Performance Evaluation Report

CalOptima

July 1, 2011–June 30, 2012

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

June 2013

TABLE OF CONTENTS

1. INTRODUCTION 1
Purpose of Report 1
Plan Overview 2
2. HEALTH PLAN STRUCTURE AND OPERATIONS 3
Conducting the Review 3
Assessing Structure and Operations 3
Medical Performance Review 3
Member Rights and Program Integrity Review 5
Strengths 6
Opportunities for Improvement 6
3. PERFORMANCE MEASURES 7
Conducting the Review 7
Validating Performance Measures and Assessing Results 7
Performance Measure Validation 7
Performance Measure Validation Findings 8
Performance Measure Results 8
Performance Measure Result Findings 11
HEDIS Improvement Plans 11
Strengths 11
Opportunities for Improvement 12
4. QUALITY IMPROVEMENT PROJECTS 13
Conducting the Review 13
Validating Quality Improvement Projects and Assessing Results 13
Quality Improvement Project Objectives 13
Quality Improvement Project Validation Findings 14
Quality Improvement Project Outcomes and Interventions 16
Strengths 18
Opportunities for Improvement 19
5. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS 20
Overall Findings Regarding Health Care Quality, Access, and Timeliness 20
Quality 20
Access 21
Timeliness 21
Follow-Up on Prior Year Recommendations 22
Recommendations 22
APPENDIX A. SCORING PROCESS FOR THE THREE DOMAINS OF CARE A-1
APPENDIX B. GRID OF PLAN'S FOLLOW-UP ON EQR RECOMMENDATIONS FROM THE JULY 1, 2010–JUNE 30, 2011 PERFORMANCE EVALUATION REPORT B-1

Performance Evaluation Report – CalOptima

July 1, 2011 – June 30, 2012

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans 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 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: February 19, 2013.
[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.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS's contracted plan, CalOptima (or "the plan"), which delivers care in Orange County, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, 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, 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 became operational in Orange county to provide MCMC services in October 1995. As of June 30, 2012, CalOptima had 391,643 enrolled Medi-Cal members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from 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. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

For this report, HSAG reviewed the most current audit reports available as of June 30, 2012, to assess CalOptima's compliance with State-specified standards. The most recent medical performance review was completed in May 2009 covering the review period of April 1, 2008, through March 31, 2009. The review included assessment of MCMC Hyde contract requirements, which cover abortion services funded only with State funds, as these services do not qualify for federal funding. HSAG reported findings from this review in CalOptima's 2009–2010 plan-specific evaluation report.[4]

As previously reported, the May 2009 medical performance review showed that CalOptima had findings in the areas of utilization management, continuity of care, availability and accessibility, member's rights, and administrative and organizational capacity. Additionally, the plan was found to be out of compliance with the MCMC Hyde contract requirements.

The DHCS *Medical Audit Close-Out Report* letter dated March 24, 2010, noted that the plan had corrected most audit deficiencies; however, one remained unresolved in the category of availability and accessibility at the time of the audit close-out report.

Below is the unresolved deficiency followed by actions the plan has taken to resolve the deficiency:

Deficiency

CalOptima's policies did not reflect payment of non-contracted emergency room providers at 100 percent of the Medi-Cal rate and that members would be notified of claim denials.

Plan Response:

- The plan submitted a revised policy to DHCS on August 24, 2009, that reflected payment of non-contracted providers at 100 percent of the Medi-Cal rate. The revised policy was submitted with the plan's CAP response.
- The plan reported that it has disputed the finding related to notifying members of claims denials and has not yet received clarification from DHCS and the Department of Managed Health Care (DMHC).

The plan had one outstanding deficiency related to the MCMC Hyde contract requirements:

Deficiency

The plan did not ensure a consistent delegation oversight audit process for sensitive services.

