Performance Evaluation Report

CalOptima

July 1, 2012–June 30, 2013

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

April 2014

TABLE OF CONTENTS

Performance Evaluation Report – CalOptima

July 1, 2012 – June 30, 2013

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

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

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

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

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, CalOptima (or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

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

CalOptima became operational to provide MCMC services in Orange County in October 1995. As of June 30, 2013, CalOptima had 453,968 MCMC members in Orange County.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers 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, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's 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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

The most recent on-site Routine Medical Survey for CalOptima was conducted April 17, 2012, through April 20, 2012. DMHC assessed the following areas:

- Quality Management
- Grievances and Appeals

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP 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 the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

- Access and Availability of Services
- Utilization Management
- Continuity of Care
- Access to Emergency Services and Payment
- Prescription (RX) Drug
- Language Assistance

The final report from this survey was issued to the MCP by DMHC on November 19, 2012. The report indicates that DMHC identified one deficiency in the area of Quality Management and one deficiency in the area of Access and Availability of Services. The report also indicates that the MCP fully corrected both deficiencies. Additionally, the report indicates that DMHC found CalOptima's operations to be compliant with the Knox-Keene Act.

In addition to identifying deficiencies as part of the survey process, DMHC analysts offer advice and assistance to MCPs in the form of survey recommendations. MCPs are not required to respond to the recommendations but are strongly encouraged to do so. The following recommendation was made to CalOptima as part of the April 2012 survey process:

- CalOptima should review the MCP's current method for monitoring customer service calls to ensure calls are appropriately processed.

The final report indicates that the MCP responded to the recommendation on October 19, 2012. In its response, CalOptima described the process the MCP will use to ensure all customer service calls are appropriately processed.

Strengths

During the April 2012 Routine Medical Survey, no deficiencies were identified in the areas of Grievances and Appeals, Utilization Management, Continuity of Care, Access to Emergency Services and Payment, Prescription (RX) Drug, and Language Assistance. Additionally, although deficiencies were identified in the areas of Quality Management and Access and Availability of Services, the MCP fully resolved the deficiencies in the required time frame.

Opportunities for Improvement

Since CalOptima resolved both deficiencies identified through the Routine Medical Survey, HSAG does not have any recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for CalOptima* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that CalOptima followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A review of the MCP's HEDIS audit report revealed the following observations:

- The auditor noted that low staff turnover is a strength for CalOptima. Staff members are familiar with the MCP's systems and processes, as well as the MCP's business model and performance results.
- The auditor encouraged CalOptima to continue close oversight of its multiple supplemental data sources.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions* ‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient 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)*
CBP	*Controlling High Blood Pressure*
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*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
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*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 below presents a summary of CalOptima's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 shows the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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 2012 and 2013 Performance Measure Results
CalOptima—Orange County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	20.73%	21.81%	★★	↔	18.98%	33.33%
ACR	Q, A	--	16.69%	--	Not Comparable	--	--
AMB–ED	‡	36.79	36.08	‡	Not Comparable	‡	‡
AMB–OP	‡	351.89	330.09	‡	Not Comparable	‡	‡
CAP–1224	A	97.67%	97.34%	★★	↔	95.56%	98.39%
CAP–256	A	92.55%	91.12%	★★	↓	86.62%	92.63%
CAP–711	A	92.05%	91.64%	★★	↓	87.56%	94.51%
CAP–1219	A	90.37%	90.41%	★★	↔	86.04%	93.01%
CBP	Q	--	64.64%	--	Not Comparable	--	--
CCS	Q,A	72.00%	75.07%	★★	↔	61.81%	78.51%
CDC–BP	Q	73.76%	73.95%	★★	↔	54.48%	75.44%
CDC–E	Q,A	69.25%	66.05%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	58.71%	56.98%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	30.97%	37.21%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	86.45%	82.33%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	50.75%	40.23%	★★	↓	28.47%	46.44%
CDC–LS	Q,A	85.59%	80.70%	★★	↔	70.34%	83.45%
CDC–N	Q,A	85.38%	83.02%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	81.30%	84.25%	★★★	↔	64.72%	82.48%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
CalOptima—Orange County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
IMA–1	Q,A,T	69.21%	80.86%	★★	↑	50.36%	80.91%
LBP	Q	79.00%	78.34%	★★	↔	72.04%	82.04%
MMA–50	Q	--	48.71%	--	Not Comparable	--	--
MMA–75	Q	--	25.60%	--	Not Comparable	--	--
MPM–ACE	Q	90.25%	90.75%	★★	↔	83.72%	91.33%
MPM–DIG	Q	90.38%	93.54%	★★	↔	87.93%	95.56%
MPM–DIU	Q	89.29%	90.65%	★★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	84.82%	78.42%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	69.38%	63.66%	★★	↔	58.70%	74.73%
W-34	Q,A,T	82.54%	86.69%	★★★	↔	65.51%	83.04%
WCC–BMI	Q	76.92%	81.39%	★★★	↔	29.20%	77.13%
WCC–N	Q	81.43%	82.78%	★★★	↔	42.82%	77.61%
WCC–PA	Q	71.62%	75.56%	★★★	↔	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

