Performance Evaluation Report

CalOptima

July 1, 2009–June 30, 2010

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

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] 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 the 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. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, CalOptima (or "the plan"), which delivers care in Orange County, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

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).

In a COHS model, the DHCS contracts with a county-organized and county-operated plan to provide managed care services to members with designated, mandatory aid codes. Under a COHS plan, beneficiaries can choose from a wide network of managed care providers. These members do not have the option of enrolling in fee-for-service (FFS) Medi-Cal unless authorized by the plan.

CalOptima began services under the MCMC Program in October 1995. As of June 30, 2010, CalOptima had 358,862 enrolled members under the MCMC Program.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2010*. 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 that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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 fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. A&I, MMU, and DMHC conducted a joint audit of CalOptima in May 2009 covering the review period of April 1, 2008, through March 31, 2009.[3] Under each area audited, HSAG lists the key findings, plan actions to address the findings, and the final outcome.

Utilization Management (UM)

The audit noted deficiencies and non-compliance with prior authorization Notice of Action (NOA) letter requirements based on a review of pharmaceutical denials. CalOptima did not include the name or contact information for the pharmacist that made the denial decision or the clinical reasons for the denial, in addition to other issues that did not meet DHCS's specifications for NOA letters. The plan was also cited for not including in its member handbook information regarding preventive services that do not require a prior authorization. The plan submitted corrective action plans, which included revised member handbook language and a revised NOA template. The DHCS considered both findings fully addressed when formally reporting the audit results in October 2009.

Continuity of Care

CalOptima did not perform adequate oversight of delegated networks to determine whether the California Children's Services (CCS) requirements were met and fully implemented. The audit also found that CalOptima needed to update its procedures for identifying CCS-eligible members. CalOptima's initial corrective action plan indicated that it was the plan's policy to waive review of certain areas if the delegate was NCQA accredited. The CAP was not accepted by the DHCS, as the DHCS does not allow the plan to waive delegation of these requirements; and additional actions were required. The plan fully addressed the other finding by updating the policy for identifying members eligible for CCS. CalOptima revised its policy for delegation oversight of CCS requirements, and the DHCS considered the issue fully resolved as of the March 2010 close-out letter date.

The plan also continued to struggle with completing initial health assessments (IHA) within 120 days of enrollment, a finding from the prior audit. To address the finding, CalOptima created a team to focus on improving IHA completion, which was accepted by the DHCS.

[3] *California Department of Health Care Services Medical Review – Northern Section, Audits and Investigations, CalOptima*, October 12, 2009.

Access and Availability

Audit findings in the area of access and availability were numerous.

The audit found that CalOptima was fully compliant with claims denial adjudication within contractually required time limits for emergency and family planning services, although some deficiencies were noted. Most deficiencies related to not notifying members of claim denials for emergency and family planning services and inconsistent information in policies and procedures related to reimbursement of non-contracted emergency room (ER) providers. In its corrective action plan, CalOptima staff members indicated that they disagreed with the findings related to the requirement to notify members of denial of services. The DHCS provided the plan with a response, clarifying the requirement for member notification and indicating that the deficiency was not corrected and still required resolution.

Although CalOptima monitored delegated networks to ensure compliance with wait time standards, the plan did not act upon deficiencies that were noted in its internal access study, including prenatal care standards. The plan addressed the finding by requiring corrective action plans (CAPs) from each delegated entity to resolve the deficiencies.

CalOptima demonstrated inconsistencies between the plan's policy and member handbook regarding urgent care appointments and the plan's guidelines for prenatal care visit scheduling exceeded the contract requirement. The plan addressed both of these findings by updating the member handbook and guidelines.

The plan exceeded the DHCS time and distance standard for primary care providers (PCPs) to members, and its internal standard was not consistent with contractual requirements. The audit team was also unclear how CalOptima monitored access to hospitals and identified a lack of hospital access in Orange County based on a review of the provider directory. The plan revised the standard and implemented a monitoring process for reasonable access to hospitals, which was accepted by the DHCS.

The plan had a repeat finding for its lack of monitoring network hospitals to ensure that members have access to medications in emergency situations. The DHCS approved the plan's CAP, which included a revised policy and monitoring of member complaints related to insufficient supplies of medications following an emergency situation.

Member Rights

A review of grievance records found that eight of 24 files lacked documentation of clinical review. The auditors also noted issues with the processing of potential quality of care cases, including incomplete documentation, lack of follow-up, and delays in sending grievance notification letters.