[4] California Department of Health Care Services. *Performance Evaluation Report, CalOptima—July 1, 2009 through June 30, 2010*. September 2011. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

Plan Response:

- CalOptima indicated that the plan submitted a revised policy and audit tool to DHCS on August 24, 2009, to address the Hyde contract deficiency.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

In CalOptima's 2010–11 evaluation report, HSAG reported on the follow-up visit MR/PIU conducted with the plan in April 2010. The visit was a follow-up to the February 2009 review that covered the period of January 1, 2008, through December 31, 2008. MR/PIU found that CalOptima fully addressed three of the four findings from the 2009 review, which were detailed in the plan's 2010–11 evaluation report.

The fourth finding involved missing notice of action (NOA) letters within prior authorization case files. Upon the initial review, four of six files reviewed for one subcontractor were missing NOA letters. During the follow-up visit, MR/PIU found that for the same subcontractor, 4 of 17 files had missing NOA letters and required additional action by the plan to resolve this finding.

Strengths

CalOptima provided documentation of steps it has taken to resolve all deficiencies identified in the plan's most recent medical performance review and resolved all but one of the 2009 MR/PIU review findings during this reporting period.

Opportunities for Improvement

CalOptima should provide documentation of steps the plan has taken to ensure its subcontractors are sending NOA letters to all members as appropriate.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of CalOptima in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

Performance Measure Validation Findings

HSAG's HEDIS Compliance Audit did not identify any concerns, and CalOptima was able to report all 2012 rates. The auditors noted that the plan had excellent processes in place to ensure accurate and complete encounter data, including an internally developed e-tracking tool to monitor and track encounter file submissions from all contracted health networks.

Performance Measure Results

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

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
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*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*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*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
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 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (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.

Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for CalOptima—Orange County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	21.8%	20.7%	★★	↔	18.8%	31.6%
AMB–ED	‡	--	36.8	--	Not Comparable	--	--
AMB–OP	‡	--	351.9	--	Not Comparable	--	--
AWC	Q,A,T	60.1%	67.5%	★★★	↑	39.6%	64.1%
CAP–1224	A	--	97.7%	--	Not Comparable	--	--
CAP–256	A	--	92.5%	--	Not Comparable	--	--
CAP–711	A	--	92.0%	--	Not Comparable	--	--
CAP–1219	A	--	90.4%	--	Not Comparable	--	--
CCS	Q,A	75.4%	72.0%	★★	↔	64.0%	78.7%
CDC–BP	Q	70.4%	73.8%	★★	↔	54.3%	76.0%
CDC–E	Q,A	61.7%	69.2%	★★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	61.2%	58.7%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	28.5%	31.0%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	86.1%	86.5%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	48.1%	50.8%	★★★	↔	27.3%	45.9%
CDC–LS	Q,A	84.5%	85.6%	★★★	↔	70.4%	84.2%
CDC–N	Q,A	83.2%	85.4%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	84.5%	81.3%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	69.2%	--	Not Comparable	--	--
LBP	Q	77.2%	79.0%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	90.3%	--	Not Comparable	--	--
MPM–DIG	Q	--	90.4%	--	Not Comparable	--	--
MPM–DIU	Q	--	89.3%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	85.8%	84.8%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	72.4%	69.4%	★★	↔	59.6%	75.2%
W-34	Q,A,T	82.5%	82.5%	★★	↔	66.1%	82.9%
WCC–BMI	Q	72.3%	76.9%	★★★	↔	19.7%	69.8%
WCC–N	Q	76.3%	81.4%	★★★	↔	39.0%	72.0%
WCC–PA	Q	68.1%	71.6%	★★★	↔	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

CalOptima performed above the HPLs on six of the performance measures, and none of the measures performed below the MPLs. Two measures (*Adolescent Well-Care Visits* and *Comprehensive Diabetes Care—Eye Exam [Retinal] Performed)* had statistically significant increases in performance from 2011. The improvement on the *Adolescent Well-Care Visits* measure resulted in performance improving from average in 2011 to above average in 2012. Three measures that performed above the HPLs in 2011 had average performance in 2012 (*Comprehensive Diabetes Care—Hemoglobin A1c[HbA1c] Control [<8.0 Percent]*, *Childhood Immunization Status—Combination 3*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*). It should be noted that although the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* was the same in 2011 and 2012, the HPL for this measure increased slightly from 2011 to 2012, resulting in this measure performing below the HPL.

