Performance Evaluation Report

CalOptima

July 1, 2010–June 30, 2011

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

June 2012

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, CalOptima (or "the plan"), which delivers care in Orange County, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

CalOptima is a full-scope Medi-Cal managed care plan operating in Orange County. CalOptima delivers care to members as a County Organized Health System (COHS).

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

CalOptima began services under the MCMC Program in October 1995. As of June 30, 2011, CalOptima had 378,987 enrolled members under the MCMC Program.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

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

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about CalOptima's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

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

For this report, HSAG reviewed the most current audit reports available as of June 30, 2011, to assess the plans' compliance with State-specified standards. The most recent medical performance review was completed in July 2009 covering the review period of April 1, 2008, through March 31, 2009. HSAG reported findings from this audit in the 2009–2010 plan evaluation report.[3]

The review showed that CalOptima had audit findings in the areas of utilization management, continuity of care, availability and accessibility, member rights, and fraud and abuse. The DHCS *Medical Audit Close-Out Report* letter dated March 24, 2010, noted that the plan had corrected most audit deficiencies; however, two issues remained unresolved in the category of access and availability at the time of the audit close-out report. CalOptima must update policies to reflect payment of non-contracted ER providers at 100 percent of the Medi-Cal rate, and must notify members of claim denials.

In addition to the joint medical audit, the audit covered a review of MCMC Hyde contract requirements. The Hyde contract covers abortion services funded only with State funds, as these services do not qualify for federal funding. The review found that the plan did not include all State Supported Service codes as identified in the contract and no CAP was submitted to address the deficiency.

Medi-Cal Managed Care Member Rights and Program Integrity Review

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

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

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

[3] California Department of Health Care Services. *Performance Evaluation Report, Cal Optima Health Plan – July 1, 2009 through June 30, 2010*. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

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

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

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

Strengths

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

Opportunities for Improvement

While the plan adequately addressed most of the medical performance review deficiencies, CalOptima should implement an internal review process to ensure that corrective action plans are fully implemented and effective, and continue to routinely monitor whether ongoing performance is compliant with contract requirements. The plan should also ensure that when a service is denied, modified, delayed, or terminated; that it sends NOA letters to the member(s) involved. Additionally, CalOptima should take steps to resolve the MCMC Hyde contract deficiency.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about CalOptima's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of CalOptima in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. The audit did not identify any concerns, and the plan was able to report all 2011 rates.

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

Performance Measure Results

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

Table 3.1—HEDIS® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of CalOptima's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan's HEDIS 2011 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the national Medicaid 10th percentile.

Table 3.2—2010–2011 Performance Measure Results for CalOptima—Orange County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	21.8%	21.8%	★★	↔	19.7%	35.9%
AWC	Q,A,T	55.7%	60.1%	★★	↔	38.8%	63.2%
BCS	Q,A	58.0%	63.2%	★★	↑	46.2%	63.8%
CCS	Q,A	71.7%	75.4%	★★	↔	61.0%	78.9%
CDC–BP	Q	72.1%	70.4%	★★	↔	53.5%	73.4%
CDC–E	Q,A	70.1%	61.7%	★★	↓	41.4%	70.1%
CDC–H8 (<8.0%)	Q	62.3%	61.2%	★★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	29.5%	28.5%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	87.3%	86.1%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	45.5%	48.1%	★★★	↔	27.2%	45.5%
CDC–LS	Q,A	85.3%	84.5%	★★★	↔	69.3%	84.0%
CDC–N	Q,A	85.0%	83.2%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	82.4%	84.5%	★★★	↔	63.5%	82.0%
LBP	Q	77.8%	77.2%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	87.5%	85.8%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	68.0%	72.4%	★★	↔	58.7%	74.4%
URI	Q	89.1%	91.1%	★★	↑	82.1%	94.9%
W34	Q,A,T	86.1%	82.5%	★★★	↔	65.9%	82.5%
WCC–BMI	Q	68.3%	72.3%	★★★	↔	13.0%	63.0%
WCC–N	Q	75.2%	76.3%	★★★	↔	34.3%	67.9%
WCC–PA	Q	63.9%	68.1%	★★★	↔	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, CalOptima demonstrated above average performance, achieving the HPLs in eight (38 percent) of the performance measures. There were no measures that fell below the MPLs. Two measures (*Breast Cancer Screening* and *Appropriate Treatment for Children With Upper Respiratory Infection)* both had statistically significant increases in performance.