CalOptima's CAP was not initially accepted, and the DHCS required additional action related to presenting medically-related issues to the plan's Credentialing and Peer Review Committee.

The plan was also cited for an inconsistency with the policy for notifying members of a suspected breach of patient health information, which was resolved quickly.

Quality Management

CalOptima was fully compliant with quality management standards.

Administrative and Organizational Capacity

The audit found issues with the plan's failure to provide timely training on the Medi-Cal Managed Care Program to its providers, which was a repeat finding. The deficiency was sufficiently addressed by the plan upon completion of the DHCS's March 2010 close-out letter.

Fraud and Abuse

The audit found that CalOptima failed to notify the DHCS of potential fraud cases within the required time frame. The DHCS considered the findings fully addressed when reporting the audit results in October 2009.

Other Contract Requirements

In addition to A&I's joint medical performance audit, A&I audited CalOptima's compliance with the requirements of the plan's MCMC Hyde contract which covers abortion services funded only with State funds, as these services do not qualify for federal funding. The contract review period was April 1, 2008, through March 31, 2009.[4] CalOptima's policy indicated that any member seeking elective abortion services may use a provider designated by her delegated health network, rather than indicating that the member may choose from the network's qualified providers. The plan also showed a deficiency in the delegation oversight of a health network. CalOptima did not review the implementation of the network's policy for member self-referral to sensitive services because the network was an NCQA-accredited health plan. The DHCS provided the plan with a response, indicating that only oversight of provider credentialing can be waived based on accreditation; and the deficiency still required resolution.

[4] *California Department of Health Care Services Medical Review – Northern Section, Audits and Investigations, CalOptima Health Plan State Supported Services*, October 12, 2009.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's 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 member rights reviews are conducted 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 member rights 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, 2010.

MRPIU conducted a follow-up visit to CalOptima in April 2010 to evaluate progress made to address findings identified in the most recent monitoring review, completed in February 2009.

The February 2009 review covered the review period of January 1, 2008, through December 31, 2008. MRPIU found CalOptima to be fully compliant with most standards and requirements, with deficiencies identified in the areas of prior authorization notifications and member services. The follow-up visit focused on four findings and steps taken to resolve the deficiencies. MRPIU found that CalOptima fully addressed three of the four findings:

- Some prior authorization case files were missing the required "Your Rights" attachment upon the initial review. The follow-up review indicated this issue was fully addressed.
- A Notice of Action (NOA) letter was not always sent out within the required time frame by CalOptima and a delegated entity, based on initial review of prior authorization case files. The follow-up review indicated this issue was fully addressed.
- CalOptima's Evidence of Coverage documents did not include the required information about organ donation upon initial review. CalOptima resolved this finding promptly before the follow-up review by providing a supplemental document to be mailed with the Evidence of Coverage documents containing the information.

The fourth finding involved missing NOA letters within prior authorization case files. Upon the initial review, four of six files reviewed for one subcontractor were missing NOA letters. Upon follow-up, MRPIU found that for the same subcontractor, four of 17 files had missing NOA letters; and MRPIU required additional action to resolve this deficiency.

Strengths

CalOptima showed substantial progress with addressing and resolving nearly all medical performance review and MRPIU deficiencies.

Opportunities for Improvement

While the plan adequately addressed most of the medical performance review deficiencies, the plan misinterpreted the Health and Safety Code requirement for notifying the member of a claim denial. CalOptima should resolve the deficiency and ensure that staff is clear and familiar with all contract requirements.

CalOptima can strengthen its delegate oversight processes by ensuring that only review of provider credentialing functions is waived based on NCQA accreditation. CalOptima also has an opportunity to ensure subcontractor compliance with prior authorization notification requirements and should enhance its oversight of subcontractors by proactively monitoring them for compliance with its policies and procedures.

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 provide 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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of CalOptima in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[5] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

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

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (< 8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
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*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

The table below presents a summary of CalOptima's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, 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.