HEDIS Improvement Plans

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

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

CalOptima was not required to implement any improvement plans in 2012.

Strengths

CalOptima showed strong performance across the HEDIS measure set with six measures above the HPLs and no measures below the MPLs. The plan exhibited exceptional performance in the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures, with all three measures performing above the HPLs. The plan attained statistically significant improvement on two measures (*Adolescent Well-Care Visits* and *Comprehensive Diabetes Care—Eye Exam [Retinal] Performed*). The improvement in 2012 on the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure is particularly significant since the plan had a statistically significant decrease in performance on this measure from 2010 to 2011.

Opportunities for Improvement

CalOptima may benefit from assessing the factors that led to the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*, *Childhood Immunization Status—Combination 3*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures having a decrease in performance from above average in 2011 to average in 2012 to prevent further decline in performance on these measures. The plan also should assess factors that led to a decline in performance on the *Cervical Cancer Screening* measure since this measure is one of the study indicators for CalOptima's internal quality improvement project (QIP).

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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* 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 plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). 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 Project Objectives

CalOptima had two clinical QIPs and one clinical QIP proposal in progress during the review period of July 1, 2011–June 30, 2012. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the current DHCS statewide collaborative QIP. CalOptima's second project, an internal QIP, aimed to increase the cervical cancer screening rate in women aged 21–64 years. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative which focused on reducing readmissions for members aged 21 years and older. Both statewide collaborative QIPs fell under the quality and access domains of care, while the internal QIP fell under the quality domain of care.

The current statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. At the initiation of the QIP, CalOptima had identified 86,184 ER room visits that were avoidable, which was 16.1 percent of the plan's ER visits. CalOptima's objective was to reduce this rate by using both member and provider improvement strategies. Accessing care in the

primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

The new statewide collaborative proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. 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.

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. At the initiation of the QIP, CalOptima identified 325 women who had not received the recommended cervical cancer screening, which represented 28.3 percent of the eligible women. CalOptima's cervical cancer screening QIP attempted to improve the quality of care delivered to women by implementing both member and provider interventions.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for CalOptima—Orange County July 1, 2011, through June 30, 2012

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	89%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIP				
Improving the Rates of Cervical Cancer Screening	Annual Submission	88%	92%	*Not Met*
	Resubmission	98%	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*.

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that CalOptima's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. The plan received a *Not Met* validation status for its *Improving the Rates of Cervical Cancer Screening* QIP submission. As of July 1, 2009, DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted the QIP and upon subsequent validation, achieved an overall *Met* validation status. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique, one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

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

Table 4.2—Quality Improvement Project Average Rates* for CalOptima—Orange County (Number = 3 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

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	80%	0%	20%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**90%**	**0%**	**10%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved	58%	17%	25%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**85%**	**5%**	**10%**

*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.

CalOptima demonstrated an appropriate application of the design and implementation stages, scoring 100 percent on all applicable evaluation elements for six of the seven activities. In Activity

VI for the *Improving the Rates of Cervical Cancer Screening* QIP, CalOptima's score was lowered since the plan did not initially provide the documentation required for its manual data collection tool.