HEDIS Improvement Plans

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

For plan measure rates that required a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with the plan's 2011 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

Strengths

CalOptima showed strong performance across the HEDIS measure set with eight measures above the HPL and no measures below the MPL. The plan exhibited exceptional performance in most of the diabetes indicators and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, with results that were either above or close to achieving the HPL. The plan attained statistically significant improvement in two measures over the 2010 results, including *Breast Cancer Screening* and *Appropriate Treatment for Children With Upper Respiratory Infection.*

Opportunities for Improvement

CalOptima should closely monitor its performance on the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure. In 2011, this measure's performance showed a statistically significant decline compared to the 2010 results. The plan should also focus on those measures that did not achieve HPLs and determine appropriate steps that should be taken to improve performance in those measures.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

CalOptima had two clinical QIPs and one QIP proposal in progress during the review period of July 1, 2010, through June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP project. CalOptima's second project, a small group collaborative, aimed to increase the appropriate treatment for children with upper respiratory infections (URIs). The third QIP targeted the increase in cervical cancer screening in women aged 21–64 years. All three QIPs fell under the quality domain of care, while the *Reducing Avoidable Emergency Room Visits* QIP also addressed the access domain of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

To increase appropriate treatment for children with upper respiratory infection, the plan's URI QIP targeted providers to reduce the frequency of prescribing antibiotics to treat URIs, which can lead to antibiotic resistance.

Low cervical cancer screening rates are an indicator of reduced preventive services and suboptimal care. The lack of screening may also indicate limited access to PCPs. CalOptima's cervical cancer screening QIP attempted to improve the quality of care delivered to women.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for three QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for CalOptima—Orange County July 1, 2010, through June 30, 2011

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	92%	90%	*Partially Met*
	Resubmission	97%	100%	*Met*
Small-Group Collaborative QIPs				
Appropriate Treatment for Children With Upper Respiratory Infection	Annual Submission	84%	100%	*Met*
Internal QIPs				
Cervical Cancer Screening	Proposal	64%	77%	*Not Met*
	Resubmission	100%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that the initial submission for *Appropriate Treatment for Children With Upper Respiratory Infection* QIP received an overall validation status of *Met.* Conversely, the plan received a *Partially Met* status for its *Reducing Avoidable Emergency Room Visits* QIP and a *Not Met* validation status for its *Cervical Cancer*

Screening QIP proposal. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted the two QIPs and upon subsequent validation, achieved an overall *Met* validation status for both QIPs.

Table 4.2 summarizes the validation results for the three CalOptima QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for CalOptima—Orange County (Number = 3 QIPs, 3 QIP Topics) July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	90%	10%	0%
	IX: Real Improvement Achieved†	50%	38%	13%
	X: Sustained Improvement Achieved	0%	50%	50%
Outcomes Total†		**74%**	**19%**	**6%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.
† The sum of an activity or stage may not equal 100 percent due to rounding.

CalOptima reported at least a second measurement period for its *Reducing Avoidable Emergency Room Visits* QIP and its *Appropriate Treatment for Children With Upper Respiratory Infection* QIP; therefore HSAG assessed these QIPs through Activity X. For the *Cervical Cancer Screening* QIP proposal, only baseline data was reported so the QIP was assessed though Activity VIII.

CalOptima demonstrated an excellent understanding of the design and implementation stages, scoring 100 percent on all applicable evaluation elements for the seven activities. Conversely, for the outcomes stage, CalOptima scored lower in Activity IX for the lack of real improvement since one of the *Appropriate Treatment for Children With Upper Respiratory Infection* QIP study indicators did not demonstrate statistically significant improvement. Additionally, for Activity X, the plan did not achieve sustained improvement for one of the *Appropriate Treatment for Children With Upper*

Respiratory Infection QIP study indicators and for the *Reducing Avoidable Emergency Room Visits* QIP outcome. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

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

Table 4.3—Quality Improvement Project Outcomes for CalOptima—Orange County July 1, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits					
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**		**Sustained Improvement¥**
Percentage of avoidable ER visits	16.1%	16.7%*	16.6%		No
QIP #2—Appropriate Treatment for Children with an Upper Respiratory Infection					
QIP Study Indicator	**Baseline Period 7/1/07–6/30/08**	**Remeasurement 1 7/1/08–6/30/09**	**Remeasurement 2 7/1/09–6/30/10**	**Remeasurement 3 7/1/10–6/30/11**	**Sustained Improvement¥**
1) Percentage of high-volume PCPs serving children not prescribing an antibiotic for a URI for a member who is under 19 years of age	90.0%	95.3%*	89.2%*	‡	No
QIP Study Indicator	**Baseline Period 1/1/06–12/31/06**	**Remeasurement 1 1/1/07–12/31/07**	**Remeasurement 2 1/1/08–12/31/08**	**Remeasurement 3 1/1/09–12/31/09**	**Sustained Improvement¥**
2) Percentage of children between 3 months and 18 years who received appropriate treatment for children with URI	79.7%	83.2%*	84.9%	89.1%*	Yes

Table 4.3—Quality Improvement Project Outcomes for CalOptima—Orange County
July 1, 2010, through June 30, 2011

QIP #3—Cervical Cancer Screening				
QIP Study Indicator	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
1) Percentage of women who received one or more Pap tests during the measurement year or two years prior	71.7%	‡	‡	‡
2) Percentage of women who received one or more Pap tests during the measurement year or two years prior who were assigned to the top 200 high volume providers	69.6%	‡	‡	‡

¥ Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.
*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05).
‡The QIP or study indicator did not progress to this phase during the review period and could not be assessed.

