Performance Evaluation Report

CalOptima

July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
Health Care Services

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1. EXECUTIVE SUMMARY

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.4 million beneficiaries in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008—June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report. The plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains. This report is specific to the MCMC Program's contracted plan, CalOptima (or "the plan").

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

The DHCS uses performance measures and QIP results to assess care delivered to members by a plan in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, the DHCS monitors aspects of a plan's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPL indicate low performance, rates at or above the HPL indicate high performance, and rates at the MPL or between the MPL and HPL demonstrate average performance.

Based on the plan's 2009 performance measure rates (which reflect 2008 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement, HSAG found that CalOptima demonstrated average to above-average performance for the quality domain of care.

CalOptima achieved rates above the MCMC-established MPL for all of its performance measures, with two measures exceeding the HPL.

During the review period, CalOptima's *Appropriate Treatment for Children with an Upper Respiratory Infection (URI)* QIP showed a statistically significant increase for one of its study indicators, which increased the percentage of children 3 months to 18 years of age who received appropriate treatment for a URI in the first remeasurement period.

CalOptima's strengths in delivering quality care to members included its rate for *Adolescent Well-Care Visits (AWC)*, for which the plan had the highest rate of all MCMC Program plans in 2009.[1] The plan exceeded the HPL for both the *Childhood Immunization Status—Combination 3 (CIS)* and the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* measures. The plan

[1] California Department of Health Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program*. July 2010.

also demonstrated an increase in appropriate treatment of URI and adults with acute bronchitis. CalOptima was compliant with the majority of compliance review standards in the area of quality management.

CalOptima can improve the quality of care for its Medi-Cal managed care members by increasing its performance measure rates on prenatal and postpartum care. These rates were below the MCMC Program average in 2009, had statistically significant decreases from the previous year, and are at risk for falling below the MPL in future years.

HSAG noted that the plan has an opportunity to improve its documentation of both QIPs to meet compliance with federal requirements for conducting a QIP. By following the Centers for Medicare & Medicaid Services (CMS) protocol for conducting a QIP, the plan increases the likelihood that it will achieve real and sustained improvement of health outcomes.

CalOptima has an opportunity to provide increased oversight of its delegated entities. Most deficiencies noted from both the joint audit and the Member Rights/Program Integrity Unit (MRPIU) review were related to issues with delegated entities and/or lack of the plan's oversight. The plan needs to incorporate monitoring of its delegated entities within its quality improvement program.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members.

The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

CalOptima demonstrated average performance for the access domain of care based on its 2009 performance measure rates that relate to access, QIP outcomes that address access, and compliance review standards that relate to the availability of and access to care.

CalOptima's 2009 performance measures related to access fell primarily between the MPLs and HPLs. The plan exceeded the HPLs for *Childhood Immunization Status—Combination 3 (CIS–3*) and *Well-Child Visits in the Fourth, Fifth, and Sixth Years of Life (W34).*

Joint audit findings showed CalOptima provided adequate monitoring of its delegated providers for coordination of care. The plan had policies and procedures and memorandums of understanding in place to facilitate coordination of the carved-out services provided through the California Children's Services (CCS) program, as well as the required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and services for persons with disabilities. The audit showed that CalOptima had procedures in place to monitor access to care for routine, urgent, and emergent care, and has standards for network adequacy.

The plan has an opportunity to improve access to care for members by ensuring that all members receive initial health assessments and individual health education behavioral assessments within 120 days of enrollment. The plan needs to incorporate standards for waiting time in provider offices, time to answer the telephone, and time to return member telephone calls. Based on sliding performance for prenatal and postpartum care, CalOptima has an opportunity to explore any access-related factors that may contribute to the decreased performance.

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on the clinical urgency of the situation, minimize any disruptions to care, and provide a health care service quickly after a need is identified.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess a plan's compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

Based on 2009 performance measure rates for providing timely care and compliance review standards related to timeliness, CalOptima demonstrated average performance in the timeliness domain of care.

