Performance Evaluation Report

CalOptima

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

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July 1, 2013 – June 30, 2014

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] 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 provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and state-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations,

[1] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, CalOptima (or "the MCP"), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

CalOptima is a full-scope MCP delivering services to its MCMC members as a County Organized Health System (COHS). A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission.

CalOptima became operational to provide MCMC services in Orange County in October 1995. As of June 30, 2014, CalOptima had 613,854 MCMC members in Orange County.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP'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. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-COHS counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

The most recent on-site routine medical survey for CalOptima was conducted April 17, 2012, through April 20, 2012. HSAG included a summary of this review in CalOptima's 2012–13 MCP-specific evaluation report.

Strengths

CalOptima has no outstanding findings from the April 2012 routine medical survey that was conducted by DHCS.

Opportunities for Improvement

Since CalOptima has no outstanding findings from the most recent routine medical survey, HSAG has no recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[4] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[4] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[6] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for CalOptima* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that CalOptima followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the findings is included below.

- CalOptima demonstrated excellent tracking and monitoring of claims and encounter submissions through various quality control reports.
- CalOptima ensured and demonstrated that no members had either the same identification number or multiple identification numbers.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of CalOptima's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 shows the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *CDC–H9 (>9.0 percent)* measure. 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.

The reader should note the following regarding Table 3.1:

- The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
  - All four *Children and Adolescents' Access to Primary Care* measures.
  - *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.
  - *Comprehensive Diabetes Care—LDL-C Control.* (This measure is being eliminated for HEDIS 2015.)
  - *Comprehensive Diabetes Care—LDL-C Screening.* (This measure is being eliminated for HEDIS 2015.)

Table 3.1—Performance Measure Results
CalOptima—Orange County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	16.69%	15.22%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	36.79	36.08	34.90	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	351.89	330.09	271.66	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	90.25%	90.75%	90.55%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	90.38%	93.54%	89.69%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	89.29%	90.65%	89.62%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	21.77%	20.73%	21.81%	20.65%	↔
Cervical Cancer Screening	Q,A	—	—	—	71.63%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	84.52%	81.30%	84.25%	79.40%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	97.67%	97.34%	97.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	92.55%	91.12%	91.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	92.05%	91.64%	92.30%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	90.37%	90.41%	89.07%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	70.37%	73.76%	73.95%	69.30%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	61.66%	69.25%	66.05%	67.91%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.06%	86.45%	82.33%	85.12%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	61.22%	58.71%	56.98%	59.07%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	48.15%	50.75%	40.23%	49.77%	↑
Comprehensive Diabetes Care—LDL-C Screening	Q,A	84.53%	85.59%	80.70%	84.88%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	83.22%	85.38%	83.02%	85.81%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	28.54%	30.97%	37.21%	32.33%	↔
Controlling High Blood Pressure	Q	—	—	64.64%	67.25%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	69.21%	80.86%	84.15%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	48.71%	50.10%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	25.60%	28.33%	↑

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	72.37%	69.38%	63.66%	58.96%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	85.79%	84.82%	**78.42%**	85.07%	↑
Use of Imaging Studies for Low Back Pain	Q	77.18%	79.00%	78.34%	75.25%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	72.35%	76.92%	81.39%	75.68%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	76.30%	81.43%	82.78%	84.19%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	68.15%	71.62%	75.56%	72.64%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	82.52%	82.54%	86.69%	83.94%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[7] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

[7] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care health plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Table 3.2 and Table 3.3, which present a summary of CalOptima's 2014 SPD measure results. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[8] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[8] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.2.

Table 3.2—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalOptima—Orange County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.83%	16.83%	▼	15.22%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.11%	91.90%	↑	90.55%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	90.06%	Not Comparable	89.69%
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.73%	91.16%	↑	89.62%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.54%	85.27%	↓	97.42%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.62%	85.47%	↓	91.43%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.64%	85.84%	↓	92.30%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	89.52%	80.71%	↓	89.07%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	74.77%	50.46%	↓	69.30%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	65.65%	63.89%	↔	67.91%
Comprehensive Diabetes Care—HbA1c Testing	83.88%	86.34%	↔	85.12%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.83%	57.64%	↑	59.07%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.96%	46.53%	↔	49.77%
Comprehensive Diabetes Care—LDL-C Screening	81.07%	86.81%	↑	84.88%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.97%	87.73%	↑	85.81%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.36%	33.33%	▲	32.33%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
CalOptima—Orange County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
226.81	32.50	573.24	51.03

*Member months are a member's "contribution" to the total yearly membership.