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

The final selected SPD measures are listed below. Following the list of measures are Tables 3.3 and 3.4, which present a summary of CalOptima's 2013 SPD measure results. Table 3.3 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.4 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*

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

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.3.

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Table 3.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CalOptima—Orange County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	11.35%	18.82%	▼	16.69%
CAP–1224	97.45%	85.60%	↓	97.34%
CAP–256	91.29%	86.36%	↓	91.12%
CAP–711	92.03%	85.40%	↓	91.64%
CAP–1219	90.99%	81.99%	↓	90.41%
CDC–BP	75.12%	70.23%	↔	73.95%
CDC–E	62.09%	70.47%	↑	66.05%
CDC–H8 (<8.0%)	48.60%	65.58%	↑	56.98%
CDC–H9 (>9.0%)	42.33%	29.53%	▲	37.21%
CDC–HT	81.86%	85.58%	↔	82.33%
CDC–LC (<100)	36.28%	46.74%	↑	40.23%
CDC–LS	79.07%	84.42%	↑	80.70%
CDC–N	77.67%	85.81%	↑	83.02%
MPM–ACE	87.58%	91.78%	↑	90.75%
MPM–DIG	91.18%	93.77%	↔	93.54%
MPM–DIU	86.39%	91.88%	↑	90.65%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

Not comparable = A rate comparison could not be made because data were not available for both populations.

Table 3.4—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
CalOptima—Orange County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
288.81	34.15	559.23	46.80

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

Performance Measure Result Findings

The following measures had rates above the HPLs in 2013:

- The three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures
- *Childhood Immunizations Status—Combination 3*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures have been above the HPLs since 2011. The rates for the *Childhood Immunizations Status—Combination 3* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures were above the HPLs in 2009, 2010, and 2011, but not in 2012.

The rate for the *Postpartum Care—Timeliness of Prenatal Care* measure declined significantly from 2012 to 2013, resulting in the rate being below the MPL in 2013. This is the first time since being held to performing above the MPLs on the External Accountability Set measures that CalOptima had a measure with a rate below the MPL.

The rates for the following two measures had statistically significant improvement from 2012 to 2013:

- *Immunizations for Adolescents—Combination 1*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The rates for the following five measures declined significantly from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Seniors and Persons with Disabilities Findings

The following SPD rates were significantly higher than the non-SPD rates:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The SPD rate for the *All-Cause Readmissions* measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population. Additionally, the SPD rates for the four *Children and Adolescents' Access to Primary Care Practitioners* measures were significantly lower than the non-SPD rates, meaning that significantly fewer SPD members in the specified age groups were seen by their primary care practitioners than members in the non-SPD population.

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

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to

improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Since CalOptima did not have any rates below the MPLs in 2012, no IPs were required. The MCP will be required to submit an IP for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure since the rate for this measure was below the MPL in 2013.

Strengths

During the 2013 HEDIS Audit, the auditor noted that low staff turnover is a strength for CalOptima, allowing staff members to become and remain familiar with the MCP's systems and processes, as well as the MCP's business model and performance results.

CalOptima had five measures with rates above the HPLs in 2013, and two measures had rates with statistically significant improvement from 2012 to 2013. The MCP has demonstrated excellent performance on the three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures, which have had rates above the HPLs since 2011.