CalOptima reported an improvement in performance for the *Reducing Avoidable Emergency Room Visits* QIP; however, the decrease in the avoidable ER visits was not statistically significant and may have been due to chance. A decrease for this measure reflects an improvement in performance. Although collaborative interventions were initiated in early 2009, they weren't associated with real improvement in the outcome. While the plan demonstrated improvement from Remeasurement 1 to Remeasurement 2, the plan did not demonstrate overall improvement from baseline to Remeasurement 2. The plan will have to maintain the recent improvement in a subsequent measurement period in order to achieve sustained improvement.

To improve appropriate treatment for children with an upper respiratory infection, CalOptima participated as a collaborative partner with the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) and 16 other health plans to develop and disseminate an antibiotic awareness provider tool kit. In addition, CalOptima initiated plan-specific interventions such as mailing providers the names of patients with a URI diagnosis for whom they may have inappropriately prescribed antibiotics. The plan reported a statistically significant decrease in the percentage of high-volume providers not prescribing antibiotics, which reflected a decline in performance. The plan did not achieve sustained improvement from baseline to Remeasurement 2 for this study indicator. Conversely, for the other study indicator, the plan

reported an increase in the percentage of children that were prescribed antibiotics appropriately from Remeasurement 2 to Remeasurement 3. The increase was statistically significant and reflected improved performance. Additionally, for this study indicator, the plan achieved sustained improvement from baseline to Remeasurement 3.

For the *Cervical Cancer Screening* QIP, only baseline data was reported, so HSAG could not assess for real and sustained improvement.

Strengths

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

From the second to the third remeasurement period, the plan demonstrated a statistically significant increase in the percentage of children between 3 months and 18 years of age who received appropriate treatment for a URI for the *Appropriate Treatment for Children with Upper Respiratory Infection* QIP. Additionally, the improvement was sustained from baseline through the third remeasurement period.

Opportunities for Improvement

CalOptima has an opportunity to improve its intervention strategies in order to achieve real and sustained improvement of its QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone. Additionally, HSAG recommends that CalOptima implement a method to evaluate the effectiveness of each intervention. Based on the evaluation results, the plan can make appropriate revisions or implement new interventions, if necessary. If the intervention evaluation demonstrates that an intervention is successful, the plan should clearly document the process and how it was used to monitor and standardize the intervention in the QIP.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

The plan showed average performance based on CalOptima's 2011 performance measure rates (which reflect 2010 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement. The plan attained the HPL on eight measures (all of which impact quality) and showed statistically significant improvement on two.

The plan met contractual standards that relate to quality, based on the medical performance and MRPIU reviews; however, the plan has an opportunity to improve its process for Notice of Action (NOA) letters on prior authorization files. MRPIU found numerous files that were missing NOA letters and this finding required additional action to resolve the deficiency.

QIP results showed the plan displayed an excellent understanding of the design and implementation stages and received *Met* scores for all evaluation elements. Although the plan achieved these scores with the benefit of the *Reducing Avoidable Emergency Room Visits* QIP resubmission and the *Cervical Cancer Screening* resubmission, the scores demonstrated a compliance with the recommendations provided in the QIP tool. From the second to the third remeasurement period, the plan demonstrated a statistically significant increase in the percentage of children between 3 months and 18 years of age who received appropriate treatment for a URI for the

Appropriate Treatment for Children With Upper Respiratory Infection QIP. Additionally, the improvement was sustained from baseline through the third remeasurement period.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated average performance based on a review of 2011 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care.

For access-related compliance standards, the plan experienced challenges with its access and availability-related policies and must make updates to reflect payment of non-contracted ER providers at 100 percent of the Medi-Cal rate. Additionally, the plan must notify members of claim denials. In the MRPIU review, the plan had no deficiencies related to access.

The plan attained the HPL on three measures that impact access and showed statistically significant improvement on one (*Breast Cancer Screening*.)

CalOptima reported an improvement in performance for the Reducing Avoidable Emergency Room Visits QIP, showing that the plan made strides in reducing unnecessary or avoidable access for its members' utilization of emergency rooms.

Timeliness

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

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

CalOptima exhibited average performance in the timeliness domain of care based on 2011 performance measure rates for providing timely care, and medical performance and member rights reviews related to timeliness. Performance measure rates regarding timeliness showed that the plan performed above the HPL for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life,* and *Childhood Immunization Status—Combination 3*.