Performance Measure Result Findings

No measures had rates below the MPLs, and the rates for the following measures were above the HPLs:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* for the fourth consecutive year
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* for the fourth consecutive year
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for the following measures improved significantly from 2013 to 2014:

- *All-Cause Readmissions*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Medication Management for People with Asthma—Medication Compliance 75% Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, resulting in the rate for the measure moving from below the MPL in 2013 to above the MPL in 2014

The rates for the following measures declined significantly from 2013 to 2014:

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Use of Imaging Studies for Low Back Pain*

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for the following measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

The SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions*
- All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures and HSAG does not provide comparative analysis.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act (PDSA) cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in

monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the Plan-Do-Study-Act cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

Based on HEDIS 2013 rates, CalOptima was required to submit an IP for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure. The MCP identified many barriers to the rate being above the MPL, including:

- Member misunderstanding of health coverage benefits.
- Lack of member access to prenatal appointments due to no appointment availability, lack of transportation, work/school schedule not accommodating an appointment, and lack of child care.
- Members using their primary care physician (PCP) for prenatal services rather than their obstetrician/gynecologist, and the PCP not completing the comprehensive prenatal assessment.
- Member lack of education on the importance of pregnancy health and the availability of pregnancy-related resources.
- Lack of education and/or training of provider office staff to accurately complete Pregnancy Notification Report (PNR) forms and send them to the health network.
- Data discrepancies when tracking/obtaining complete PNRs from provider offices.
- Member refusal of health network and provider services.

To address the barriers, CalOptima implemented several interventions, including:

- Educated provider office staff on consistently submitting complete PNRs.
- Created a step-by-step information sheet for members about pregnancy services covered by Medi-Cal and how to ensure retention of coverage.
- Implemented a tracking system for receipt of PNRs that triggered the MCP providing information to pregnant members about keeping healthy during pregnancy and accessing local pregnancy resources.

In addition to the IP, CalOptima implemented a PDSA cycle focused on increasing the number of PNRs received by educating both providers and health networks on the importance of PNR submission and the PNR process.

CalOptima's efforts resulted in the rate for this measure improving significantly from 2013 to 2014 and moving from below the MPL in 2013 to above the MPL in 2014. The MCP will not be required to continue this IP in 2014. Additionally, since the rates for all measures were above the MPLs in 2014, CalOptima will not be required to submit any new IPs in 2014.

Strengths

CalOptima followed the appropriate specifications to produce valid performance measure rates, and the HSAG auditor identified no concerns. CalOptima had no measures with rates below the MPLs and seven measures with rates above the HPLs. The rates for five measures improved significantly from 2013 to 2014, and the improvement for one of the measures (*Prenatal and Postpartum Care—Timeliness of Prenatal Care*) resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

Opportunities for Improvement

While the rates for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* and *Use of Imaging Studies for Low Back Pain* measures remained above the MPLs, CalOptima has the opportunity to assess the factors leading to the rates for these measures declining significantly from 2013 to 2014 and implement strategies to prevent further decline. Additionally, the MCP has the opportunity to assess the factors leading to the SPD rates for six measures being significantly worse than the non-SPD rates to ensure that the needs of the SPD population are being met.

Conducting the EQRO 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 CMS validation protocol[9] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

HSAG organized, aggregated, and analyzed CalOptima's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[9] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Quality Improvement Project Objectives

CalOptima participated in the statewide collaborative QIP and had two internal QIPs in progress during the review period of July 1, 2013–June 30, 2014.

Table 4.1 below lists CalOptima's QIPs and indicates whether the QIP is clinical or nonclinical and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects for CalOptima
July 1, 2013, through June 30, 2014

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Improvement of Prenatal Visit Rates for Pregnant Members	Clinical	Q, A, T
Improving the Rates of Cervical Cancer Screening	Clinical	Q

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

Upon the initiation of the *Improving the Rates of Cervical Cancer Screening* QIP, CalOptima identified 325 women who had not received the recommended cervical cancer screening, which represented 28.3 percent of the eligible women. Low cervical cancer screening rates are an indicator of reduced preventive services and suboptimal care. Lack of screening may also indicate limited access to primary care physicians. CalOptima's *Improving the Rates of Cervical Cancer Screening* QIP attempted to improve the quality of care delivered to women by implementing both member and provider interventions.