Opportunities for Improvement

CalOptima has the opportunity to continue its practice of closely overseeing its multiple supplemental data sources to ensure complete and accurate data. Additionally, CalOptima has an opportunity to improve its measures' rates by focusing on the five measures with rates that declined significantly from 2012 to 2013, including the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, which had a rate below the MPL in 2013. By identifying the factors that have caused these measures to either decline in performance or be below the MPL, CalOptima can improve the rates on these measures. Finally, for measures with SPD rates that were significantly worse than the non-SPD rates, CalOptima has the opportunity to assess the factors leading to the rates being significantly worse for the SPD population and identify strategies to ensure that the MCP is meeting this population's needs.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

CalOptima participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

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

Table 4.1—Quality Improvement Projects for CalOptima
July 1, 2012, through June 30, 2013

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Improving the Rates of Cervical Cancer Screening	Clinical	Q

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

Prior to initiation of the statewide collaborative QIP, CalOptima had a 30-day readmission rate of 15.1 percent among Medi-Cal beneficiaries 21 years of age or older. CalOptima also found that the 30-day readmission rate for the SPD population was 17.8 percent, which was higher than the 9.3 percent rate for the non-SPD population.

At the initiation of the *Improving the Rates of Cervical Cancer Screening* QIP, CalOptima identified 325 women who had not received the recommended cervical cancer screening, which represented 28.3 percent of the eligible women. Low cervical cancer screening rates are an indicator of reduced preventive services and suboptimal care. The lack of screening may also indicate limited access to primary care physicians. 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

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

Table 4.2—Quality Improvement Project Validation Activity
CalOptima—Orange County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Improving the Rates of Cervical Cancer Screening	Annual Submission	86%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by CalOptima of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 90 percent of evaluation elements met. CalOptima received a *Met* validation status for its *Improving the Rates of Cervical Cancer Screening* annual submission with 100 percent of critical elements and 86 percent of evaluation elements met.

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

Table 4.3—Quality Improvement Project Average Rates*
CalOptima—Orange County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

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%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	78%	11%	11%
Design Total**		**93%**	**4%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	89%	11%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**92%**	**8%**	**0%**
Outcomes	IX: Real Improvement Achieved	25%	50%	25%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**40%**	**40%**	**20%**

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

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

HSAG validated Activities I through VI for CalOptima's *All-Cause Readmissions* study design submission and Activities I through X for the MCP's *Improving the Rates of Cervical Cancer Screenings* QIP annual submission.

CalOptima demonstrated a strong application of the Design stage, meeting 93 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. In Activity VI for the *All-Cause Readmissions* QIP, CalOptima did not describe the MCP's data analysis plan, which resulted in a lower score on this activity. CalOptima received a lower score on Activity VI for its *Improving the Rates of Cervical Cancer Screening* QIP because the MCP did not provide documentation of what test would be used to determine statistical significance.

Only the *Improving the Rates of Cervical Cancer Screening* QIP progressed to the Implementation and Outcomes stages during the reporting period. The MCP demonstrated a strong application of the Implementation stage, meeting 92 percent of the requirements for all applicable evaluation elements within the study stage. CalOptima did not accurately and consistently report the *p* values

for the QIP, resulting in a lower score for Activity VII. Although Study Indicator 2 demonstrated sustained improvement at Remeasurement 2, since Study Indicator 1 declined in performance at Remeasurement 2 and did not yet achieve statistically significant improvement over baseline, CalOptima received a *Partially Met* score for Activity IX for this QIP. CalOptima received a *Met* score for Activity X since Study Indicator 2 achieved statistically significant improvement over baseline at Remeasurement 1 and sustained that improvement at Remeasurement 2.

Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

The *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information for this QIP is included in this report.

Table 4.4—Quality Improvement Project Outcomes for CalOptima—Orange County July 1, 2012, through June 30, 2013

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

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

* 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.

Improving the Rates of Cervical Cancer Screening QIP

CalOptima's objective for the *Improving the Rates of Cervical Cancer Screening* QIP was to exceed the NCQA Medicaid 90th percentile of the applicable year for the HEDIS *Cervical Cancer Screening* measure and to increase the year-to-year rate of cervical cancer screening for the top 200