CalOptima experienced challenges with timely notification Notice of Action (NOA) letters in the MRPIU review results. However, MRPIU noted that this deficiency was corrected.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. CalOptima's self-reported responses are included in Appendix A.

Conclusions and Recommendations

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

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

- Implement an internal review process to ensure that corrective action plans are fully implemented and effective.
- Continue to routinely monitor whether ongoing performance is compliant with contract requirements.
- Take steps to resolve the MCMC Hyde contract deficiency.
- Closely monitor performance on the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure, as this measure's performance showed a statistically significant decline compared with the 2010 results.

- Improve its intervention strategies to order to achieve real and sustained improvement of its QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone.
- Implement a method to evaluate the effectiveness of each intervention. Based on the evaluation results, the plan can make appropriate revisions or implement new interventions, if necessary. If the intervention evaluation demonstrates that an intervention is successful, the plan should clearly document the process and how it was used to monitor and standardize the intervention in the QIP.

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

APPENDIX A. GRID OF PLAN'S FOLLOW-UP ON EQR RECOMMENDATIONS FROM THE JULY 1, 2009–JUNE 30, 2010 PERFORMANCE EVALUATION REPORT

for CalOptima

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with CalOptima's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions that the plan self-reported in the grid.

Table A.1—Grid of CalOptima's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	CalOptima's Self-Reported Actions That Address the EQR Recommendation
Conduct periodic, internal, prior-authorization file audits of subcontractors and plan functions to ensure compliance with the DHCS standards.	◆ Subcontractors are required to submit a monthly log of Notices of Action (NOAs) ◆ CalOptima randomly selects files for review to include Turnaround Time (TAT) and notification appropriate criteria ◆ Anything less than 100% requires a Corrective Action Plan (CAP) ◆ NOA scores are reported to the Compliance Committee quarterly
Address outstanding medical performance review deficiencies to ensure full compliance with all DHCS contract requirements.	◆ CalOptima's oversight process does not exclude National Committee for Quality Assurance (NCQA) certified subcontractors from the annual review process. The only exception is for Credentialing files which allows us to perform desktop policy and procedure reviews.
Incorporate formal monitoring activities to ensure that all revisions made to policies and procedures as a result of CAPs are fully implemented internally and by delegated entities.	Findings of the CAP are incorporated in the policy and procedure review that then becomes a part of a focus review of Delegation Oversight.
Remain vigilant in maintaining and/or improving performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure.	CalOptima participates in The California Medical Association (CMA) Foundation's Alliance Working for Antibiotic Resistance Education (AWARE) Project to promote appropriate antibiotic use. AWARE is a partnership that includes physician organizations; health care providers; health systems; health plans; public health agencies; consumer and community based health organizations; federal, state, and local government representatives, and the pharmaceutical industry. The AWARE project has developed and disseminated over 28,000 AWARE Provider Toolkits to health care providers for this cold and flu season. The toolkit contains an array of clinical resources and patient education materials to help reduce inappropriate antibiotic use. In 2011, CalOptima specifically targeted 149 Health Families Program providers and 363 Medi-Cal providers that prescribed antibiotics inappropriately. The AWARE Project has also partnered with Reckitt Benckiser to distribute cough/cold kits to physician offices. Each kit to be provided to patients contains educational cough and cold materials, a packet of tissues, a "fever strip," and sample cough/cold products. Last year, 5,000 cough/cold kits were available and all supplies were exhausted. This year, 20,000 cough/cold kits have been made available. Physicians and other health care providers are encouraged to utilize these resources to educate patients about appropriate antibiotic use.

Table A.1—Grid of CalOptima's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	CalOptima's Self-Reported Actions That Address the EQR Recommendation
Review the 2010 plan-specific CAHPS results report and develop strategies to address the *Customer Service, Getting Care Quickly,* and *Getting Needed Care* priority areas.	CalOptima's Customer Satisfaction Quality Improvement Work Team has implemented the following interventions: 1. Fax monthly provider/office staff tips on how to improve patient satisfaction. 2. Article in the Provider Newsletter on Shared Decision Making. 3. Promoted the "Ask Me 3" campaign to encourage patients to speak up and ask their PCPs questions at their well-care visits. 4. Implemented a supplemental payment grant for health networks to expand primary care services after hours and urgent care services to our members. 5. Provider incentive to encourage provider offices to implement strategies listed in the California Quality Collaborative's Guide to Improving Patient Experience. 6. Provider incentive to encourage providers to conduct Initial Health Assessments. 7. Conduct member satisfaction survey at point of service. Providers get an incentive for each survey completed by their patient. Train-the-Trainer PowerPoint presentation for the health networks to train their providers on how to improve customer service at the office.