CalOptima's *Improvement of Prenatal Visit Rates for Pregnant Members* QIP focused on improving the care women receive during pregnancy. Being able to maintain regular prenatal care visits throughout a pregnancy may help identify and treat any problems that arise and increase the number of healthy babies being delivered.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
CalOptima—Orange County
July 1, 2013, through June 30, 2014

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				
All-Cause Readmissions	Annual Submission	94%	100%	*Met*
Internal QIPs				
Improvement of Prenatal Visit Rates for Pregnant Members	Study Design Submission	56%	29%	*Not Met*
	Study Design Resubmission 1	100%	100%	*Met*
Improving the Rates of Cervical Cancer Screening	Annual Submission	82%	90%	*Partially Met*

[1] **Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP 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*.

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that CalOptima's annual submission of its *All-Cause Readmissions* QIP achieved an overall *Met* validation status, with 94 percent of the evaluation elements and 100 percent of the critical elements receiving a met score. The *Improvement of Prenatal Visit Rates for Pregnant Members* QIP study design submission received an overall validation status of *Not Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, CalOptima resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score.

CalOptima's annual submission of the *Improving the Rates of Cervical Cancer Screening* QIP received an overall *Partially Met* validation status. DHCS and HSAG had discussions with CalOptima and determined that, due to changes in the HEDIS specifications for the *Cervical Cancer Screening*

measure, the QIP should be closed with no further validation. CalOptima was not responsible for submitting further documentation regarding this QIP.

Table 4.3 summarizes the aggregated validation results for CalOptima's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
CalOptima—Orange County
(Number = 4 QIP Submissions, 3 QIP Topics)
July 1, 2013, through June 30, 2014

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)	75%	25%	0%
	III: Clearly Defined Study Indicator(s)	78%	22%	0%
	IV: Correctly Identified Study Population	75%	25%	0%
	V: Valid Sampling Techniques (if sampling is used)	94%	6%	0%
	VI: Accurate/Complete Data Collection**	86%	5%	10%
Design Total		**88%**	**9%**	**3%**
Implementation	VII: Sufficient Data Analysis and Interpretation	85%	0%	15%
	VIII: Appropriate Improvement Strategies	60%	40%	0%
Implementation Total		**78%**	**11%**	**11%**
Outcomes	IX: Real Improvement Achieved	25%	75%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**75%**	**0%**

*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 stage and/or activity totals may not equal 100 percent due to rounding.

Please note that the aggregated percentages for Activities I through IX in Table 4.3 include the scores from CalOptima's *Improving the Rates of Cervical Cancer Screening* QIP. HSAG provides no details regarding deficiencies noted during the validation process in this report since the MCP was not required to resubmit the QIP to address the deficiencies and the QIP was closed.

HSAG validated Activities I through VIII for CalOptima's *All-Cause Readmissions* annual submission, Activities I through VI for the MCP's *Improvement of Prenatal Visit Rates for Pregnant Members* QIP study design submission, and Activities I through IX for the MCP's *Improving the Rates of Cervical Cancer Screening* annual submission.

CalOptima demonstrated an adequate application of the Design stage, meeting 88 percent of the requirements for all applicable evaluation elements within the study stage. The MCP met 100 percent of the requirements for all applicable evaluation elements within the Design stage for the *All-Cause Readmissions* QIP. For the *Improvement of Prenatal Visit Rates for Pregnant Members* QIP, CalOptima did not provide an accurate study question or study indicator; inaccurately documented the study population; omitted the acceptable margin of error; did not include staff qualifications for collecting manual data or provide a copy of the manual data collection tool; and did not provide the process used to determine the amount of administrative data used, resulting in a lower score for Activities I through VI. The MCP corrected the deficiencies in the resubmission, resulting in the QIP achieving an overall *Met* validation status. The remaining deficiencies attributed to this stage were found in the MCP's documentation in the *Improving the Rates of Cervical Cancer Screening* QIP. Since this QIP was closed prior to achieving a *Met* status, HSAG provides no details regarding deficiencies noted during the validation process.