The plan performed within the MCMC-established thresholds for well-child visits, prenatal and postpartum visits, and childhood immunizations in the timeliness domain of care.

Joint audit review and MRPIU review findings noted several opportunities for improvement for CalOptima related to oversight of its delegated entities, specifically providing members with a notice of action within the required time frames, as well as including all information related to members' rights.

Conclusions and Recommendations

Overall, CalOptima demonstrated average to above-average performance in providing quality care to Medi-Cal managed care members and average performance in providing accessible and timely health care services to its members.

CalOptima's performance measure rates primarily were between the MCMC-established MPLs and HPLs. CalOptima exceeded the HPL for its *Childhood Immunization Status—Combination 3(CIS)* measure and its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*. The plan had no measures below the MPL for the current or previous year. The plan's rate for prenatal and postpartum care showed the greatest opportunity for performance measure improvement.

The plan had a statistically significant increase for one of its URI QIP study indicators, which demonstrated an increase in appropriate treatment for URI. The plan has an opportunity to improve documentation of its QIPs to meet CMS requirements.

CalOptima demonstrated compliance with most DHCS standards for structure and operations, as well as quality measurement and improvement. The plan had opportunities for improvement related to member rights, availability and accessibility, and the grievance system.

Based on the overall assessment of CalOptima in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- Explore factors contributing to decreased performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* and *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)* measures and implement strategies to improve these rates.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance toward increasing compliance with the CMS protocol for conducting QIPs.
- Increase oversight of the plan's delegated entities by formalizing a process of monitoring within the quality improvement program and work plan.
- Address and monitor deficient areas noted in the audits until fully corrected.
- Incorporate standards for waiting time in the providers' offices, time to answer the telephone, and time to return member telephone calls.

In the next annual review, HSAG will evaluate CalOptima's progress with these recommendations along with its continued successes.

Plan Overview

CalOptima is a full-scope Medi-Cal managed care plan operating in Orange County. CalOptima delivers care to members as a County Organized Health System (COHS). CalOptima began contracting with the MCMC Program in October 1995. As of June 30, 2009, CalOptima had 334,485 enrolled members.[2]

In a COHS model, the DHCS contracts with a county-organized and county-operated plan to provide managed care services to all Medi-Cal beneficiaries in the county, except for those in a few select aid codes. These mandatory members do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the DHCS. Beneficiaries enrolled in the COHS plan can choose from a wide range of managed care providers in the plan's network.

[2] *Medi-Cal Managed Care Enrollment Report, June 2009*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process to assess plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about CalOptima's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

The DHCS's Audits and Investigations (A&I) Division works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, the DHCS's A&I Division periodically conducts non-joint medical audits of five MCMC plans; however, CalOptima is not among those plans designated for a non-joint medical audit.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. The joint audit for CalOptima was conducted in May 2009; however, the DHCS was not able to provide results at the time of this review.

The previous joint audit occurred in January 2006. Results revealed that CalOptima was compliant with many areas covered under the scope of the audit; however, there were also some noncompliant findings.

Under the utilization management (UM) category of review, CalOptima demonstrated a UM program that uses written criteria to determine medical necessity. CalOptima reviews and updates the criteria annually. The plan had mechanisms to assess under- and over-utilization of services. One of CalOptima's delegated providers had deficiencies with prior authorization request processing related to timely adjudication of requests, notification to members and providers of deferrals and denials, and physician review of all denials. Additionally, the denial letters contained incorrect language and address information for State fair hearings. The audit also showed that the plan did not monitor the provision of an adequate supply of medication to members in emergency situations.

CalOptima monitored its delegated providers for continuity and coordination of care through the use of facility site reviews, annual evaluation of its program and work plan, and grievance information. The plan had policies and procedures and memoranda of understanding in place to facilitate coordination of California Children's Services, early interventions services, and services for persons with disabilities. The audit found that the plan was not compliant with providing an initial health assessment to all members within 120 days of enrollment, a repeat finding from the previous audit.