Table 3.2—2009–2010 Performance Measure Results for CalOptima—Orange County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	24.1%	21.8%	★★	↔	20.2%	33.4%
AWC	Q,A,T	56.3%	55.7%	★★	↔	37.9%	59.4%
BCS	Q,A	56.2%	58.0%	★★	↑	45.0%	63.0%
CCS	Q,A	74.3%	71.7%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	72.1%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	66.0%	70.1%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	62.3%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	40.3%	29.5%	★★	↑	50.6%	29.2%
CDC–HT	Q,A	83.2%	87.3%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	36.1%	45.5%	★★★	↑	27.2%	44.7%
CDC–LS	Q,A	81.2%	85.3%	★★★	↔	71.5%	82.5%
CDC–N	Q,A	82.2%	85.0%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	79.1%	82.4%	★★★	↔	62.4%	80.6%
LBP	Q	‡	77.8%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	76.7%	87.5%	★★	↑	78.5%	92.2%
PPC–Pst	Q,A,T	58.3%	68.0%	★★	↑	57.9%	72.7%
URI	Q	84.9%	89.1%	★★	↑	81.1%	94.5%
W34	Q,A,T	84.9%	86.1%	★★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	68.3%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	75.2%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	63.9%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-square 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 DHCS did not require plans to report this measure in 2009.
NA = The DHCS does not establish an MPL/HPL for first year measures.
★ = 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.
Not Comparable = Performance could not be compared due to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, CalOptima demonstrated average to above average performance, achieving the HPL in four measures and no rates falling below the MPL.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline steps to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans. CalOptima did not have any 2009 performance measure rates that required an improvement plan.

Strengths

CalOptima showed strong performance in children's immunizations, well-child visits, and diabetes LDL-C testing and control, exceeding the HPL. The plan exhibited exceptional performance in most of the diabetes indicators, with results that were either above or close to achieving the HPL. CalOptima attained statistically significant improvement in six measures over the 2009 results, including both prenatal care indicators, which, in the year prior, experienced lower performance and a decline in the postpartum care rate.

Opportunities for Improvement

CalOptima should closely monitor its performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure. This measure's performance declined compared with the 2009 result, although the decline was not statistically significant. The 2010 result is close to the MPL for the measure.

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 clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Quality Improvement Projects Conducted

CalOptima had two clinical QIPs in progress during the review period of July 1, 2009, through June 30, 2010. 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 project. CalOptima's second project, a small group collaborative, 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 to reduce the frequency of prescribing antibiotics to treat URIs, which can lead to antibiotic resistance.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both of CalOptima's QIPs across the CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for CalOptima—Orange County July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	76%	90%	*Partially Met*
	Resubmission	92%	100%	*Met*
Small-Group Collaborative QIPs				
Appropriate Treatment for Children With Upper Respiratory Infection	Annual Submission	97%	90%	*Partially Met*
	Resubmission	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the initial submission by CalOptima of both QIPs received an overall validation status of *Partially Met*. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted the QIPs and upon subsequent validation, achieved an overall *Met* validation status for both QIPs.

Table 4.2 summarizes the validation results for both of CalOptima's QIPs across the CMS protocol activities during the review period. The validation scores presented in Table 4.2 reflect the last submission validated before June 30, 2010.

Table 4.2—Quality Improvement Project Average Rates* for CalOptima—Orange County
(Number = 2 QIPs, 2 QIP Topics)
July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved†	63%	0%	38%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**88%**	**0%**	**12%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

† The sum of an activity or stage may not equal 100 percent due to rounding.

CalOptima demonstrated an excellent understanding of the design and implementation stages, scoring 100 percent on all evaluation elements. Conversely, for the outcomes stage, CalOptima scored lower in Activity IX for the lack of real improvement since two of the three study indicators did not demonstrate statistically significant improvement.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for CalOptima—Orange County (Number = 2 QIPs, 2 QIP Topics) July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period (1/1/07–12/31/07)**	**Remeasurement 1 (1/1/08–12/31/08)**	**Remeasurement 2 (1/1/09–12/31/09)**	**Sustained Improvement**
Percentage of avoidable ER visits	16.1%	16.7%*	‡	‡
QIP #2—Appropriate Treatment for Children with an Upper Respiratory Infection				
QIP Study Indicator 1	**Baseline Period (7/1/07–6/30/08)**	**Remeasurement 1 (7/1/08–6/30/09)**	**Remeasurement 2 (7/1/09–6/30/10)**	**Sustained Improvement**
Percentage of high-volume PCPs serving children not prescribing an antibiotic for a URI for a member who is under 19 years of age	90.0%	96.2%*	‡	‡
QIP Study Indicator 2	**Baseline Period (1/1/06–12/31/06)**	**Remeasurement 1 (1/1/07–12/31/07)**	**Remeasurement 2 (1/1/08–12/31/08)**	**Sustained Improvement**
Percentage of children between 3 months and 18 years who received appropriate treatment for children with URI	79.7%	83.2%*	84.8%*	Yes

*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05).
‡The QIP did not progress to this phase during the review period and could not be assessed.