Both the *All-Cause Readmissions* and the *Improving the Rates of Cervical Cancer Screening* QIPs progressed to the Implementation stage during the reporting period. CalOptima demonstrated an adequate application of the Implementation stage for these QIPs, meeting 78 percent of the requirements for all applicable evaluation elements within the study stage. For the *All-Cause Readmissions* QIP, CalOptima did not indicate if there were any factors that threatened the internal or external validity of the findings, resulting in a lower score for Activity VII. This was the only deficiency in the *All-Cause Readmissions* QIP submission. The remaining deficiencies attributed to this stage were in the MCP's documentation in the *Improving the Rates of Cervical Cancer Screening* QIP. Since this QIP was closed prior to achieving a *Met* status, HSAG provides no details regarding deficiencies noted during the validation process.

Only the *Improving the Rates of Cervical Cancer Screening* QIP progressed to the Outcomes stage during the reporting period. The score for Activity IX was lowered since Study Indicator 1 did not achieve statistically significant improvement over baseline. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved. Note that Study Indicator 2 achieved sustained improvement at Remeasurement 2, so HSAG conducted no additional assessment related to sustained improvement for this indicator at Remeasurement 3.

Quality Improvement Project Outcomes and Interventions

The *Improvement of Prenatal Visit Rates for Pregnant Members* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report.

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for the *All-Cause Readmissions* QIP:

- Implemented a transitional care model program based on Eric Coleman's Care Transitions Intervention Program. Members in the target population are invited to participate in the no-cost program which includes a home visit, follow-up calls, and possible referrals. Members who decline a home visit are offered coaching via telephone.
- Members who decline participation in the transitions of care program are sent a discharge kit that includes a personal health record, medication lists, a medication pillbox, health education material, and resources.

Outcome information for the *All-Cause Readmissions* QIP will be included in CalOptima's 2014–15 MCP-specific evaluation report.

Although the *Improving the Rates of Cervical Cancer Screening* QIP was closed, since the MCP reported outcomes for the QIP, they are included in this report. Table 4.4 summarizes the *Improving the Rates of Cervical Cancer Screening* QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Table 4.4—Quality Improvement Project Outcomes for CalOptima—Orange County
July 1, 2013, through June 30, 2014

QIP #1—Improving the Rates of Cervical Cancer Screening				
Study Indicator 1: Percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer during the measurement year or two years prior.				
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
71.7%	75.5%	72.0%	75.1%	‡
Study Indicator 2: Percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer during the measurement year or two years prior who were assigned to the top 200 high-volume providers.				
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
69.6%	71.0%*	71.1%	71.0%	Yes

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Improving the Rates of Cervical Cancer Screening QIP

CalOptima's objective for the *Improving the Rates of Cervical Cancer Screening* QIP was to exceed the NCQA Medicaid 90th percentile of the applicable year for the HEDIS *Cervical Cancer Screening* measure and to increase by 3 percentage points the year-to-year rate of cervical cancer screenings performed by the top 200 high-volume providers. At Remeasurement 3, the QIP still had not achieved statistically significant improvement over baseline for Study Indicator 1. Study Indicator 2 achieved statistically significant improvement over baseline during the Remeasurement 1 period and sustained the improvement through Remeasurement 3.

Strengths

CalOptima demonstrated an excellent application of the QIP process for the *All-Cause Readmissions* QIP. The MCP met all requirements for all applicable evaluation elements within the Design stage for its *All-Cause Readmissions* QIP and achieved a *Met* validation status for this QIP on the first submission.

For the *Improving the Rates of Cervical Cancer Screening* QIP, CalOptima was successful sustaining the improvement achieved in Remeasurement 1 for Study Indicator 2, maintaining the percentage increase achieved at Remeasurement 1 (of women who received a Pap test from the MCP's top 200 high-volume primary care physicians).

Opportunities for Improvement

CalOptima has the opportunity to ensure that all required documentation is included in the QIP Summary Form since the MCP continued to have several instances of incomplete data. The MCP should reference the QIP Completion Instructions and the feedback in the QIP Validation Tool to ensure that all documentation requirements for each activity have been addressed prior to submission.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the MCPs' medical audit/SPD medical survey reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix C.

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[10]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP 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, DHCS monitors aspects of an MCP'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. DHCS also uses the results

[10] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

CalOptima's quality improvement program description includes details of the MCP's quality program structure and goals and objectives designed to ensure that quality care is provided to members. The MCP's quality improvement program also incorporates continuous quality improvement strategies focused on the specific needs of multiple stakeholders, including members, providers, and community agencies.