Under the availability and accessibility of services category, CalOptima delegates assessment of access to its health networks; however, the plan was unable to show adequate oversight of its delegated entities. Additionally, the audit found that one of its delegated entities denied some out-of-plan emergency services for late filing even though providers submitted them within an appropriate time frame.

While CalOptima had a notice of privacy practices, the audit found that the plan lacked documentation explaining how it or its contracted providers should notify the privacy officer of a breach of personal health information and notify the DHCS.

Under the quality management category, the audit revealed that CalOptima lacked monitoring and oversight of its delegated providers within its quality management program. In addition, the plan lacked appropriate oversight for credentialing of its delegated entities.

Audit findings showed that CalOptima lacked documentation that newly contracted providers received MCMC training. The plan's policy did not indicate who was qualified to do provider training, the topics covered as part of the training, or how compliance was monitored.

Member Rights and Program Integrity Monitoring Review

The Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These reviews are done before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

MRPIU conducted an on-site review of CalOptima in February 2009, covering the review period of January 1, 2008, through December 31, 2008.

MRPIU found CalOptima to be fully compliant with the requirements reviewed for member grievances, cultural and linguistic services, and fraud and abuse. The review identified four findings related to prior authorization notifications and member services.

Under the prior authorization notifications, MRPIU found that four of six files reviewed from a specific delegated entity lacked a notice of action. Three of those six files were missing the "Your Rights" attachment, an MCMC requirement. Additionally, not all prior authorization files met the required time frame for notification to the enrollee within 14 calendar days.

MRPIU noted that CalOptima's Evidence of Coverage lacked required information about organ donation.

Strengths

CalOptima demonstrated compliance with many areas covered by both the joint audit and the MRPIU review. CalOptima was fully compliant with all requirements for member grievances, cultural and linguistic services, and fraud and abuse. The plan has taken action to correct noncompliant areas identified for corrective action.

Opportunities for Improvement

CalOptima has an opportunity to provide increased oversight of its delegated entities. Most deficiencies noted on both the joint audit and MRPIU review were related to issues with delegated entities and/or lack of the plan's oversight.

Audit findings impacted all domains of care for quality, access, and timeliness; however, the majority fell under timeliness. The plan has an opportunity to ensure compliance with providing a notice of action to members within the required time frames, as well as including all information related to members' rights. CalOptima needs to incorporate monitoring of its delegated entities within its quality management program for all aspects of delegation, including availability and access to care, credentialing of providers, and prior authorization notifications.

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provides a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about CalOptima's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™[3] of CalOptima in 2009. HSAG found all measures to be reportable and that CalOptima's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit included more thorough encounter data tracking in order to provide better insight into data completeness. Additionally, CalOptima should take steps to reconcile the disposition of rejected encounters.

[3] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance Audit™ is a trademark of the NCQA.

Performance Measure Results

The table below presents a summary of CalOptima's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the national Medicaid 10th percentile.

Appendix A includes a performance measure name key with abbreviations contained in the following table.

Table 4.1—2008–2009 Performance Measure Results for CalOptima

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	20.9%	24.1%	★★	↑	20.6%	35.4%
ASM	Q	90.8%	90.2%	★★	↔	86.1%	91.9%
AWC	Q,A,T	56.3%	56.3%	★★	↔	35.9%	56.7%
BCS	Q,A	55.2%	56.2%	★★	↔	44.4%	61.2%
CCS	Q,A	70.1%	74.3%	★★	↔	56.5%	77.5%
CDC–E	Q,A	70.4%	66.0%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	35.5%	34.0%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	38.1%	40.3%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	84.5%	83.2%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	36.2%	36.1%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	82.8%	81.2%	★★	↔	66.7%	81.8%
CDC–N	Q,A	80.7%	82.2%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	76.9%	79.1%	★★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	86.0%	76.7%	★★	↓	76.6%	91.4%
PPC–Pst	Q,A,T	64.9%	58.3%	★★	↓	54.0%	70.6%
URI	Q	83.2%	84.9%	★★	↑	79.6%	94.1%
W15	Q,A,T	74.3%	65.4%	★★	↓	44.5%	73.7%
W34	Q,A,T	83.9%	84.9%	★★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.
[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[5] Performance comparisons are based on the *z* test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, CalOptima demonstrated average performance, falling between the MPL and HPL for most of its reported performance measures in 2009. The plan exceeded the MCMC goal for two measures: *Childhood Immunization Status—Combination 3 (CIS)* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34).* The plan did not have below-average performance for any measures.