high-volume providers by 3 percentage points. From Remeasurement 1 to Remeasurement 2, the MCP did not achieve the project objective for either study indicator. At Remeasurement 2, the rate for Study Indicator 1 decreased, and the rate for this indicator had not yet achieved statistically significant improvement over baseline. Although the Study Indicator 2 rate did not reach the MCP's goal of exceeding NCQA's Medicaid 90th percentile, this study indicator achieved sustained improvement at Remeasurement 2. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- In the previous year's QIP Validation Tool, HSAG recommended that CalOptima indicate in its QIP documentation what statistical test would be used. In the August 2012 submission, CalOptima did not include the information on what test the MCP used to determine the statistical significance reported. Since the MCP did not include the documentation, the score for one of the elements in Activity VI was *Partially Met* instead of *Met*.
- CalOptima conducted data analysis according to the data analysis plan, and the plan included all required elements.
- The MCP calculated the correct *p* values for statistical testing between Remeasurement 1 and Remeasurement 2 for both study indicators; however, the *p* values in the data table in Activity IX did not match the values in the narrative.
- CalOptima completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process. The documentation included system interventions that were likely to have a long-term effect and described problem-solving techniques using data analysis to identify possible causes and solutions.
- The interventions implemented were not successful in improving the rate for Study Indicator 1.

Strengths

CalOptima demonstrated an excellent application of the QIP process for the Design and Implementation stages. The MCP achieved a *Met* validation status without having to resubmit either QIP, indicating proficiency with the QIP validation process. Additionally, when submitting its QIPs in 2012, CalOptima incorporated HSAG's QIP recommendations from the 2011–12 MCP-specific evaluation report regarding conducting a causal/barrier analysis and evaluating each intervention.

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

Opportunities for Improvement

CalOptima has the opportunity to improve the MCP's documentation on the QIP Summary Form by including all information recommended by HSAG as part of the QIP validation process. This includes missing and inaccurate information. For the *Improving the Rates of Cervical Cancer Screening* QIP, CalOptima has the opportunity to assess the barriers to the rate for Study Indicator 1 showing improvement, and modify existing or identify new interventions to address the identified barriers.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

CalOptima's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about CalOptima's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 5.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 5.3 through Table 5.4 present the star ratings for the global ratings and composite measures for CalOptima's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
CalOptima—Orange County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★★	★★	★★★★	★★★
Child	★★★	★★	★★★★	★
+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.				

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care County-Level Composite Measures
CalOptima—Orange County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★★★	★★	★★	★★★★★
Child	★	★	★	★

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Strengths

Overall, CalOptima received the highest ratings for the adult and child global ratings measures, with the *Rating of Personal Doctor* measure receiving a *Very Good* rating for both the adult and child populations and the *Rating of Health Plan* measure receiving a *Good* rating for both populations. Additionally, the *Rating of Specialist Seen Most Often* measure received a *Good* rating for the adult population. In the composite measures, the *Customer Service* measure received an *Excellent* for the adult population and the *Getting Needed Care* measure received a *Good* rating for the adult population.

CalOptima improved its ratings on the following measures from 2010 to 2013:

- *Rating of Health Plan*—adult populations
- *Rating of All Health Care*—adult populations
- *Rating of Personal Doctor*—adult populations
- *Rating of Specialist Seen Most Often*—adult populations
- *Getting Needed Care*—adult populations
- *Getting Care Quickly*—adult populations
- *Customer Service*—adult populations

Opportunities for Improvement

Overall, CalOptima's CAHPS results showed below-average performance for the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as CalOptima's highest priorities: *Getting Care Quickly, Rating of All Health Care,* and *Rating of Specialist Seen Most Often*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 CalOptima CAHPS MCP-Specific Report.* Areas for improvement spanned the quality and timeliness domains of care.

Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

CalOptima's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

Overall, the information provided in CalOptima's Roadmap and supplemental questionnaire consistently demonstrate that the MCP has sound operational policies and practices for the creation, validation, correction, and ongoing monitoring of encounter data submissions. CalOptima has made some improvements to integral systems such as its claims data system and has contracted with a new pharmacy benefit manager (PBM) vendor with extensive quality assurance checks.