The rates for the following quality performance measures were above the HPLs:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* for the fourth consecutive year
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* for the fourth consecutive year
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for the following quality measures improved significantly from 2013 to 2014:

- *All-Cause Readmissions*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Medication Management for People with Asthma—Medication Compliance 75% Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, resulting in the rate for the measure moving from below the MPL in 2013 to above the MPL in 2014

The rate for the *Use of Imaging Studies for Low Back Pain* measure, which falls into the quality domain of care, declined significantly from 2013 to 2014.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and the SPD rates for six of the measures were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to more monitoring of care. The SPD rates were significantly worse than the non-SPD rates for the following quality measures:

- *All-Cause Readmissions*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

All three of CalOptima's QIPs fell into the quality domain of care. Only the *Improving the Rates of Cervical Cancer Screening* QIP progressed to the Outcomes stage. One of the two QIP study indicators achieved statistically significant and sustained improvement, demonstrating that significantly more women in the target population were screened for cervical cancer in the required time frame by the MCP's top 200 high-volume providers.

Overall, CalOptima showed above-average performance related to the quality domain of care.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed CalOptima's available quality improvement information and found that the MCP included goals in its 2014 Quality Improvement Work Plan to improve member access to needed health care services. The CalOptima 2013 Quality Improvement Program Evaluation document describes an accessibility study conducted to look at daytime appointment scheduling and after-hours access at CalOptima provider offices. The MCP uses the study to determine if CalOptima's contracted providers are compliant with the MCP's accessibility standards. The MCP reported that Medi-Cal met 13 of the 20 accessibility standards.

The rates for the following access performance measures were above the HPLs:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for the following access measures improved significantly from 2013 to 2014:

- *All-Cause Readmissions*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, resulting in the rate for the measure moving from below the MPL in 2013 to above the MPL in 2014

The rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure, which falls into the access domain of care, declined significantly from 2013 to 2014.

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and the SPD rates for two of the measures were significantly better than the non-SPD rates. The SPD rates for five measures were significantly worse than the non-SPD rates.

The *All-Cause Readmissions* and *Improvement of Prenatal Visit Rates for Pregnant Members* QIPs fell into the access domain of care. Since neither QIP progressed to the Outcomes stage, HSAG was not able to assess the QIPs' success at improving access to care for the MCP's MCMC members.

Overall, CalOptima showed above-average performance related to the access domain of care.

Timeliness

The timeliness domain of care relates to an MCP'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.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' 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. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

CalOptima's quality improvement program description includes information on activities related to member rights, responsibilities, and protections; grievances; continuity and coordination of care; and utilization management, which all affect the timeliness of care delivered to members.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which falls into the timeliness domain of care, was above the HPL in 2014. The rate for the *Prenatal and*

Postpartum Care—Timeliness of Care measure, which also falls into the timeliness domain of care, improved significantly from 2013 to 2014, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014.

The *Improvement of Prenatal Visit Rates for Pregnant Members* QIP fell into the timeliness domain of care. Since the QIP did not progress to the Outcomes stage, HSAG was not able to assess the QIP's success at improving the timeliness of prenatal care delivered to Medi-Cal members.

Overall, CalOptima showed average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. CalOptima's self-reported responses are included in Appendix D.

Recommendations

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

- While the rates for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* and *Use of Imaging Studies for Low Back Pain* measures remained above the MPLs, CalOptima has the opportunity both to assess the factors leading to the rates for these measures declining significantly from 2013 to 2014 and to implement strategies to prevent further decline.
- Assess the factors leading to the SPD rates for the following measures being significantly worse than the non-SPD rates to ensure that the needs of the SPD population are being met:
  - *All-Cause Readmissions*
  - All four *Children and Adolescents' Access to Primary Care Practitioners* measures
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- Ensure that all required documentation is included in the QIP Summary Form. The MCP should reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission.

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

Table A.1 provides two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table A.1—HEDIS 2014 SPD Trend Table
CalOptima—Orange County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	18.82%	16.83%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	46.80	51.03	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	559.23	573.24	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.78%	91.90%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	93.77%	90.06%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.88%	91.16%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	85.60%	85.27%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.36%	85.47%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.40%	85.84%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	81.99%	80.71%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	70.23%	50.46%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.47%	63.89%	↓
Comprehensive Diabetes Care—HbA1c Testing	85.58%	86.34%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	65.58%	57.64%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.74%	46.53%	↔
Comprehensive Diabetes Care—LDL-C Screening	84.42%	86.81%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.81%	87.73%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	29.53%	33.33%	↔

*Member months are a member's "contribution" to the total yearly membership.