Strengths

CalOptima performed above the MCMC goal on the *Childhood Immunization Status—Combination 3 (CIS)* and the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* measures. While 2009 rates of both measures increased over the respective 2008 rate, neither increase was statistically significant. Additionally, CalOptima's rate for *Adolescent Well-Care Visits (AWC)* was only 0.4 percentage points below the HPL, and it outperformed all other Medi-Cal managed care plans.[4] All three of these measures span the domains of quality, access, and timeliness.

In addition, two measures showed statistically significant improvement—*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)* and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*, which demonstrated the plan's efforts to improve quality care.

Based on its 2008 and 2009 performance, CalOptima was not required to submit improvement plans since no measures fell below the MPL in either year.

Opportunities for Improvement

CalOptima had three measures with statistically significant decreases from the 2008 to 2009 HEDIS rate: *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre), Prenatal and Postpartum Care—Postpartum Care (PPC–Pst),* and *Well-Child Visits in the First 15 Months of Life (W15).*

CalOptima's rate for its *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* measure was only 0.1 of a percentage point above the 2009 MPL, which was 9.3 percentage points below its 2008 performance and presents a significant opportunity for improvement. Similarly, after a 6.6 percentage-point decrease for *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst),* the rate for this measure (58.3 percent) is only 4.3 percentage points above the 2009 MPL. CalOptima's performance may indicate the need to address issues in the area of prenatal and postpartum care since both scores are under the MCMC Program average, both had significant decreases from the prior year, and both are at risk of falling below the MPL.

[4] The California Department of Health Care Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program.* July 2010.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas.

HSAG reviews each QIP using CMS' validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about CalOptima's performance in providing quality, accessible, and timely care and services to its MCMC members. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

CalOptima had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. CalOptima's second project, an internal QIP, aimed to increase the appropriate treatment for children with upper respiratory infections (URIs).

Both QIPs fell under the quality domain of care, while the *Reducing Avoidable Emergency Room Visits* QIP also addressed the access domain of care. The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

To increase appropriate treatment for children with upper respiratory infection, the plan's URI QIP targeted providers in an effort to reduce antibiotics being prescribed for URI, which can lead to antibiotic resistance.

Quality Improvement Project Validation Findings

In the second half of 2008, the DHCS contracted with HSAG as its new EQRO. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

Table 5.1 summarizes the validation results for both of CalOptima's QIPs across CMS protocol activities during the review period.

Table 5.1—Quality Improvement Project Validation Results for CalOptima (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	100%	0%	0%
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	50%	29%	21%
IV.	Correctly Identified Study Population	17%	33%	50%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	33%	17%	50%
VII.	Appropriate Improvement Strategies	33%	50%	17%
VIII.	Sufficient Data Analysis and Interpretation	44%	6%	50%
IX.	Real Improvement Achieved	63%†	13%†	25%†
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements *Met*		**49%**		
Validation Status		***Not Applicable****		

‡ The QIP did not progress to this activity during the review period and could not be assessed.
* QIPs were not given an overall validation status during the review period.
† The sum may not equal 100 percent due to rounding.