Record Completeness

Overall, CalOptima had relatively low record omission and record surplus rates for the long-term care (LTC) claim type, indicating relatively complete LTC data when comparing DHCS's data and the encounter data extracted from CalOptima's data system for this study. However, the Hospital/Inpatient, Medical/Outpatient, and Pharmacy types had relatively incomplete data from the two data sources. The Hospital/Inpatient claim type had a record omission rate of 19.2 percent, which was 9.1 percentage points worse than the statewide rate. The majority of the omitted records for the Hospital/Inpatient claim type were from members whose client identification numbers (*CINs*) were not in DHCS's data or whose *CINs* were in DHCS's data but the dates of service were not in DHCS's data. The record surplus rates for the MCP were poor for the Medical/Outpatient and Pharmacy records, with rates worse than the statewide rate by 8.5 percentage points and 46.5 percentage points, respectively. The majority of the surplus records for

the Medical/Outpatient claim type were from members whose *CINs* were not in the MCP's data or whose *CINs* were in the MCP's data but the dates of service were not. The Pharmacy claim type had a very poor record surplus rate because the MCP's data did not contain the adjustment history, while the DHCS data warehouse contained the full adjustment history.

Data Element Completeness

CalOptima had good data element completeness results, with element omission and element surplus rates of less than 2.5 percent for all of the key data elements except three. The element omission rate of 7.9 percent for the *Referring/Prescribing/Admitting Provider Number* in the Medical/Outpatient claim type was worse than the statewide rate by 6.7 percentage points. The *Rendering Provider Number* in the Medical/Outpatient claim type and the *Secondary Diagnosis Code* in the Hospital/Inpatient claim type had element surplus rates worse than the statewide rates by 9.7 percentage points and 5.8 percentage points, respectively. The remaining rates were all similar to or better than the statewide rates.

Data Element Accuracy

CalOptima had both high and low element accuracy rates across the four claim types, ranging from a high of 100.0 percent to a low of 18.9 percent. The Pharmacy claim type had very good element accuracy with all-element accuracy rates of 99.7 percent or above. For the Medical/Outpatient claim type, five of the data elements had element accuracy rates at or above 98 percent, while the *Billing/Reporting Provider Number, Rendering Provider Number*, and *CPT/HCPCS Codes* had element accuracy rates below 81 percent and below the statewide rates by 16.6 percentage points or more. For the Hospital/Inpatient claim type, five of the data elements had element accuracy rates above 99 percent. However, the *Billing/Reporting Provider Number, Referring/Prescribing/Admitting Provider Number,* and *Provider Type* had element accuracy rates of less than 50 percent and were well below their respective statewide rates by 66.2 percentage points, 44.2 percentage points, and 68.3 percentage points, respectively. The LTC claim types had accuracy rates above 99 percent for three elements and rates below 74 percent for the *Billing/Reporting Provider Number* and *Referring/Prescribing/Admitting Provider Number*. The low accuracy rates were due to a variety of reasons, such as different types of provider numbers (Medi-Cal legacy provider identification numbers versus national provider identifier [NPI]), truncation of provider numbers from 12 characters to 10 characters, different provider type mapping ("16" [Community Hospital Inpatient] versus "15" [Community Hospital Outpatient Departments]), and local procedure codes versus current procedural terminology (CPT) codes ("C008A" versus "85018"), among others.

The Pharmacy claim type had an all-element accuracy rate of 99.7 percent, which was 20.9 percentage points above the statewide rate. However, due to the poor element accuracy rates in

numerous data elements, the all-element accuracy rates for the Medical/Outpatient, Hospital/Inpatient, and LTC claim types fell below their respective statewide rates by 51.7 percentage points, 63.8 percentage points, and 1.4 percentage points, respectively.

Recommendations

Based on its review, HSAG recommends the following:

- For the data CalOptima submitted to HSAG, the *CRNs* were missing for approximately 28 percent of the Medical/Outpatient records, 82 percent of the Hospital/Inpatient records, and nearly 100 percent of the LTC records. All records without *CRNs* were from CalOptima's FFS system. The MCP stated that it started a new process to track the *CRNs* for the FFS claims in the middle of 2010, and that because the process was new, some *CRNs* were missing in the data submitted to HSAG. CalOptima should continue to improve its process so the *CRNs* can be tracked for the FFS claims.
- CalOptima's data system did not contain values for the data element *CRN* in the Pharmacy data because the files the PBM created for CalOptima to load to its data warehouse do not contain this information. CalOptima should request the data element *CRN* to be added, so that it can better monitor the Pharmacy data that its PBM submits to DHCS.
- CalOptima should investigate the relatively poor record omission rate for the Hospital/Inpatient claim type and create strategies for improvement.
- CalOptima should investigate the relatively poor record surplus rates for the Medical/Outpatient and Pharmacy claim types and create strategies for improvement.
- CalOptima should investigate the relatively poor element omission rate for the *Referring/Prescribing/Admitting Provider Number* in the Medical/Outpatient claim type, so that it can improve the element omission rate for this data element in the future.
- CalOptima should investigate the relatively poor element surplus rate for the *Rendering Provider Number* in the Medical/Outpatient claim type and for the *Secondary Diagnosis Code* in the Hospital/Inpatient claim type and create strategies for improvement.
- CalOptima had nine element accuracy rates at or below 85 percent. The MCP should review the inaccuracies, investigate the cause(s), and improve its processes and procedures so that it can improve these accuracy rates in the future.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