Table B.1 provides two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table B.1—HEDIS 2014 Non-SPD Trend Table
CalOptima—Orange County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.35%	10.83%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	34.15	32.50	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	288.81	226.81	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.58%	86.11%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	91.18%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.39%	83.73%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.45%	97.54%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.29%	91.62%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.03%	92.64%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.99%	89.52%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	75.12%	74.77%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	62.09%	65.65%	↔
Comprehensive Diabetes Care—HbA1c Testing	81.86%	83.88%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.60%	48.83%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.28%	46.96%	↑
Comprehensive Diabetes Care—LDL-C Screening	79.07%	81.07%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.67%	78.97%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	42.33%	41.36%	↔

*Member months are a member's "contribution" to the total yearly membership.

Quality, Access, and Timeliness Scoring Process

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[11] This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1)

Quality Domain

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
   - If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.
3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

[11] The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
   - If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

Validation *(Table 4.2)*: For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.4)*: Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.4)*: Activity X—Achieved Sustained Improvement

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Some, but not all, study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

APPENDIX D. MCP'S SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2012–JUNE 30, 2013 PERFORMANCE EVALUATION REPORT

for CalOptima

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with CalOptima's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table D.1—CalOptima's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to CalOptima	Actions Taken by CalOptima During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Continue to engage in close oversight of the MCP's multiple supplemental data sources to ensure complete and accurate data.	All supplemental files were audited and approved for use. Supplemental files are audited yearly.
2. Assess the factors leading to the rates on the following measures being significantly worse in 2013 when compared to 2012 and identify interventions to be implemented that will result in an improvement on performance.	
a. *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*	2012 rate: 92.55%; 2013 rate: 91.12%—change of 1.43 percentage points—just below the 75th percentile Rate has increased in 2014 to 91.44% and is once again above the 75th percentile. Interventions: • Healthy You (About Your Baby) newsletters are sent to members annually on their birth month to promote well-care visits with their doctor. • Child Health Guide was developed to assist members with self-care treatment options and promote well-care visits with doctors. The health guide will be distributed to new Medi-Cal members during orientation starting fourth quarter of 2014. • Televox reminder telephone calls and mailings for children who may have missed a vaccination at 8 months, 17 months, and 24 to 56 months of age. Outreach to members is conducted on a bi-monthly basis. • The Medi-Cal newsletter is sent to all members annually. Topics include information on how to obtain a member handbook, how to change a health network or PCP, members' standards of care, and more. • Annually update and mail out the child preventive schedule that tells our members when their child needs to go in for a preventive visit.

2012–13 External Quality Review Recommendation Directed to CalOptima	Actions Taken by CalOptima During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
b. *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*	2012 rate: 92.05%; 2013 rate: 91.64%—change of 0.41 percentage point—below the 75th percentile Rate has increased in 2014 to 92.30% and is just below the 75th percentile. Interventions: • Healthy You (About Your Child) newsletters are sent to members annually on their birth month to promote well-care visits with their doctor. • Child Health Guide was developed to assist members with self-care treatment options and promote well-care visits with doctors. The health guide will be distributed to new Medi-Cal members during orientation starting fourth quarter of 2014. • The Medi-Cal newsletter is sent to all annually. Topics include information on how to obtain a member handbook, how to change a health network or PCP, members' standards of care, and more. • Annually update and mail out the child preventive schedule that tells our members when their child needs to go in for a preventive visit.
c. *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*	2012 rate: 30.97%; 2013 rate: 37.21%—change of 6.24 percentage points—below the 75th percentile—**Lower is better.** Rate decreased in 2014 to 32.33%—above the 75th percentile. Interventions: • Article on A1c control in the Medi-Cal annual newsletter. Newsletter is mailed to over 581,000 members.
d. *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*	2012 rate: 50.75%; 2013 rate: 40.23%—change of 10.52 percentage points—below the 75th percentile Rate has increased in 2014 to 49.77% and is above the 90th percentile. Interventions: • Article on LDL control included in the OneCare spring newsletter. Newsletter is mailed to over 15,000 OneCare members.
e. *Prenatal and Postpartum Care—Timeliness of Prenatal Care* **Note:** In addition to the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure declining significantly from 2012 to 2013, the rate for this measure was below the MPL in 2013.	Prenatal 2012 rate: 84.82%; 2013 rate: 78.42%—change of 6.40 percentage point –below the 50th percentile Rate has increased in 2014 to 85.07%—consistent with 2012 rate. Postpartum 2012 rate: 69.38%; 2013 rate: 63.66%—change of 5.72 percentage points –below the 50th percentile The 2014 rate is 58.96% and continues below the 50th percentile, but is not below the MPL.