For the outcomes stage, the plan was scored lower in Activity IX for not achieving statistically significant improvement of its *Reducing Avoidable Emergency Room Visits* QIP outcome and one of its *Improving the Rates of Cervical Cancer Screening* QIP outcomes. Only the *Reducing Avoidable Emergency Room Visits* QIP had at least a second remeasurement period and could be assessed for sustained improvement in Activity X. For this QIP, the plan was unable to achieve sustained improvement from baseline to the third remeasurement period. 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 and Interventions

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, 2011, through June 30, 2012

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**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable^	16.1%	16.7%*	16.6%	18.0%	No
QIP #2—Improving the Rates of 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¥**
Percentage of women who received one or more Pap tests during the measurement year or two years prior	71.7%	75.4%	‡		‡
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%	71.0%*	‡		‡

^A lower percentage indicates better performance.

¥ 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 prior measurement period (p value < 0.05).

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

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, CalOptima set an objective to achieve a year-over-year decrease of five percent for the percentage of ER visits designated as avoidable. For this project outcome, a lower rate demonstrates improved performance. The plan did not meet its overall objective. Additionally, the plan was unable to reduce the percentage of avoidable ER visits by a statistically significant amount between measurement periods. Consequently, without improvement, there was no improvement to sustain. The third remeasurement rate was 1.9 percentage points higher than the baseline rate, demonstrating a decline in performance over the course of the project. An analysis of the plan's improvement strategy identified some weaknesses which may have led to the lack of improvement in outcome.

- The plan discussed its general process to identify barriers and develop interventions; however, the specific results were not documented. The plan did not provide the rationale for how it prioritized barriers. Furthermore, many of the barriers listed were too vague (e.g., "information gaps" and "lack of member awareness.") The plan did not update the barrier analysis information for each measurement period or provide the rationale for continuing interventions that were not associated with outcome improvement.
- CalOptima relied primarily on the collaborative interventions to reduce avoidable ER visits; however, the plan was unable to document success with the interventions. For calendar year 2010, the plan reported that it received 100 percent of the ER visit data from its participating hospitals within five days; however, it did not contact any of these members during the first six months of 2010 and contacted only 49 percent of the members in the last six months of 2010. Additionally, evaluation of this intervention showed that the avoidable ER visit rates were actually higher for the participating hospitals than the non-participating hospitals.
- Plan-specific interventions focused on member and provider education delivered primarily through member and provider newsletters. This non-targeted education did not lend itself to evaluation and was not associated with any improvement in performance.

  Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

Improving the Rates of Cervical Cancer Screening QIP

For the *Improving the Rates of Cervical Cancer Screening* QIP, the plan set the project objective to exceed the NCQA Medicaid 90th percentile of the applicable year for the HEDIS cervical cancer screening outcome and to increase the year-to-year rate of cervical cancer screening for the top 200 high-volume providers by three percentage points. From baseline to the first remeasurement period, the plan did not achieve the project objective for either outcome. The plan was able to achieve statistically significant improvement from baseline to the first remeasurement period for the cervical cancer screening rates for the top 200 high-volume providers; however, the cervical cancer

screening rates for the entire eligible population did not demonstrate statistically significant improvement. A critical analysis of the plan's improvement strategy identified the following:

- The plan conducted brainstorming sessions to identify barriers and develop interventions. Based on the fishbone diagram created in these sessions, the plan implemented provider and member interventions to address the identified barriers. However, the plan did not prioritize the barriers or provide the data-driven rationale for the selection of the interventions.
- CalOptima listed "lack of multilinguistic resources/information" as a barrier linked to seven different interventions, which in turn did not directly address that barrier. Additionally, the plan reported that the non-English-speaking women's cervical cancer screening rates were higher than those for English-speaking women.
- The plan implemented interventions targeted to the top 200 high-volume providers whose cervical cancer screening rates were 80 percent or less. Interventions included a list of the providers' members not receiving Pap tests and a provider incentive for conducting Pap tests. The plan did not provide the specific information regarding the type or monetary value of the incentive.
- CalOptima implemented a member incentive program for cervical cancer screening; however, the plan did not report any details of the incentive; how many members received the incentive; and how many women who had previously not received Pap tests were now being screened after receiving the letter informing them of the incentive. Additionally, while the plan offered continuing medical education (CME) credits to all providers who attended seminars addressing the importance of cervical cancer screening, the plan did not document a method to evaluate the intervention. Similarly, the plan did not describe any process to identify specific providers that could be targeted for more intense one-on-one education due to low performance.