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

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

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

CalOptima's 2012 Medi-Cal Quality Improvement Annual Evaluation, 2013 Medi-Cal Quality Improvement Program document, and 2013 Medi-Cal Quality Improvement Work Plan include descriptions of processes and activities the MCP has implemented to ensure quality care for CalOptima's Medi-Cal members. The documents also include descriptions of monitoring processes that reflect a continuous quality improvement process.

The five measures with rates above the HPLs in 2013 all fall into the quality domain of care. These measures were:

- *Childhood Immunizations Status—Combination 3*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

The rates for the three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures have been above the HPLs since 2011, which is the first year the MCPs were held to performing above the MPLs on these measures. CalOptima has a history of performing very well on the *Childhood Immunizations Status—Combination 3* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures, with the rates for these measures also being above the HPLs in 2009, 2010, and 2011.

Two quality measures, *Immunizations for Adolescents—Combination 1* and *Annual Monitoring for Patients on Persistent Medications—Diuretics*, had rates with statistically significant improvement from 2012 to 2013, and the following quality measures had rates that declined significantly from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

The decline in the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* led to the rate on this measure moving from above the MPL in 2012 to below the MPL in 2013. This is the first time the MCP has had a measure with a rate below the MPL.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and eight of these measures had SPD rates that were significantly better than the non-SPD

rates. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. The SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

All CAHPS measures fall into the quality domain of care. Overall, CalOptima had below-average ratings on the measures, suggesting that members are not satisfied with the quality of care they are receiving. Although most measures received below-average ratings, the *Customer Service* measure received an *Excellent* rating for the adult population and the *Rating of Personal Doctor* measure received a *Very Good* rating for both the adult and child populations.

Both of CalOptima's QIPs fall into the quality domain of care. The *All-Cause Readmissions* QIP did not progress to the Outcomes stage, so HSAG was not able to assess this QIP's success at improving the quality of care provided to the MCP's Medi-Cal members. For the *Improving the Rates of Cervical Cancer Screening* QIP, CalOptima was successful at sustaining the improvement achieved in Remeasurement 1 for Study Indicator 2, maintaining the percentage increase achieved at Remeasurement 1 of women who received a Pap test from the MCP's top 200 high-volume primary care physicians.

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

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed CalOptima's 2012 Medi-Cal Quality Improvement Annual Evaluation, 2013 Medi-Cal Quality Improvement Program document, and 2013 Medi-Cal Quality Improvement Work Plan. The MCP includes activities to ensure Medi-Cal members' access to needed services.

CalOptima reports that the MCP routinely conducts studies to assess members' access to services and implements interventions to address barriers to access. Overall, CalOptima reports that the MCP is performing well on access-related goals.

Two measures falling into the access domain of care had rates above the HPLs in 2013:

- *Childhood Immunizations Status—Combination 3*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the access domain of care, improved significantly from 2012 to 2013. The rates for three access measures declined significantly from 2012 to 2013, and the decline for one of the measures, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, moved this measure's rate from being above the MPL in 2012 to below the MPL in 2013.

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and the SPD rates for the following three measures were significantly better than the non-SPD rates:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. Although the SPD rate for the other access-related diabetes measure, *Comprehensive Diabetes Care—HbA1c Testing*, was not significantly better than the non-SPD rate, the SPD rate for this measure was higher than the non-SPD rate by more than 3 percentage points.

The SPD rates for the *All-Cause Readmissions* and four *Children and Adolescents' Access to Primary Care Practitioners* measures were significantly worse than the rates for the non-SPD population. This means that members in the SPD population may not have adequate access to the services needed to prevent readmissions or to primary care practitioners.