For the statewide ER collaborative QIP, CalOptima implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. CalOptima experienced a statistically significant increase in the avoidable ER visits between baseline and the first remeasurement period, indicating a decline in performance. Since collaborative interventions were not initiated until 2009, HSAG could not evaluate the effectiveness of those interventions.

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 for whom they may have inappropriately prescribed antibiotics. For the URI QIP, the plan reported Remeasurement 1 data for the first study indicator and Remeasurement 2 data for the second study indicator. The first study indicator demonstrated a statistically significant increase in the number of high-volume providers not prescribing antibiotics for members with a URI, which was an improvement in performance. For the second study indicator, the plan experienced statistically significant improvement from Remeasurement 1 to Remeasurement 2 and sustained improvement from baseline to Remeasurement 2.

Strengths

CalOptima displayed an excellent understanding of the design and implementation stages and received *Met* scores for all evaluation elements. Although the plan achieved these scores with the benefit of the *Reducing Avoidable Emergency Room Visits* QIP resubmission, the scores demonstrated a compliance with the recommendations provided in the QIP tool.

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. Additionally, the improvement was sustained from baseline through the second remeasurement period.

Opportunities for Improvement

To address the decline in performance for the *Reducing Avoidable Emergency Room Visits* QIP and the first study indicator for the URI QIP, HSAG recommends that CalOptima conduct, at minimum, annual causal-barrier and subgroup analyses to determine why and for what groups the current interventions did not produce improvement in Remeasurement 1.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[6]

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS Surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about CalOptima's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

Table 5.2—CalOptima—Orange County
Medi-Cal Managed Care County-Level Global Ratings

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★★★	★
Child	★★★	★★★	★★★★★	★★★★+

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.3—CalOptima—Orange County
Medi-Cal Managed Care County-Level Composite Measures

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★★	★	★★	★+	★★
Child	★+	★	★	★★+	★★★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

CalOptima performed well on the child global rating scores, with the *Rating of Personal Doctor* measure exceeding the highest performance threshold.

Opportunities for Improvement

CalOptima's CAHPS results showed primarily poor performance for all adult global rating categories except *Rating of Personal Doctor*. Child survey CAHPS results showed poor performance for three child composite ratings *(Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate)*. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as CalOptima's highest priority: *Customer Service, Getting Care Quickly,* and *Getting Needed Care*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 CalOptima CAHPS Plan-Specific Report*. Areas for improvement spanned the quality, access, and timeliness domains of care.

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 the results of performance measures and quality improvement projects (QIPs) 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. Finally, some member satisfaction measures relate to quality of care.

The plan showed average to above-average performance based on CalOptima's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, member satisfaction survey results, and the results of the medical performance and member rights reviews as they related to measurement and improvement. The plan attained the HPL on four measures (all of which impact quality) and showed statistically significant improvement on six.

CalOptima performed well on *Rating of Personal Doctor* in both adult and child surveys, with the child results exceeding the highest performance threshold. The plan met contractual standards that relate to quality, based on the medical performance and MRPIU reviews; however, the plan has an opportunity to implement ongoing monitoring of its grievances to ensure that its medical director reviews potential quality of care issues.

QIP results showed that the plan did well with documenting the QIP study design and implementation phases; however, the plan produced mixed results with QIP outcomes. The plan had good results with its URI QIP, achieving statistically significant improvement for one indicator and sustained improvement for the other indicator. The plan had a decline in performance in the collaborative QIP, although results for Remeasurement 2 are not yet available.

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 a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. 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.

The plan demonstrated average to below-average performance based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results. While performance measure results showed high performance in children's immunization and well-child visits (measures of access), the collaborative QIP showed a decline in performance for the first remeasurement period.

Member satisfaction related to access was low, as shown by the *Getting Needed Care* composite results.

For access-related compliance standards, several audit findings were noted. The plan experienced challenges with ensuring compliance of delegated networks with established wait times, exceeded the standard for time and distance for PCPs to members, and indicated a potential hospital access issue in Orange County. The plan also had deficiencies noted by both the medical performance review and the MRPIU review related to prior authorization notifications. While some of the findings were addressed, the DHCS determined that additional actions were needed to fully resolve the deficiencies.