2012–13 External Quality Review Recommendation Directed to CalOptima	Actions Taken by CalOptima During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	Interventions: • Updated the Pregnancy Notification Reports (PNRs). • Developed a guide for physicians on how to accurately complete a PNR. • Created an e-mail address for physicians to submit the PNR via e-mail to CalOptima (PNRs were previously only submitted via fax). • Conducted provider office education and training on how to submit PNRs accurately and consistently. • Mailed out an information sheet on preconception health that encourages women who are thinking of getting pregnant to see their PCP and seek care. • Continually run a Prenatal Vitamin Report (PVR) to track pregnant members and to follow up with providers who have not submitted a PNR. • Sent prenatal packets that include pregnancy health and resource information to pregnant members.
3. For measures with SPD rates that were significantly worse than the non-SPD rates, assess the factors leading to the rates being significantly worse for the SPD population and identify strategies to ensure that the MCP is meeting this population's needs.	For the SPD/non-SPD comparison of the CDC measure: All submeasures except one were better for the SPD population. The only measure significantly lower for the SPD population was B/P < 140/90. Non-SPD BP 140<90 rate: 75.12%; SPD BP 140<90 rate: 70.23% Both rates are above the 75th percentile.
4. Thoroughly review all feedback from HSAG on the QIP Validation Tools and include all missing information on the subsequently submitted QIP Summary Form. Additionally, as applicable, ensure that inaccurate information is corrected in subsequent submissions.	Cervical Cancer QIP: On August 30, 2013, CalOptima submitted the *Improving the Rates of Cervical Cancer Screening Among Women* QIP. The QIP was reviewed and CalOptima received validation on the QIP for Remeasurement 3 on September 23, 2013. For this validation cycle, the reported QIP results were considered not valid or reliable and CalOptima received a "Partially Met" validation finding. However, a decision was made by DHCS that the QIP closed and the plan should proceed with submitting a new QIP topic proposal to DHCS for approval. Readmissions QIP: On September 30, 2013, CalOptima submitted the *All-Cause Readmissions* QIP. The QIP was reviewed, and CalOptima received validation on the QIP for baseline on October 22, 2013. For this validation cycle, the reported QIP results were considered valid and reliable. Only one element (VII3) received a "Not Met" in this submission. CalOptima will be sure to document if there were factors that threatened the internal and external validity of the findings in future submissions.

2012–13 External Quality Review Recommendation Directed to CalOptima	Actions Taken by CalOptima During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
5. For the *Improving the Rates of Cervical Cancer Screening* QIP, assess the barriers to the rate for Study Indicator 1 showing improvement and modify existing or identify new interventions to address the identified barriers.	Barriers **identified** and prioritized: Interventions implemented were related to the focus barriers identified by the Quality Improvement Work Team. These included lack of provider recommendation for screening, member lack of education, cultural beliefs, linguistic challenges, and fear of screening. The barrier analysis (along with research on reasons why this target population has low rates for cervical cancer screenings) led CalOptima to want to focus efforts on outreaching to Spanish, Vietnamese, and Farsi speaking members. CalOptima analyzed the data further by pulling the rates for Spanish-speaking only, Vietnamese-speaking only, and Farsi-speaking only. The rates were 69.78%, 81.52%, and 73.16%, respectively. These rates for non-English speaking CalOptima members were higher than the overall cervical cancer screening rate of 67.86%. As a result, CalOptima decided not to focus efforts on outreaching to non-English speaking members and selected the following interventions that would likely have a permanent effect on increasing the rate of cervical cancer screening. The member survey results were analyzed for the 381 surveys returned. The top three reasons reported for why women do not get their routine Pap test to screen for cervical cancer were lack of knowledge about the test/importance, scared/afraid, and embarrassed/shy. Revised, standardized, and/or new interventions planned/implemented post-QIP: CalOptima has continued the following interventions during 2013 since the goals for Study Indicators 1 and 2 were not met: • Mailing of cervical cancer screening reminder letter and brochure in August 2013. • Quarterly mailings to the top 200 high-volume providers with female members ages 21 to 64 years of age that include lists of CalOptima members needing cervical cancer screening. In addition to the member lists, updated clinical practice guidelines and provider cervical cancer screening rate and ranking amongst peers were included in the mailings.
6. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Getting Care Quickly, Rating of All Health Care,* and *Rating of Specialist Seen Most Often* priority areas.	*Getting Care Quickly* 2013 rate: 77.1%; MCMC Weighted Avg.: 77.3%— CalOptima score was 0.02% below the MCMC Weighted Avg. *Rating of All Health Care* 2013 rate: 53.4%; MCMC Weighted Avg.: 52.2%—CalOptima score was 1.2% above the MCMC Weighted Avg. *Rating of Specialist Seen Most Often* 2013 rate: 62.6%; MCMC Weighted Avg.: 66.9%—CalOptima score was 4.3% below the MCMC Weighted Avg.