With the implementation of any intervention and especially for multiple interventions, the plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

Strengths

CalOptima accurately documented the QIP process as evidenced by a *Met* validation status for the annual submission of its *Reducing Avoidable ER Visits* QIP.

For the *Improving the Rates of Cervical Cancer Screening* QIP, the plan's improvement strategy included identifying the top 200 high-volume providers and implementing targeted interventions. The plan

was able to significantly increase the percentage of women who received a Pap test from this group of providers.

Opportunities for Improvement

CalOptima should improve the documentation of barrier analyses by providing the supporting results, identifying the targeted population, and documenting the rationale for the prioritization of the barriers.

The interventions implemented should address the high-priority barriers. The plan should document methods to evaluate the effectiveness of each intervention and provide the results of each intervention's evaluation for every measurement period.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

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

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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.

CalOptima demonstrated above-average performance in the quality domain of care. The plan's 2012 Quality Improvement Work Plan and 2012 Quality Improvement Program Description provide documentation of processes the plan has implemented to ensure quality care for MCMC members. The plan performed above the HPLs on six measures (all of which impact quality) and showed statistically significant improvement on two measures. While CalOptima saw a slight decrease on the *Cervical Cancer Screening* measure rate, the plan's QIP improvement strategy of identifying the top 200 high-volume providers and implementing targeted interventions resulted in

a statistically significant increase in the percentage of women who received a Pap test from this group of providers.

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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

CalOptima demonstrated above average performance in the access domain of care. Two of the measures on which the plan performed above average are in the access domain of care, and all other access-related measures demonstrated average performance. The plan received a *Met* score on its *Reducing Avoidable Emergency Room Visits* QIP proposal; however, the QIP did not see sustained improvement at Remeasurement 3.

CalOptima's 2012 Quality Improvement Work Plan and 2012 Quality Improvement Program Description document processes and objectives that show the plan's commitment to ensuring MCMC members have access to health care services. CalOptima's 2011 Quality Improvement Annual Evaluation Medi-Cal report describes the plan's results for surveys related to access and availability. These results show that, overall, CalOptima's MCMC members have access to needed services.

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.

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 demonstrated average performance in the timeliness domain of care. The plan performed above average on one measure within the timeliness domain of care and average on all other measures within the timeliness domain. CalOptima's 2011 Quality Improvement Annual Evaluation Medi-Cal report describes opportunities for improvement related to timeliness standards and the interventions the plan will implement to improve its providers' ability to meet them. CalOptima also has opportunity for improvement in the area of ensuring that the plan's subcontractors are sending NOA letters to all members as appropriate.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. CalOptima's self-reported responses are included in Appendix B.

Recommendations

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

- Provide documentation of the steps CalOptima has taken to ensure its subcontractors are sending NOA letters to all members as appropriate.
- Provide documentation of the QIP barrier analysis, provide the supporting data analysis results, identify the targeted population, and document the rationale for the prioritization of the barriers.
- Document how the QIP interventions address the high-priority barriers and document methods to evaluate the effectiveness of each intervention, as well as the results of the intervention's evaluation for each measurement period.

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

Quality, Access, and Timeliness

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

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

- **Validation** *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.
  - **Above Average** is not applicable.
  - **Average** = *Met* validation status.
  - **Below Average** = *Partially Met* or *Not Met* validation status.
- **Outcomes** *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**
  - **Above Average** = All study indicators demonstrated statistically significant improvement.
  - **Average** = Not all study indicators demonstrated statistically significant improvement.
  - **Below Average** = No study indicators demonstrated statistically significant improvement.