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, to minimize any disruptions to care, and to 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 plans' 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.

CalOptima exhibited average to below-average performance in the timeliness domain of care based on 2010 performance measure rates for providing timely care, medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness.

Performance measure rates regarding timeliness showed that the plan performed above the HPL for childhood immunizations and had achieved statistically significant improvements for prenatal care indicators, both of which measure access.

Member satisfaction results showed that the plan had poor performance in the *Getting Care Quickly* category for both adult and child populations. This suggests that members perceive that they do not always receive care in a timely manner.

CalOptima experienced challenges with timely notification of prior authorization denials as indicated by both the medical performance and MRPIU review results. The plan also experienced delays in sending out grievance notification letters.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. CalOptima's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, CalOptima achieved above average performance in providing quality health care services to its MCMC members. The plan demonstrated average performance, however, in providing accessible and timely services.

CalOptima made notable improvements in its performance measures rates in 2010 compared with 2009 rates. The plan was generally compliant with documentation requirements across performance measures, QIPs, and State and federal requirements; however, the plan experienced some challenges with improving actual health outcomes for members for both QIPs.

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

- Conduct periodic, internal, prior-authorization file audits of subcontractors and plan functions to ensure compliance with the DHCS standards.
- Address outstanding medical performance review deficiencies to ensure full compliance with all DHCS contract requirements.
- Incorporate formal monitoring activities to ensure that all revisions made to policies and procedures as a result of CAPs are fully implemented internally and by delegated entities.
- Remain vigilant in maintaining and/or improving performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure.
- Review the 2010 plan-specific CAHPS results report and develop strategies to address the *Customer Service, Getting Care Quickly,* and *Getting Needed Care* priority areas.

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

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
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.	◆ Barrier Analysis conducted for Prenatal Care ◆ Barrier Analysis conducted for Postpartum Care ◆ Newsletter article written and distributed to members on prenatal and postpartum care visits and when these visits need to occur ◆ Postpartum Brochure ("After Your Baby Is Born...Get Your Postpartum Checkup") created and distributed to pregnant women to promote and explain the postpartum visit ◆ Postpartum Poster ("Your Health Is A Gift to Your Baby") created and distributed to OB/GYNs to place in their offices, which highlights the importance of obtaining a timely postpartum visit ◆ Purchased Pregnancy Health Guides for distribution to members (includes information on prenatal/postpartum care) and created a standing "Are You Pregnant?" article in the biannual member newsletter, asking members to notify CalOptima as soon as they discover they are pregnant and to contact CalOptima for a Pregnancy Health Guide
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance toward increasing compliance with the CMS protocol for conducting QIPs.	HSAG QIP Summary Forms used for: ◆ ER Collaborative QIP ◆ Appropriate Treatment for Children With Upper Respiratory Infection (URI) QIP
Increase oversight of the plan's delegated entities by formalizing a process of monitoring within the quality improvement program and work plan.	CalOptima enhanced the quality improvement (QI) program and work plan to include quarterly monitoring of QI activities and delegated functions (formerly annual monitoring). Findings are reported to the Quality Improvement Committee and other Board of Directors-appointed committees. Scope and responsibilities were defined in greater detail in separate delegation agreements (formerly part of provider contracts). CalOptima created automated reporting of delegation reports and metrics via an FTP site.
Address and monitor deficient areas noted in the audits until fully corrected.	CalOptima formalized the corrective action plan process with reporting to the Quality Improvement and Compliance committees. A detailed oversight report for each delegated entity is provided to the committees.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
Incorporate standards for waiting time in the providers' offices, time to answer the telephone, and time to return member telephone calls.	CalOptima maintains standards for accessibility and wait time set forth in CalOptima Policy GG.1600: Access and Availability Standards: ◆ The total wait time for a member to reach a non-recorded voice shall not exceed 10 minutes. ◆ Non-urgent and non-emergency messages during business hours: A practitioner shall return a call within 24 hours after the time of message. ◆ Urgent message during business hours: A practitioner shall return the call within 30 minutes after the time of message. ◆ Emergency message during business hours: A practitioner shall return the call within 5 minutes after the time of message. CalOptima contracted with a vendor to conduct an Access and Availability Study to determine whether CalOptima providers were in compliance with CalOptima Access and Availability Standards.