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

2012–13 External Quality Review Recommendation Directed to CalOptima	Actions Taken by CalOptima During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	Interventions: • A provider toolkit was developed and implemented, which included tools and tips on improving office efficiencies; offering same-day appointments, Tips to Manage Patient Flow, and patient agenda- setting tools. • Corrective action plans (CAPs) were issued to health networks (HN) with low CAHPS scores. HNs are implementing different tactics to improve rates. • Tips on how to improve patient experience in the monthly faxblast to PCPs.
7. Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.	The data under consideration are date of service (DOS) July 1, 2010 through June 30, 2011, submitted to DHCS by October 31, 2012; files mirroring CalOptima submissions were created from data in CalOptima's data warehouse and sent to HSAG in February 2013. This was done because CalOptima does not have many of the actual submission records. Not until mid-2010 did CalOptima begin the process of archiving the historical data submissions. The Claim Record Number (CRN) is the unique ID tagging for each record within the State file; however, within the data warehouse CRNs are not added to most of the fee-for-service claims records, just the physician-administered drug and capitated encounter records. Without the actual submission records, CalOptima could not include this in the data to HSAG (except for the physician-administered drug and capitated encounter data). This explains why there are so many missing CRNs as well as why there are several instances of data discrepancies. Because the process to store the DHCS data records has been in place for several years now, CalOptima expects fewer data discrepancies in any future data validation studies. Regarding missing CRNs in the pharmacy data, the current pharmacy benefit manager does send this in the file uploaded to CalOptima's data warehouse. CalOptima did not begin sending national provider identifier (NPI) in billing/rendering provider fields for all claim types until 2011–2012; but CalOptima did send NPI for all records, when available, in the HSAG file. This accounts for several of the provider discrepancies identified. Based on the HSAG report, CalOptima did identify and subsequently address an ongoing reporting issue with referring and admitting provider IDs wherein the NPI had "NP" at the beginning of the field value. Because the field was longer than a standard NPI, DHCS truncated the value reported, resulting in invalid NPIs. This accounted for another provider discrepancy. An ongoing warning message on CalOptima data sent to DHCS/Xerox has been, "RECIPIENT NOT ELIGIBLE FOR MTH OF SVC" or "BENEFICIARY ID AND Client Index Number (CIN) ARE NOT FOUND ON ELIG FILE;" but CalOptima has received eligibility information from

2012–13 External Quality Review Recommendation Directed to CalOptima	Actions Taken by CalOptima During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	DHCS for these members, and the members are showing as eligible in Medi-Cal Eligibility Data System for the dates of service reported on the encounters. DHCS worked with Xerox in April 2014 to investigate the issue and concluded it is an issue with Xerox processing, not a CalOptima data issue. Also, CalOptima sees many cases where the CIN has changed. Together, these help explain the majority of nonmatching records or those that are found in one data set but not the other. CalOptima crosswalks the nonstandard Child Health and Disability Prevention codes ("Cxxxx") to standard CPT/HCPCS codes in the outbound files to DHCS. Unfortunately this instruction was not communicated for the HSAG data extract, so the procedure codes for these services did not match the records at DHCS. The encounter data validation study report has helped CalOptima identify further areas of improvement, beyond process improvements put into place within the last two years. CalOptima takes its contractual obligation to capture and report timely, accurate encounter data very seriously. CalOptima strives to continually improve its processes and data submissions to regulatory agencies (especially with the future transition to 837 and National Council for Prescription Drug Programs formats) and welcomes feedback from DHCS at any time.