- **Sustained Improvement** *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**
  - **Above Average =** All study indicators achieved sustained improvement.
  - **Average =** Not all study indicators achieved sustained improvement.
  - **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 performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity 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.

Appendix B. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

for CalOptima

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with CalOptima's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table B.1—Grid of CalOptima's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	CalOptima's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Implement an internal review process to ensure that corrective action plans are fully implemented and effective.	CalOptima has implemented an internal review process for corrective action plans. Plans are reviewed by the quality improvement work group and incorporated into QI projects. Interventions developed from corrective actions are monitored and evaluated for effectiveness throughout the QI project.
Continue to routinely monitor whether ongoing performance is compliant with contract requirements.	CalOptima must update policies to reflect payment of non-contracted ER providers at 100% of the Medi-Cal rate and must notify members of claim denials. a. DHCS recommendations were: i. Update Plan policy to reflect payment for non-contracted ER providers at 100% of the Medi-Cal rate. 1. CalOptima submitted revised policy FF.1003 to reflect payment of non-contracted providers at 100% of the Medi-Cal rate with the CAP response to DHCS on 8/24/09. ii. Notify members of claims denials. 1. In its CAP response submitted to DHCS on 8/24/09, CalOptima disputed this finding which DHCS said was based on Health and Safety Code 1367.01 (h) and All Plan Letters 04006 and 05005. Based on this information, CalOptima does not believe it is required to provide members with notices of the claims denials because the denial reasons for the claims reviewed in the audit were not utilization management claims based upon medical necessity determinations. The claims reviewed were claims for which prior authorization is neither permitted by the DHCS Medi-Cal contract nor required or undertaken by CalOptima. The claims denials were based on administrative reasons such as duplicate claims; Medicare is the primary payer, or other health coverage. Therefore, CalOptima was only required to provide notice of the claims denials to the provider submitting the claim (the claimant) which was done. The notice requirements contained in Health and Safety Code section 1367.01(h) are not applicable to claims denials that are unrelated to medical necessity. We asked for additional clarification from DHCS and DMHC which we never received. We respectfully continue to dispute this finding.

Table B.1—Grid of CalOptima's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	CalOptima's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Take steps to resolve the MCMC Hyde contract deficiency.	Take steps to resolve the MCMC Hyde contract deficiency. a. DHCS recommendations were: i. Revise Policy GG. 1508 allowing Health Network members to choose from the Health Network's qualified providers in receiving pregnancy termination services instead of one designated by the health network. Provider designation may be construed as authorization requirement. 1. CalOptima submitted revised policy GG. 1508 to reflect that members can choose from qualified providers (removed "designated" from the current policy). This revised policy was submitted with the CAP response to DHCS on 8/24/09. ii. Ensure consistent performance of delegation oversight audit for sensitive services—a review of Health Net was waived because the entity is NCQA accredited. 1. CalOptima submitted its Medi-Cal Addendum Audit Tool as evidence that all health networks, including NCQA-accredited HMOs will be audited for compliance with the requirements, utilizing this tool. This tool was submitted with the CAP response to DHCS on 8/24/09. iii. We respectfully dispute the comments in the HSAG report that say that CalOptima did not submit a CAP for these findings. We responded timely to the findings as they were communicated to us in the final report from DHCS.
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.	This measure is being monitored in a QI project, as part of disease management, and through monitoring of clinical practice guidelines. To improve adherence to guidelines, this measure was added to CalOptima's Health Network Pay for Performance Program.
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.	CalOptima conducts barrier analysis based on results from each measurement period. In some cases, quarterly analysis is conducted to identify opportunities for improvement more frequently. Targeted and population-based interventions are implemented to achieve improvement.

Table B.1—Grid of CalOptima's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	CalOptima's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
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.	CalOptima uses the QI project process to evaluate the effectiveness of each intervention. Interventions are developed based on identified barriers. After a period of implementation, interventions are evaluated for effectiveness and modified as necessary. Information regarding interventions is documented on the QI project form.