CalOptima submitted baseline data for the ER QIP during the review period; therefore, the QIP has not progressed to the point of remeasurement and HSAG could not assess for real and sustained improvement. For the URI QIP, the plan submitted incomplete data for Study Indicator 1 and Baseline through Remeasurement 1 data for Study Indicator 2, which HSAG evaluated for real improvement. Next year, the plan will submit data for the second remeasurement period of the second indicator, and HSAG will access the measure for sustained improvement.

In general, plans found that HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the MCMC plans. Neither of CalOptima's QIPs validated during the review period fully met HSAG's requirements for compliance with CMS' protocol for conducting QIPs. Therefore, upon DHCS approval, HSAG provided CalOptima with an overall validation status of *Not Applicable* for both QIPs to allow the plan time to become oriented to HSAG's validation requirements and receive technical assistance and training.

Quality Improvement Project Outcomes

Table 5.2 shows CalOptima's baseline data for its ER QIP. The plan's goal was a reduction of 10 percent in its avoidable ER visit rate. The plan will submit its data for the first remeasurement period next year, at which time HSAG will assess for real improvement. For the URI QIP, HSAG was unable to assess the Study Indicator 1 data since the plan did not report a complete year of data. Both QIPs included the entire eligible population in the study.

Table 5.2—Quality Improvement Project Outcomes for CalOptima

QIP #1—Reducing Avoidable Emergency Room Visits				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	1 1/1/08–12/31/08	2 1/1/09–12/31/09	Sustained Improvement
Percentage of ER visits that were avoidable	16.1%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Appropriate Treatment for Children with an Upper Respiratory Infection				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/06–12/31/06	1 1/1/07–12/31/07	2 1/1/08–12/31/08	Sustained Improvement
1) Percentage of high-volume PCPs serving children prescribing an antibiotic for a URI for a member who is under 19 years of age	¥	¥	‡	‡
2) Percentage of children between 3 months and 18 years who received appropriate treatment for children with URI	79.7%	83.2%*	‡	‡
¥ Complete year of data was not reported. ‡ The QIP did not progress to this phase during the review period and could not be assessed. * Designates statistically significant improvement over the prior measurement period.				

To improve appropriate treatment for children with an upper respiratory infection, CalOptima participated as a collaborative partner with the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) and 16 other health plans to develop and disseminate an antibiotic awareness provider tool kit. In addition, CalOptima initiated plan-specific interventions such as mailing providers the names of patients with a URI diagnosis and for whom they may have inappropriately prescribed antibiotics.

CalOptima had a statistically significant increase from its baseline rate to its first remeasurement rate for the percentage of children who received appropriate treatment for a URI. The plan's participation in the small-group collaborative with concerted effort among plans and the California Medical Association may have increased CalOptima's likelihood of success.

For the statewide ER collaborative QIP, CalOptima implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. CalOptima identified that many of the avoidable ER visits were attributable to children with upper respiratory infections. The plan contends that the success of the URI QIP interventions will positively affect the avoidable ER visit rate.

Strengths

CalOptima demonstrated a good understanding of documenting support for its QIP topic selections by providing plan-specific data to support the selection of an actionable area in need of improvement. In addition, the plan showed real improvement with a statistically significant increase for one URI QIP study indicator that increased the percentage of children between 3 months and 18 years of age who received appropriate treatment for a URI in the first remeasurement period.

CalOptima's URI QIP also increased the plan's performance measure rate for *Appropriate Treatment for Children With Upper Respiratory Infection (URI),* which showed a statistically significant increase between HEDIS 2008 and HEDIS 2009 rates.

Opportunities for Improvement

CalOptima has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

The plan identified early in 2008 that its data systems did not provide timely ER data to its providers. The plan is still developing a timely data exchange and working to identify a hospital to participate in the pilot project focused on more timely coordination between the ER and the plan. The plan has an opportunity to fully develop and implement this intervention.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A.1––HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ASM	*Use of Appropriate Medications for People With Asthma*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–E	*Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed*
CDC–H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
CDC–H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC	*Comprehensive Diabetes Care—LDL-C Control*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*