The *Getting Needed Care* CAHPS measure falls into the access domain of care. The results show that members are more satisfied with adults' access to services compared to access for children, with the MCP receiving a *Good* rating on this measure for the adult population and a *Poor* rating for the child population.

The *All-Cause Readmissions* QIP falls into the access domain of care. Since this QIP did not progress to the Outcomes stage, HSAG was not able to assess this QIP's success in improving access to care for the MCP's Medi-Cal members.

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

Timeliness

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

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

CalOptima's 2013 Medi-Cal Quality Improvement Program document outlines several processes to ensure the MCP meets or exceeds timeliness standards, including monitoring and improvement activities.

Two measures falling into the timeliness domain of care had rates above the HPLs in 2013:

- *Childhood Immunizations Status—Combination 3*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rate for one timeliness measure, *Immunizations for Adolescents—Combination 1*, improved significantly from 2012 to 2013; however, the rate for another timeliness measure, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, declined significantly from 2012 to 2013, resulting in the rate for this measure being below the MPL in 2013.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. CalOptima performed below average on this measure, receiving a *Fair* rating on this measure for the adult population and a *Poor* rating for the child population. The results suggest that members are not satisfied with the time it takes to receive health care services.

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

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-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 the following to the MCP:

- Continue to engage in close oversight of the MCP's multiple supplemental data sources to ensure complete and accurate data.
- Assess the factors leading to the rates on the following measures being significantly worse in 2013 when compared to 2012 and identify interventions to be implemented that will result in an improvement on performance:
  - *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
  - *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
  - *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

  In addition to the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure declining significantly from 2012 to 2013, the rate for this measure was below the MPL in 2013.
- For measures with SPD rates that were significantly worse than the non-SPD rates, assess the factors leading to the rates being significantly worse for the SPD population and identify strategies to ensure that the MCP is meeting this population's needs.
- Thoroughly review all feedback from HSAG on the QIP Validation Tools and include all missing information on the subsequently submitted QIP Summary Form. Additionally, as applicable, ensure that inaccurate information is corrected in subsequent submissions.
- For the *Improving the Rates of Cervical Cancer Screening* QIP, assess the barriers to the rate for Study Indicator 1 showing improvement and modify existing or identify new interventions to address the identified barriers.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Getting Care Quickly, Rating of All Health Care,* and *Rating of Specialist Seen Most Often* priority areas.

- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

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

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

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.4)

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

Appendix B. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for CalOptima

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with CalOptima's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table B.1—CalOptima's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	CalOptima's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Provide documentation of the steps CalOptima has taken to ensure its subcontractors are sending notice of action (NOA) letters to all members as appropriate.	CalOptima reviews all Health Network (HN) and CalOptima Direct (COD)/ CalOptima Care Network (CCN) NOAs on a monthly basis. CalOptima pulls a sampling of all HN and COD/CCN denial letters from denial logs submitted monthly. CalOptima utilizes the NCQA denial letter audit tool to assure all elements of a NOA are met. Subcontractors must submit CAPs if NOA reviews are out of compliance. If a subcontractor is found out of compliance more than twice, the subcontractor issues are presented to the CalOptima Office of Compliance Committee for recommendation. The Office of Compliance recommendations may vary from a warning, sanction, de-delegation, or termination. All HNs and CalOptima internal staff attend in-services annually on NOA letter writing processes. This year, CalOptima has hosted two Industry Collaboration Effort (ICE) Webinars on denial letter processes/requirements and plain language.
2. 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.	Documentation of QIP barrier analysis, data analysis results, information on targeted populations, and rationales for prioritization of barriers are detailed on pages 22–37 of the attached document, "QIP Summary Form." HSAG Comment: The QIP Summary Form referred to is the one most recently submitted by the MCP as part of the QIP validation process. The information regarding the MCP's overall validation status on this QIP is included in this MCP-specific evaluation report in Section 4: Quality Improvement Projects.
3. 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.	An explanation and documentation of QIP interventions, methods used, and results observed when targeting high-priority barriers are detailed on pages 22–37 of the attached document, "QIP Summary Form." HSAG Comment: The QIP Summary Form referred to is the one most recently submitted by the MCP as part of the QIP validation process. The information regarding the MCP's overall validation status on this QIP is included in this MCP-specific evaluation report in Section 4: Quality Improvement Projects.