: Performance Measurement (HEDIS) Reports.

California Department of Health Care Services. *Results of the 2007 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Medi-Cal Managed Care Health Plans*. Retrieved November 14, 2008, from website: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx, see subheading: Member Satisfaction Survey (CAHPS) Reports.

California Department of Health Care Services. *What is the Office of the Ombudsman?* Retrieved October 17, 2008, from MMCD Office of the Ombudsman webpage: http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx.

California Healthy Families, *HFP Quality (HEDIS) Reports*. Retrieved December 12, 2008, from website: http://www.mrmib.ca.gov/MRMIB/quality_reports.html, subheading: 2007 Quality Measurement (HEDIS) Report.

Centers for Medicare and Medicaid Services, Definition of "Quality." Retrieved August 1, 2008, from website: http://www.cms.hhs.gov/apps/glossary.

Centers for Medicare and Medicaid Services, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)* (2003). Retrieved June 23, 2008, from website: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac, see subheading: Overview / Tools Tips and Protocols.

National Committee for Quality Assurance (2007), *Standards and Guidelines for the Accreditation of Managed Care Organizations*. Quality Improvements 5: Accessibility of Services.